MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 7 NOVEMBER 2019 AT 14:00
BLAKENALL VILLAGE, 79 THAMES ROAD, WALSALL, WS3 1LZ

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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	1420
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 3rd October 2019	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	
6.	Chair's Report	Information	Chair	ENC 4	1425
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	1430
SAFE HIGH QUALITY CARE					
8.	BAF Risk S01 - Safe High Quality Care	Discussion	Director of Nursing	ENC 6	
9.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 7	1435
10.	Mortality Report	Information	Medical Director	ENC 8	1445
VALUE COLLEAGUES					
11.	BAF Risk S05 - Valuing Colleagues	Discussion	Director of People & Culture	ENC 9	
12.	Update on Leadership and Talent Management	Information	Director of People & Culture	ENC 10	1455
BREAK – TEA/COFFEE PROVIDED					1505
RESOURCES					

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
13.	BAF Risk S06 - Use of Resources	Discussion	Director of Finance	ENC 11	
14.	Performance Report	Discussion	Director of Finance & Performance	ENC 12	1510
PARTNERS					
15.	BAF Risk S03 - Partners	Discussion	Interim Walsall Together Director	ENC 13	
16.	Walsall Together Update	Information	Interim Walsall Together Director	ENC 14	1530
GOVERNANCE AND COMPLIANCE					
17.	Walsall Undertakings	Information	Director of Governance	ENC 15	1540
18.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	ENC 16	1550
19.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	ENC 17	
20.	People & Organisational Development Committee Highlight Report	Information	Committee Chair	ENC 18	
21.	Walsall Together Partnership Board Highlight Report	Information	Committee Chair	ENC 19	
22.	Audit Committee Highlight Report	Information	Committee Chair	Not received	
23.	**QUESTIONS FROM THE PUBLIC**				
24.	**DATE OF NEXT MEETING** Public meeting on **Thursday 5th December 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 7TH NOVEMBER 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 ☒		

Caring for Walsall together

Register of Directors Interests at October 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.
		Non-Executive Director – Royal Wolverhampton NHS Trust
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).
		Non-Executive Director – Birmingham and Solihull Mental Health Trust.
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd
		Associate Consultant at Provex Solutions Ltd
		Clinical Strategy Lead – Worcester Acute Hospitals NHS Trust.
Ms Pamela Bradbury	Non-executive Director	Chair of Healthwatch Dudley
		Consultant with Health Education England
		People Champion – NHS Leadership Academy
		Partner is an Independent Clinical Lead with Sandwell and West Birmingham Clinical Commissioning Group
Mr B Diamond	Non-executive Director	Partner - Registered nurse and

		General Manager at Gracewell of Sutton Coldfield Care Home. Director of The Aerial Business Ltd
Mrs Sally Rowe	Associate Non-executive Director	Executive Director Children's Services, Walsall MBC
		Trustee – Grandparents Plus, registered charity
Mr P Assinder	Associate Non-executive Director	No Interests to declare.
Mr R Virdee	Associate Non-executive Director	No Interests to declare.
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: October 2019

RECOMMENDATIONS

The Board are asked to note the report

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 3RD OCTOBER 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 B Diamond	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:

Ms S Rowe	Associate Non-Executive Director
Mr R Virdee	Associate Non-Executive Director
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Ms J Wells	Senior Executive PA (Minutes)

Members of the Public 1
Members of Staff 4
Observers 4

093/19 Staff Story

Ms Angela Davies, Deputy Director of Nursing attended the meeting with Mr Aaron Bate, Ward Manager to showcase the improvements made on ward 2 within the last 15 months. The team discussed the improvements made at a team level to benefit the care and experience of patients.

Mr Bate spoke about the changes made, and how these changes were inspired by Tommy Whitelaw, the inspirational keynote speaker at the Trust's nursing strategy conference. Mr Bate spoke about his experience as a Mental Health Nurse and how this influenced some of the changes within nursing care, especially around one to one nursing care, Mr Bate went on to explain how the changes in care and reducing the reliance on one to one care had reduced the number of agency staff required and improved staff morale.

Mr Bate expressed his pride that 21 of the ward staff had

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completed a leadership qualification and therefore had a better understanding of the changes required and also change methodology which has had a massive impact on the cultural shift on the ward.

Ms Davies provided a presentation highlighting the outcomes of the changes on the ward, including;

- Reduction in agency staff had decreased.
- Sickness rates had reduced significantly
- There were no vacancies within the team and there were staff who had requested to work on ward 2.
- Incidents were still being reported
- Further work was required in relation to falls on the ward, however not using agency staff or one to one sitters had not resulted in a higher number of falls.
- The Friends and Family Test results demonstrated that the majority ‘recommended’ the ward.

Ms Oum thanked Ms Davies and Mr Bate for the presentation and expressed appreciation of the scale of the impact which was very impressive. Ms Oum extended her thanks to the teams involved.

Dr Dunderdale also extended her thanks to Mr Bate and the team. Dr Dunderdale praised the leadership programme lead by Ms Davies and added that Ruth May had expressed an interest in visiting one of the intergenerational tea parties that had been introduced on ward 2. Stoke Mandeville Hospital had also visited to review the framework with a view to implementation at their organisation.

Mrs Baines queried the initiatives that could be transferred to other wards. Mr Bates replied that the Tommy Whitelaw visit was insightful and suggested that all levels of staff had the opportunity to attend his seminar.

Mr Virdee referenced the sickness figures and asked how individuals were dealt with. Mr Bate replied that that the sickness management policy was followed though not everyone would engage completely when changes are made.

Mr Dunn found the presentation really inspiring and gave his congratulations to the effort made for improvement.

Ms Oum highlighted the power of really effective inspirational leadership and being part of a team, treating staff fairly and valuing their ideas.

094/19 Apologies for Absence

Ms Oum welcomed new members to the Board

- Mr Diamond, Non-Executive Director,
- Mr Virdee, Associate Non-Executive Director

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- Mr Assinder, Associate Non-Executive Director.

Apologies were received from Mr P Assinder.

095/19 Declarations of Interest and quorum

Ms Oum informed that she had joined the Royal Wolverhampton NHS Trust as a Non-Executive Director.

Mr Gayle updated that he had joined Birmingham and Solihull Mental Health Trust as a Non-Executive Director.

096/19 Minutes of the Board Meeting held in Public on 5th September 2019

Item 076/19 should state Dr Richard Wilson not David Wilson

The minutes were agreed as a true and accurate record with the above amendment.

097/19 Matters Arising and Action Sheet

234/18 Improvement Update – Dr Lewis informed Board members that mental capacity assessments had been discussed on numerous occasions at the Quality, Patient experience and Safety Committee. Dr Lewis informed the Board that the Trust would be moving forward with RESPECT which would be adopted and the mental capacity forms would be revised. The change would also raise the profile of assessing mental capacity and also provide additional training, support and embedded better practice.

Dr Dunderdale informed that there had been an external review of safeguarding training conducted which reviewed documentation and training. In addition, the Trust would be a host provider for a safeguarding programme with a view to including multiagency training. Work was underway with local authorities

027/19 Chief Executive's Report – Mr Beeken updated that a detailed report was reviewed at the Performance, Finance and Investment Committee.

Resolution

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

098/19 Chair's Report

The report was taken as read.

Resolution

The Board received and noted the Chair's report.

099/19 Chief Executive's Report

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

- A Quality Stocktake meeting took place on 24th September

in relation to the Trusts most recent CQC inspection. It was a positive meeting with regulators, the CCG, and Public health.

- The STP long term plan had been drafted and demonstrated how finances were being spent. The first draft which did not require Board scrutiny was submitted to regulators on the 27th September. The next draft would be reviewed at the next Trust Board meeting.

Mr Heer queried the heavy agenda going forward and asked whether the Trust had the capacity and capability to deliver, and if further support was required? Mr Heer went on to ask, when the Board would be sighted on the prioritisation, together with any investments required.

In response Mr Beeken explained that there was a 3 part journey to achieve outstanding: Sweeping our side of the street clean, Walsall Together and collaboration across acute providers in the Black Country. Mr Beeken went on to describe the priorities for years 1, 2 and 3 would be driven by the Improvement programme. Walsall Together was already emerging and the business cases would be progressing through the Governance structure in the coming months. There were emerging priorities with acute collaboration work such as the formation of the Black Country bank and shared services.

Mr Dunn referenced the long term plan and asked whether there would be a narrative and options provided for the next stage, including how they could be applied. Mr Beeken responded that the accountable bodies would be engaged as part of the national planning process but there was tension in the narrative between national standards. Mr Dunn asked how Board members would be informed of progress. Mr Beeken replied that feedback would be supplied at Trust Board on a regular basis.

Ms Oum encouraged shared discussion at Board meetings.

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

100/19 Monthly Nursing and Midwifery Safer Staffing Report

Dr Dunderdale introduced the reinvigorated summary report to provide assurance of safe staffing levels and triangulation of staffing measures. The following key points were highlighted:

- Overall fill rates continued at 92%.
- Chart 3 outlined that temporary staffing had a greater level of control. Various change points and control measures had been introduced.
- Charts 5 and 7 focused on sickness and capacity. There had been an increase in the use of temporary workforce in order to provide support, however there was an improved

trajectory.
- Chart 8 indicated only 1 shift of tier 4 agency had been used. No tier 3 had been utilised at all for over a year.
- Work was underway to build a trajectory to stop agency usage. Early signs of which had been seen as shown in the staff story. The Quality, Patient Experience and Safety Committee and the People and Organisational Development Committee would continue to review.
- Collaborative bank support discussions had been taking place with Ms Griffiths.

Ms Oum observed a discrepancy in the agency staffing underlying run rate and forecast shown in comparison to the report presented at the Performance, Finance and Investment Committee. Mr Dunn replied that there was a debate around the reasoning which related to ward capacity as Ward 14 was open, the Allocate staffing system implementation and an increase of sickness seen throughout August. Mr Dunn encouraged to now focus on looking forward and making predictions for the following year.

Mr Caldicott informed that the temporary staffing trend was reducing overall. The Forecast outturn reflected those positions though the increased capacity opened reflected consequence.

Mr Gayle referenced bank staff and asked about the trajectory going forward. Dr Dunderdale replied that 75% of temporary workforce was filled through bank, and this has increased due to the improvements made to recruit more staff to the internal bank. Dr Dunderdale explained that the next step was to establish a collaborative bank across the Black Country and papers are due to be presented to People and Organisational Development Committee and the Performance, Finance and Investment Committee in November.

Mrs Bradbury advised that a collaborative bank carried opportunity but massive risk. Ms Griffiths informed that the introduction of the Allocate system would open doors and it was anticipated that there would be a 3 month pilot.

Ms Oum thanked Dr Dunderdale for the work being done. Ms Oum suggested that the paper be amended next month, ensuring that the charts were enlarged to make it easier for Board Members to read.

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

101/19 Improvement Update

Mr Beeken introduced the Improvement Update, adding that it was one of the three routes to Outstanding. Mr Beeken explained that the paper presented was a position statement of progress. The update was not a definitive or final list of work streams nor was it

reflective of the prioritisation process. Lots of progress was being made and scoping of work streams is well underway. The Executive Programme Board would complete a review shortly and the PMO skill set would differ as a result.

Mrs Baines expressed confusion with the overlapping programmes, links with Walsall Together and care at home and was not assured that progress was being made as it should. Mr Beeken provided assurance that the programme was moving forward though the anticipated external resource from NHSI to assist Dr Dunderdale did not provide as much support as originally intended.

Mr Dunn thanked Mr Beeken for the update and requested an assurance on the route back to the Board. In response Mr Beeken assured members of the Board that the improvement programme would report in its entirety to the Board, with each workstream aligned to a Committee.

Dr Dunderdale informed that the first Improvement Board was scheduled over the coming weeks which may develop into a Trust Board sub-committee. Dr Dunderdale acknowledged that more speed needed to be injected into the programme. Mr Beeken continued that a regular report would be provided for the Board but the evidence of a wider scope by PMO regarding progress would be then fed through the relevant sub-committee of the Board.

Ms Oum reiterated that the programme was so wide ranging and significant to the future of the Trust that the Board required more assurance than could be provided by the proposed executive committee. Ms Oum advised that further governance work was also required and further discussions needed to take place.

102/19 Winter Plan

Mr Hobbs informed that the winter plan had been reviewed by the Quality, Patient Experience and Safety Committee and the Performance, Finance and Investment Committee who recommended endorsement of the plan.

Mr Hobbs advised that a review of last winter and lessons learnt had formed part of the planning and development of the Winter plan. One of the key areas of learning was the Trusts approach to the festive period; Mr Hobbs explained that during the previous year, bed occupancy rose by 50% which was largely due to fewer discharges in order to address this, a range of interventions will be implemented.

Mr Hobbs informed the Board that an additional £400k of interventions above the plan was required to enact the plan which had been discussed at Performance, Finance and Investment Committee. Mr Hobbs highlighted further risks to the plan

- A number of the interventions relied upon clinical workforce taking on extra shifts and the reliance of the on good will of staff.
- Modelling had been built on the last year as a baseline; however last year did not have extreme norovirus, influenza or extreme weather conditions.

Mr Hobbs concluded that the risks had been mitigated to a satisfactory level.

Mrs Baines cautioned the language and stated that she was unsure of some of the phrasing of the schemes. Mrs Baines also questioned the risk process and the broadness of risks. Mr Hobbs replied that each of the interventions had been suggested by the clinical divisions of the Trust. Risks had been assessed at each level of the organisation and mitigations had been put in place.

Mr Heer asked for further clarity of figures outlined on page 14 of the plan. Mr Hobbs replied that the variance planned for this year was to address the increased attendances and these were based on the predications in line with the STP. Specifics were built in to target the festive period to reduce the risk entering January and to build in some resilience to planning for unforeseen circumstance such as an outbreak or adverse weather.

Resolution
The Board received and approved the winter plan.

103/19 Human Resource and Organisational Development Improvement Update

Ms Griffiths presented an update on the progress against the Human Resources and Organisational Development workstreams which aligned with the Trust Improvement Programme. A number of schemes were underway with a focus on valuing colleagues and changing culture.

Ms Griffiths informed board members that progress would continue to be monitored through the People and Organisational Development Committee, with a focus on staff engagement and making staff feel empowered.

Mr Heer was pleased with the quality of the paper though it did lack pace. Mr Heer added that priorities were included but asked if there were any quick wins.

Ms Griffiths advised that a plan would be reviewed at the People and Organisational Development Committee in November followed by a Board Development session.

Mr Virdee referenced age brackets within the data and queried whether retention was an issue within certain brackets. Mr Virdee reiterated the importance of sustaining skills, experience and

knowledge within the organisation. Ms Griffiths replied that the data was indicative of a national data pack. Ms Oum reflected that the clearly useful data could be utilised to drive the plan.

Mr Fradgley highlighted the crossover between the different organisational cultures and had discussed with Ms Griffiths. Bringing different organisations together and getting the measures right was pivotal.

104/19 Performance Report

Quality, Patient Experience and Safety Committee

Dr Dunderdale highlighted the following key points from the report

- That there continued to be no mixed sex wards.
- The mental capacity act had been discussed at Quality, Patient Experience, and Safety Committee, and the actions to improve compliance would continue to be monitored
- Falls resulting in severe harm was a key focus of the next committee and linked in to the Board Development session held earlier in the day.
- C section rates continued to be monitored, particularly birth to midwife ratio. Discussions were taking place regarding splitting elective and emergency. There had been an increase from 7-14% in elective C-sections and a review was taking place to understand the reasons why.

Ms Oum referred to the ward layout risk and facilities on west wing and asked what was being done to address it. Dr Dunderdale replied that each ward was being scoped regarding the management of the areas and the split of genders.

Mr Gayle queried the progress of VTE. Dr Lewis informed that there was a lot of work going on in order to address the issue. Local projects within teams and the QI Academy were in progress. Dr Lewis was tracking performance himself and fed back to colleagues. Other options had been explored in order to improve the process and accountability. VTE remained a clear priority and was reviewed through the Medical Advisory Committee.

Integration

Mr Fradgley highlighted the following key points from the report

- updated that the Single Point of Access Team had taken over 1000 calls and demonstrated high admission avoidance rates.
- A 4th ACP would join the Raid Response Team at the beginning of October.
- The discharge process for stroke patients would be

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reviewed by the Executive Team followed by a business case proposal.
- Medically fit numbers were starting to see some stabilisation, reducing to around 60-70 down from 100-120. Steps needed to be taken to ensure that numbers did not peak throughout the winter period.

Mr Hobbs endorsed the work of medically fit patients and the flow through the hospital.

Mr Heer asked if there would be a new system wide dashboard.
Mr Fradgley informed that as pathways were being pieced together, system data would become available.

People and Organisational Development Committee

Ms Griffiths highlighted the following key points;
- The Health and Wellbeing Team had been working with local partners such as Samaritans and Pure Gym to offer advice and incentives to staff.
- Training infrastructure continued to be reviewed supporting training completion.
- Sickness absence and retention would be the key focus of the next committee.
- Ms Griffiths reminded colleagues of the upcoming Leadership Conference.

Performance, Finance and Investment Committee

Mr Hobbs reported significant improvement in ED access performance in the second quarter of the year despite the 8.6% rise in attendance. There was enhanced ambulatory care units, ED workforce and access to Radiology for inpatients.

2 week wait on cancer standards failed target as a result of system pressure demand on both cancer and breast referrals. Mr Hobbs advised that steps were being taken to ensure that local patients were not having to wait longer as a result of taking referrals from Wolverhampton.

Diagnostics achieved however RTT was a concern and was currently under scrutiny.

Dr Lewis referenced breast referrals, advising that the Trust had made a conscious decision to support a neighbouring Trust which was the right thing to do for patients. The service would be returning to normal imminently.

Mr Caldicott advised that the Trust had attained a £1.68 deficit to plan at month 4. The deficit position needed to be recovered in the final quarter of the year.

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Indication of the run rate risk stood at £0.5m per month which could result in a £6m over risk which was only partially mitigated.

STP work continued and were reviewing Commissioner positions.

Mrs Baines asked if there was level of confidence in achieving run rate. Mr Caldicott responded that there were escalations in place. The 3 main Divisions all had mitigations in place to deliver their plans. Dr Dunderdale echoed Mr Caldicott's comments, adding that regular Performance Review meetings were taking place.

Mr Dunn cautioned that the risks were very real. There were some productivity shortfalls due to levels of demand and extra money for the winter plan.

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

105/19 Walsall Together Update

Mr Fradgley presented the update and highlighted the following key points:

- PCN Clinical Directors had been approached requesting engagement and had received a response confirming their intentions. Named leads for all locality areas and coordinating GPs were in the process of confirmation.
- System challenges and constraints had been identified and consisted of significant pressure on operational leader services and the number of work steams commencement at the same time.
- Programme plans had been updated with latest updates against key work streams.
- The bid for £2.8m for family safeguarding had been confirmed and would bring the community children's and adults teams together. £150k would be received for the one public sector estate and £50k for the mobilisation project. Ms Rowe confirmed the Trust would receive shares of the money however no national press had yet been released. Only 15 health authorities had been selected. Social Workers were being recruited which was a huge step forward.

Ms Oum thanked Mr Fradgley and Ms Rowe for the update and the good news regarding the bid which would assist with moving to the next stage.

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

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106/19 Health and Safety Policy

Ms Davies introduced the policy for approval. The policy had been considered and supported by the People and Organisational Development Committee and the Quality, Patient Experience and Safety Committee.

Ms Davies asked members to note a commitment to support health and well-being.

The Health and Safety Policy was supported and approved.

Resolution:

The Board:

- **Received and noted the content of the report.**
- **Approved the Health and Safety Policy**

107/19 Risk Management Strategy

Ms Davies presented the Risk Management Strategy which had been reviewed at the Quality, Patient Experience and Safety Committee but asked members to note that the governance around risk management was changing. The Strategy would drive the culture of risk management focus on training and development of staff.

Mr Beeken highlighted a paragraph of commitment on page 10 which was not explicitly reflected and asked for a commitment to resolve this quickly. **Ms Davies**

The strategy was approved subject to an amendment to page 10

Resolution:

The Board

- **Received and noted the content of the report.**
- **Approved the Risk Management Strategy with an amendment to page 10.**

108/19 EPRR Submission

Mr Hobbs presented the paper to be taken as read, noting that the paper would have progressed through the Performance, Finance and Investment Committee but due to timing, approval was sought at Trust Board. The Board was asked to approve as partially compliant against core standards which was in line with the previous year, though there had been some improvements.

Mr Dunn asked whether the Trust was clear of all outstanding audits in that area. Mr Hobbs informed that there had been recent external input and did not believe there were outstanding audits against EPRR compliance.

Mr Dunn suggested that a revised action tracker was reviewed at the Audit Committee the following week. Mr Hobbs replied that there were no actions for EPRR.

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Mr Heer asked whether Brexit preparation was included within EPRR. Mr Hobbs informed that it was a self-assessment against all core standards. Though it was not specific, Brexit preparation would be incorporated. The Trust were using the national guidelines and framework. Mr Hobbs added that the primary preparation of risk for Brexit was the procurement supply chain and plans were in place.

The EPRR Submission was approved.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Approved the EPRR Submission.**

109/19 Quality, Patient Experience and Safety Committee Highlight Report

The report was taken as read.

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

110/19 Performance, Finance and Investment Committee Highlight Report

The report was taken as read.

Resolution
The Board received and noted the content of the report

111/19 People and Organisational Development Committee Highlight Report

The report was taken as read.

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

112/19 Integrated Care Partnership Committee Highlight Report

The report was taken as read.

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

113/19 Questions from the Public

A member of the public raised the following question:
Based on the general knowledge at the moment, in conjunction of the expansion plans of A&E, when will car park D be closed?
Mr Caldicott replied that it would likely be March or April next year. The Trust were looking at other areas where car parking could be utilised with a clear plan for disabled people.

The member of the public queried where deliveries to the door of to the League of Friends Shop would be possible following the

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closure of car park D. Mr Caldicott advised that he believed there was an access road around the rear.
Ms Oum observed a commitment to have a conversation with the project director to ensure a satisfactory resolve.

114/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 7th November 2019 at 2:00p.m. at Blakenall Village.

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: October 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
234/18		Improvement Update	Dr Lewis to review the underlying evidence in relation to mental capacity act. Feedback to be reviewed at the Quality, Patient Experience and Safety Committee.	Medical Director/QPES	04/09/2019	This was presented to QPES in November	Complete
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	Inlcuded within the update on the private Board agenda	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	the Trust are still awaiting for the outcome of the Ann Casey review	Delayed
072/19	06/09/19	Patient Story	Dr Dunderdale would review why the patient's splint was removed and the lack of training in relation to self-injections. Fundamentals of care to be reviewed at QPES.	Director of Nursing	07/11/2019	Update to be provided at the meeting	Open
079/19	06/09/19	Nursing & Safer Staffing Report	A review of hard and soft measures of performance to take place at the People and Organisational Development Committee.	Director of Nursing/Director of People & Culture	07/11/2019	Further work is required and has been deferred until December	Open
103/19	03/10/19	HR/OD Improvement Update	Ms Griffiths to present a plan for review at the People and Organisational Development Committee in November followed by a Board Development session.	Director of Culture & People	05/12/2019	An update paper was provided. Board Development session planned for Febuary	Open

Complete
Open
Delayed (1 meeting)

Action log

Updated from Trust Board Meeting: October 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
Overdue (14+ days)							

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th November 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	This is a regular paper providing oversight of Chair and Non-Executive Director (NED) activities relating to the Well-Led framework. The paper includes details of key activities undertaken since the last Board meeting including NED development and resourcing; governance developments; service visits and NED visibility; and external meetings with partners and other stakeholders.		
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 ☒		

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Chair's Update

PRIORITY OBJECTIVES FOR 2019/20

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

We all share the aim for Walsall to be truly 'Baby Friendly' and I was delighted to attend and speak at an engagement event for implementing Baby Friendly Sustainability within the Trust. Our vision is that our Baby Friendly journey to full accreditation and beyond will be easier when these standards are embraced and embedded, resulting in more consistent practice and leading to sustainable care for all babies, their mothers and families

2. Improve our financial health through our robust improvement programme

I participated in a Financial Cabinet meeting, which was formed with Board Colleagues to test out ideas and approaches in relation to the delivery of financial improvement for this year and planning for next year.

Also this month I attended the NHS Providers Conference which focused on: better planning, shift to prevention, intolerable pressure on staff is unsustainable, concrete and comprehensive plans to deliver the 10 LTP outcomes and realism of NHS offer.

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

I was delighted to have been invited to open this year's leadership conference which was a great opportunity to bring together our clinical and operational leaders and take stock of the current position of the Trust, share priorities for our future and develop the leadership culture that we need to support our journey towards Outstanding. We were joined at the event by Chris Hopson the Chief Executive of NHS Providers who updated us on the national picture

I led a session with attendees of the Leadership & Management Development Programme for Matrons, Ward Managers and Clinical Directors to give an insight into the role of the Chair and Trust Board. The session focused upon leadership, talent management and workforce development.

Along with the Chief Executive and Director of People & Culture, I attended an Inclusion Going Beyond the Conversation event which was designed to support Trusts in better supporting equality, diversity and inclusion across the West Midlands.

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

I have recently joined the Board of Royal Wolverhampton Hospital as a Non- Executive Director, and I have attended my first board meeting. Through my role with both organisations it gives me the opportunity to see the benefits of closer working to improve the services offered to both Walsall and Wolverhampton Patients.

5. **Meetings/Events**

I visited the RTT team and spent some time talking to staff around improvements and challenges. I was impressed with some of the work being undertaken and have invited them to attend and provide an overview to colleagues at a future Trust Board.

Along with the Chief Executive, I met with colleagues from Healthwatch for a quarterly update meeting.

RECOMMENDATIONS

The Board are asked to note the content of the report

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MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th November 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 I have been engaged in during the past month, set against the organisation's strategic objectives. This month, I focus on the onset of winter pressures, the regulatory ask of us regarding our financial plan for 2020/21, the key themes from my speech at our annual leadership conference and also reflect on the issues arising from my chairmanship of two new regional executive boards. The report also sets out to the Board, the significant level of guidance, instruction and best practice adoption we received during May 2019 and assures the Board through an allocation of the actions required, to the relevant executive director.		
Recommendation	Members of the Trust Board are asked to: Note the report and discuss the content		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report outlines the activities undertaken by the Chief Executive Officer aligned to each of the organisation's strategic objectives. This report provides assurance around the mitigation of a number of our strategic risks and also provides context in which the Board can triangulate information.		
Resource implications	There are resource implications associated with our management of winter pressures, captured within our winter plan budget signed off by the Board in October. There are resourcing implications associated with our considerations both as a Board and a wider BCWB STP, of the "control total" expectations of us in 2020/21 financial year.		
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 I have been engaged in during the past month, set against the organisation's strategic objectives.

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

2. BACKGROUND

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

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

3. DETAILS

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

At the time of writing this report, winter pressures, both in Walsall and across the wider Black Country, seem to have arrived. On Monday 21/10, we saw our third busiest day on record in the ED and the associated patient flow pressures were experienced. All our winter plan extra capacity and resilience was deployed and I was delighted with how quickly we bounced back and shut off some of that capacity, by the Wednesday following. Nevertheless, the pressures seen in other, local Trusts did seem relatively worse and the resilience and coherence of our winter plan, commended again at the BCWB Urgent Care Board on 18/10, will stand us in good stead for what will be a very challenging period.

3.2 Valuing our colleagues

On 24/10 we will be holding our leadership conference as a Trust. Over 250 leaders from all levels in the organisation, will be attending. The theme of the event is "Values based leadership". In my opening address, I will be covering the following, important messages in this space:

- Reaffirmation of our vision, objectives, values and organisational ambition
- Describing what "outstanding" looks like against each strategic objective
- That as a Trust, we are no longer an island, if we ever were
- Focusing on our offer to our leaders (reducing frustrating bureaucracy, appraisal driven professional development, leadership development, investing for the future in improved safety and improved financial efficiency)
- Focusing on what we need as a Board from our leaders (taking responsibility and being accountable, developing their Care Groups and Divisions as mini-Trust Boards in their own right, everyone working to the maximum of their leadership ability and scope in role, role modelling our values)

By the time we meet as a Board on 7/11, we will have had chance to reflect and discuss the leadership conference, feeding back on its successes and outcomes.

3.3 Partners

The executive team have had a productive executive to executive session with colleagues from Walsall CCG. As we are now working much more at both "place" and "system" level, it is paramount that we ensure there is consensus and no dispute around the key elements of joint work in Walsall. At the latest meeting we discussed:

- Safeguarding staffing and statutory responsibilities
- Walsall Together plans and investment assumptions
- Delivery assumptions for 2020/21 set against the commitments of the Long Term Plan
- An "open book" approach to managing our financial pressures together so that as a minimum, the Walsall pound balances and does not deviate from our plans

The insistence of NHSE/I allocating control total expectations to each constituent, sovereign organisation this year as opposed to a control total by place or even system, is in some ways unfortunate. However, the CCG and ourselves have committed to sharing plans and amending those plans together, to ensure there are

no disputes within Walsall. The Board will be considering our control total offer in this context and what we know of other “place” based financial expectations, so as to be able to respond to NHSE/I by the deadline of 15/11/19.

As shared in my last Board report, I have taken on the chair role for both the West Midlands Neonatal Network Board and the BCWB Urgent & Emergency Care Board. In their own way, each provided a fascinating insight into the new paradigm of networking and mutual accountability, in which we are all expected to work:

- Clinical network funding has been cut over the last few years of national public sector funding austerity and yet the need for them to be effective and manage themselves as groups of providers, has never been greater. In neonatal services, the quality standards we have to attain are nationally set out in the neonatal critical care review document and there is significant variation across the region. A network improvement plan with regular and intensive performance management of that plan is required, yet the management resources to enable us to do that are few and funding/hosting arrangements for the small network team uncertain
- The BCWB UEC Board covered agenda items such as mutual assurance on winter planning resilience, standardisation of best practice and delivery of Long Term Plan priorities in urgent care. The plan we will adopt across the system will ensure more balance between the current bias of the plan towards the commissioning of NHS 111 and 999 response services and acute hospital/community service response to this hugely important agenda

3.3 RECOMMENDATIONS

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

Richard Beeken
Chief Executive
23/10/19

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	**Reducing single-use plastics in the NHS** All NHS organisations are now being asked to remove single-use plastics from their catering services and reduce NHS waste by over 100 million plastic items by 2021.	**Action** **PFIC Committee**	**Chief Operating Officer**
1.2	**Updated information around continuity of medicines supply if there is a no-deal EU exit** Information for patients regarding the continuity of medicines supply if there is a no-deal EU exit has been updated.	**Action** **Quality, Patient Experience & Safety Committee**	**Medical Director**
1.3	**Business intelligence overseas visitor dashboard** A new business intelligence (BI) dashboard has been created. It provides the data required to correctly complete the Overseas Visitors Debtors position in the monthly provider finance return. Trusts to integrate the dashboard with existing BI reporting.	**Action** **PFIC Committee**	**Director of Finance**
1.4	**Patient level costing collections for 2019/20 — mental health** Mental health service cost data for 2019/20 will be collected at a patient level in 2020 (except for community NHS providers). Trusts are asked to ensure that costing systems are compliant with the minimum software requirements and the costing processes follow the healthcare costing standards. Submission of patient level costing data and compliance with the standards is a requirement of the provider licence.	**Action** **PFIC Committee**	**Director of Finance**

BAF Risk- S01
Risk Owner; Director of Nursing
Date of Review; 22nd October 2019

Strategic Objective; **Safe, High Quality Care** – through the development of an integrated improvement programme to ensure sustainable change	**Risk Appetite;** The Trust is committed to delivering high quality services provided to patients and we will seek to implement a **low appetite** for taking risks that will compromise quality, patient safety or affect the experience of our service users	Initial Risk Rating 4 (L) x 5 (I) =20, Major Current Risk Rating 3 (L) x 4 (I) = 12, Moderate Target Risk Rating 3 (L) x 3 (I) = 9, low
Risk; Failure to improve fundamental standards of care impacts on the Quality of Patient Care, Experience and may result in harm to Patients	**Rationale for current score** • Ward review process in place and is demonstrating improvements, as well as supporting areas where performance is deteriorating • Action plan developed to respond to the latest CQC report. • Compliance with regulatory standards • Meeting national quality standards/bench marks • Improvement in mortality processes	**Future risks** • Capacity and Capability to implement new Liberty Protection Safeguards • Impact of Brexit on care delivery
Controls / Assurance • Robust Governance and quality standards managed and monitored through the governance structures of the organisation, performance reviews and the CCG/CQC • Professional Forums established by the Clinical Executive • Workforce programmes established for Medical and Nursing staff • Nurse establishment review process in place • Improved CQC report including ‘outstanding’ for caring.	**Gaps in controls / assurance** • NHSi Infection control visit identified improvements required within the organisation. • VTE performance continues to be below the Trust Target • Deterioration in the Trusts complaints response performance •	**Future Opportunities** • Improvement Programme • New Patient Safety Framework

MEETING OF THE PUBLIC TRUST BOARD - 7th November 2019			
Monthly Nurse Staffing Report – September 2019 Data			**AGENDA ITEM: 9**
Report Author and Job Title:	Angie Davies Deputy Director of Nursing	**Responsible Director:**	Dr Karen Dunderdale Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This Paper provides the Board with assurance of the Trusts performance against the national safer staffing guidance The RN fill rate average for September overall was 91.32% which splits in to the following day and night average: • 88.07% for day shifts • 95.74% for night shifts To date there has been no correlation between incidents and staffing levels. The total temporary staffing usage is showing an improving position of reduced usage with a reducing amount of variability. A number of process actions have been strengthened to ensure grip and control remains around request of temporary staffing.		
Recommendation	The Board is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 1; Failure to deliver high quality and safe care 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 ☒		

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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.

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

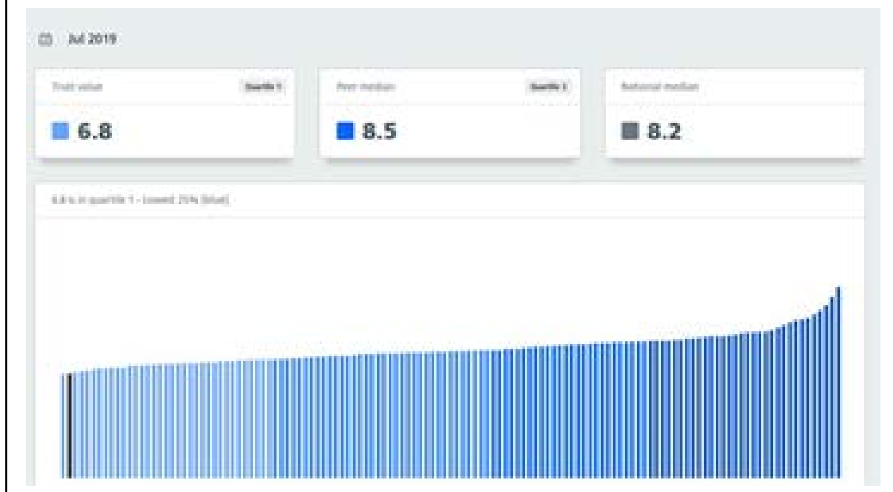
1.1 RN Fill Rate

The RN fill rate average for September overall was 91.32% which splits in to the following day and night average:

- 88.07% for day shifts
- 95.74% for night shifts

To date there has been no correlation between incidents and staffing levels.

1.2 Care Hours Per Patient Day (CHPPD)



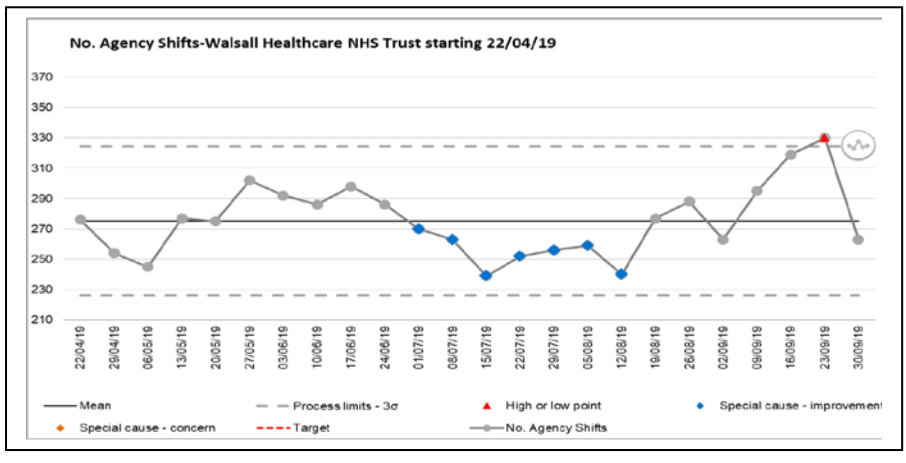
The CHPPD data shows that WHT is consistently within the lowest quartile (black line). The process for data collection is still being reviewed to strengthen the governance around this, the new Erostering system will support this. NHSi have recently renewed the templates to now include Nurse Associates and Trainee Nurse Associates and the Trust has now started to submit data in this new format from September 2019.

Value colleagues

2.1 Total Temporary Staffing Use

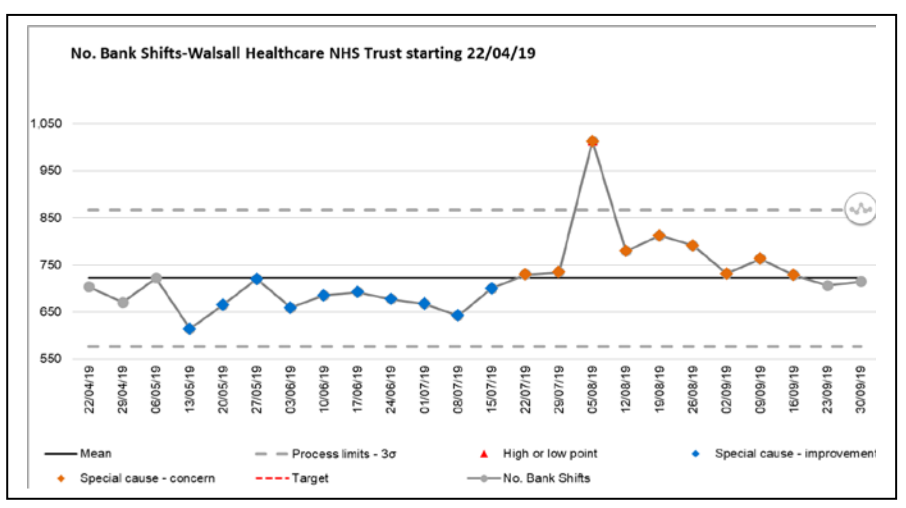
Since October 2018 a number of key changes have been embedded leading to a reduction in the use of agency nurses and an increase in the use of bank nurses.

Chart 1



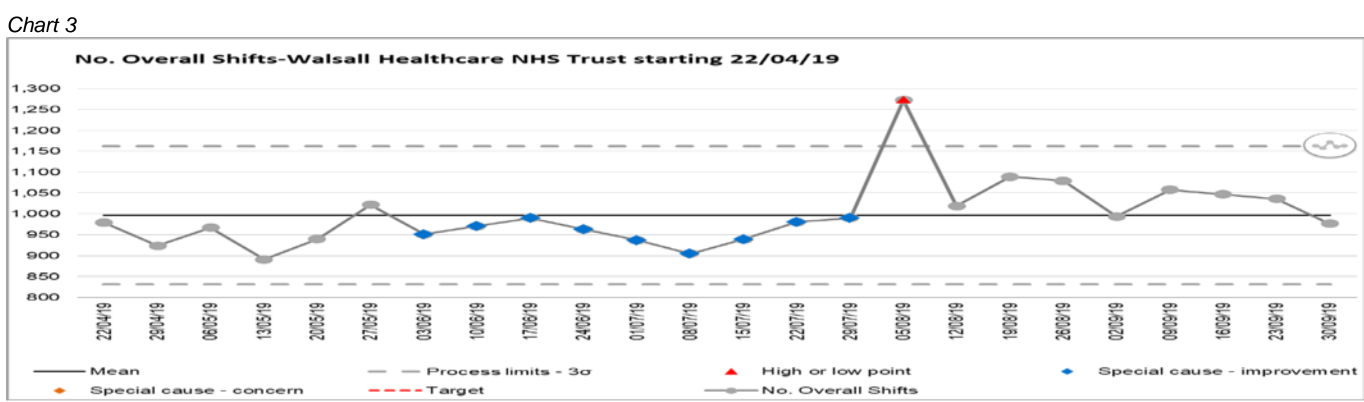
The number of temporary staffing shifts booked within September shows an increase due to additional capacity beds opening with a reducing use over month as beds closed

Chart 2



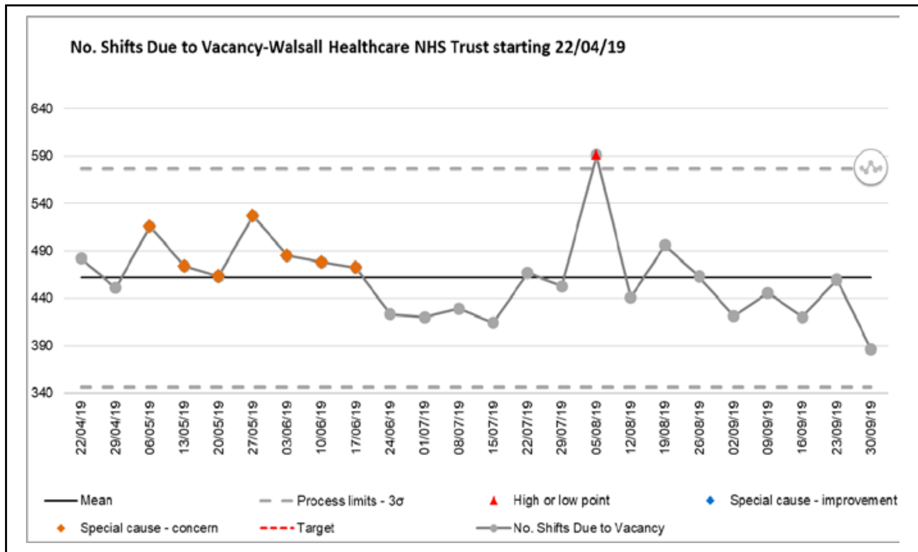
The number of Bank shifts booked within September is below target, work is ongoing to achieve target use. This includes a pilot of like for like payments for band 6 &7 for bank shifts.

Chart 3

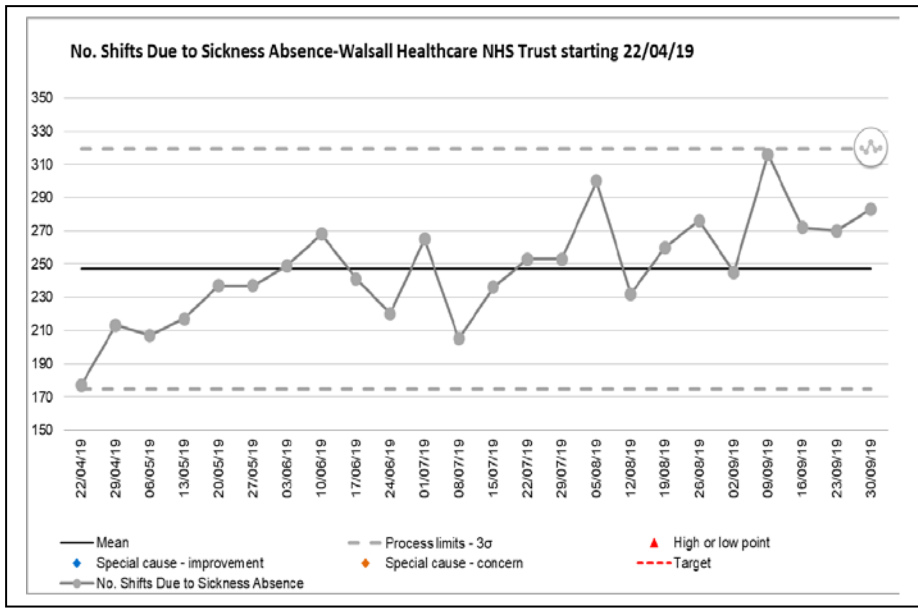


Booking Reasons

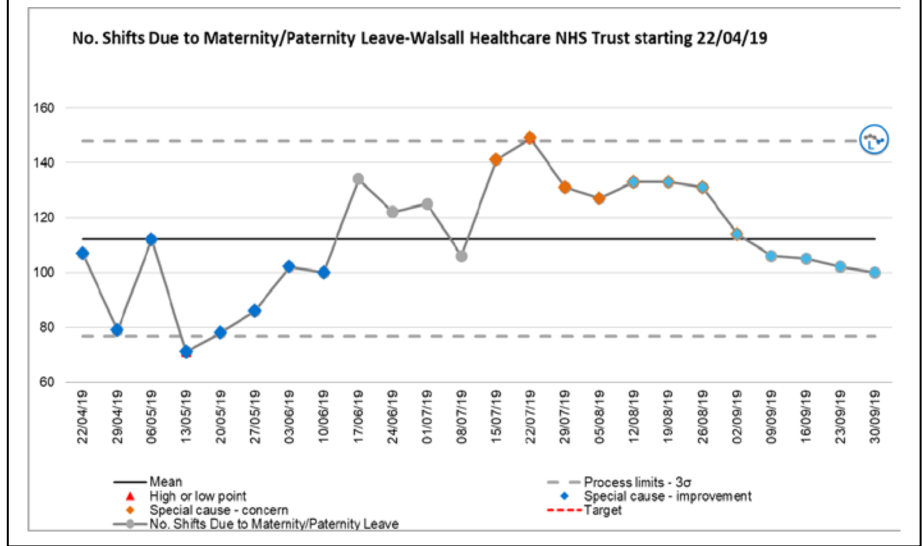
The top four reasons for Agency staff use within this financial year, which include unfunded capacity are shown below:



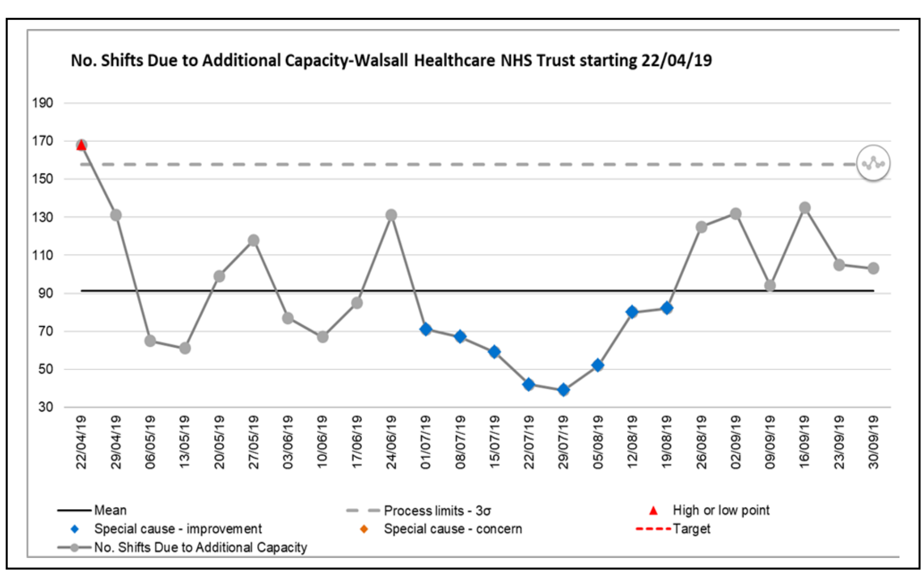
Overall the booking reason of vacancy is reducing across the Divisions and can be correlated to the reducing vacancy rate, so although there is no cause for concern, ongoing effort to maintain control to show sustained improvement.



The shifts booked for the reason of sickness are cross referenced with the individual member of staff who are off sick to ensure the bookings reflect the actual need to cover staff sickness.



Shift bookings for maternity leave are cross referenced with the staff names for those on Maternity/Paternity leave. The Trust does not have an allocated headroom allowance for Maternity leave.



Additional capacity use fluctuated during September. Areas opened with short notice for extra capacity contributed to an elevation in Agency use. Some temporary workforce use was mitigated though moving substantive staff to ensure cover for extra capacity areas.

5.0 RECOMMENDATIONS

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

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.

MEETING OF THE PUBLIC TRUST BOARD - 7th November 2019			
Hospital Mortality			**AGENDA ITEM: 10**
Report Author and Job Title:	Mrs J Adams Business Manager to the Medical Directorate	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	• HSMR for the first three months of 2019/20 has been reported as 117.17, 107.28 and 109.73 respectively with a year to date of 111.62. • SHMI for the first two months of 2019/20 has been reported as 96 and 98 and currently 97 year to date. • Alerts have identified potential concerns for Acute and unspecified renal failure, Respiratory failure, Fracture neck of femur and Pneumonia which have prompted further actions. • Extensive advice and support has been sought to improve the processes and reporting of mortality in the trust. A broad paper outlining the actions has been submitted to QPES. • The Medical Examiner process aligning to the Learning from Death Strategy is expected to start in December 2019.		
Recommendations	Members of the Committee are asked to note: • Performance data • Key areas for attention • Future actions and developments		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register • Systems and processes for the identification and learning from issues in care have been identified as ineffective by the CCG		
Resource implications	N/A		
Legal and Equality and Diversity implications	The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. National legislation relating to the review of child and perinatal deaths is being implemented.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Introduction

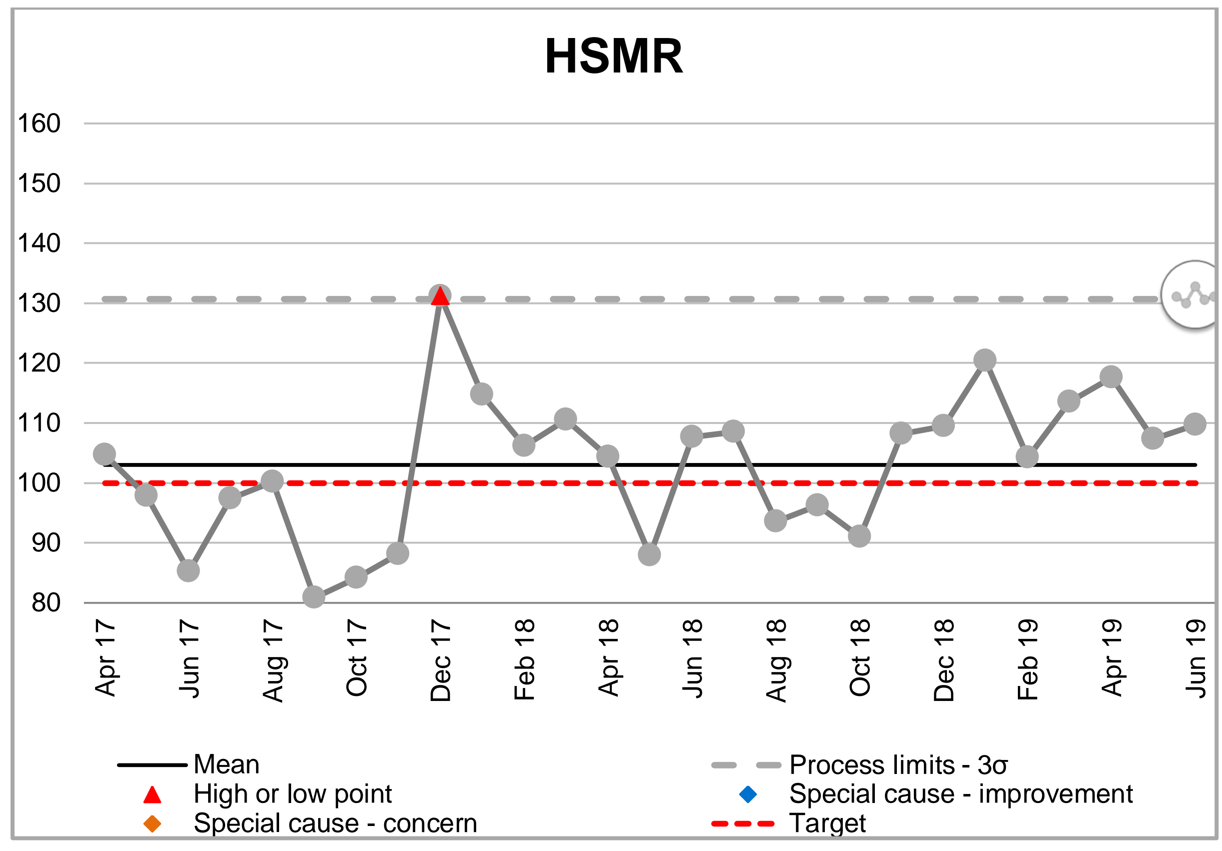
This report details:
1. **Performance** data relevant to the trust, compared with regional and national comparator sites, where appropriate
2. **Key areas for attention**, together with analysis, actions and outcomes
3. **Future actions** and developments in understanding mortality data

1. PERFORMANCE

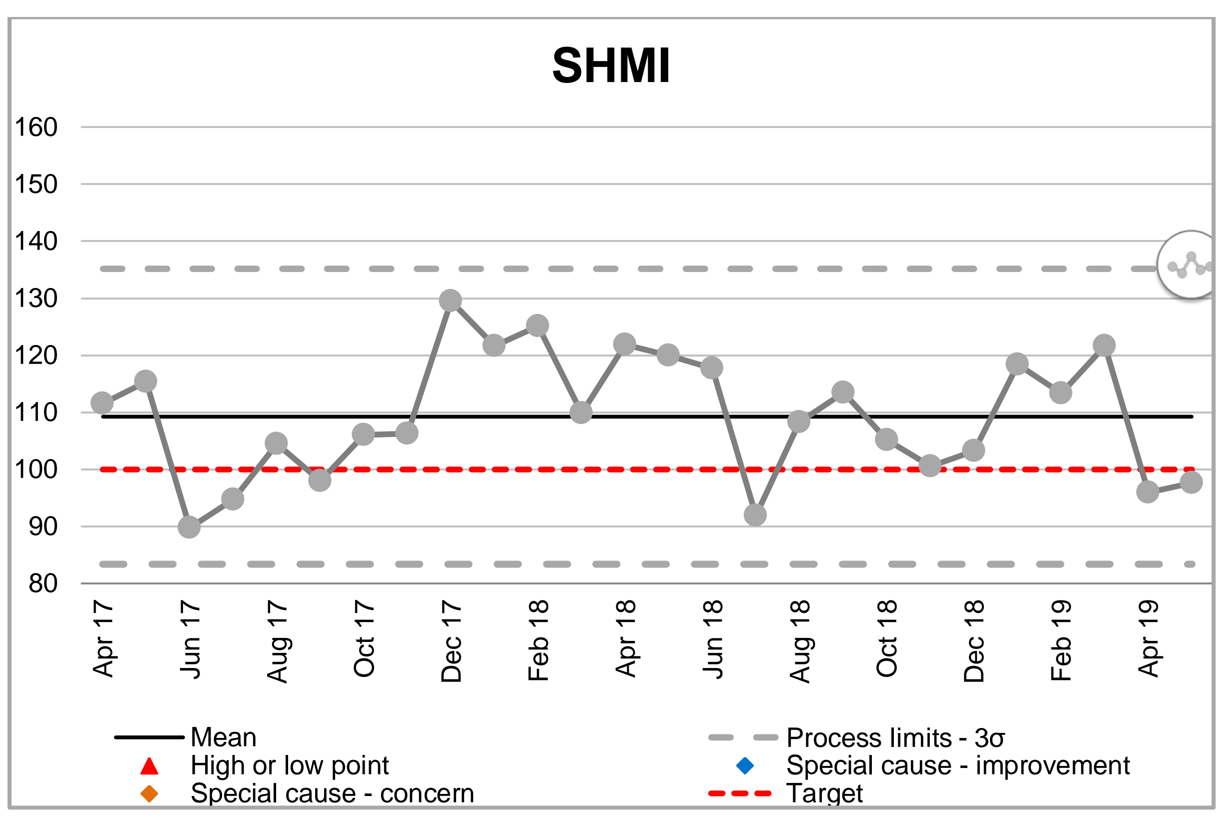
National Benchmarks

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

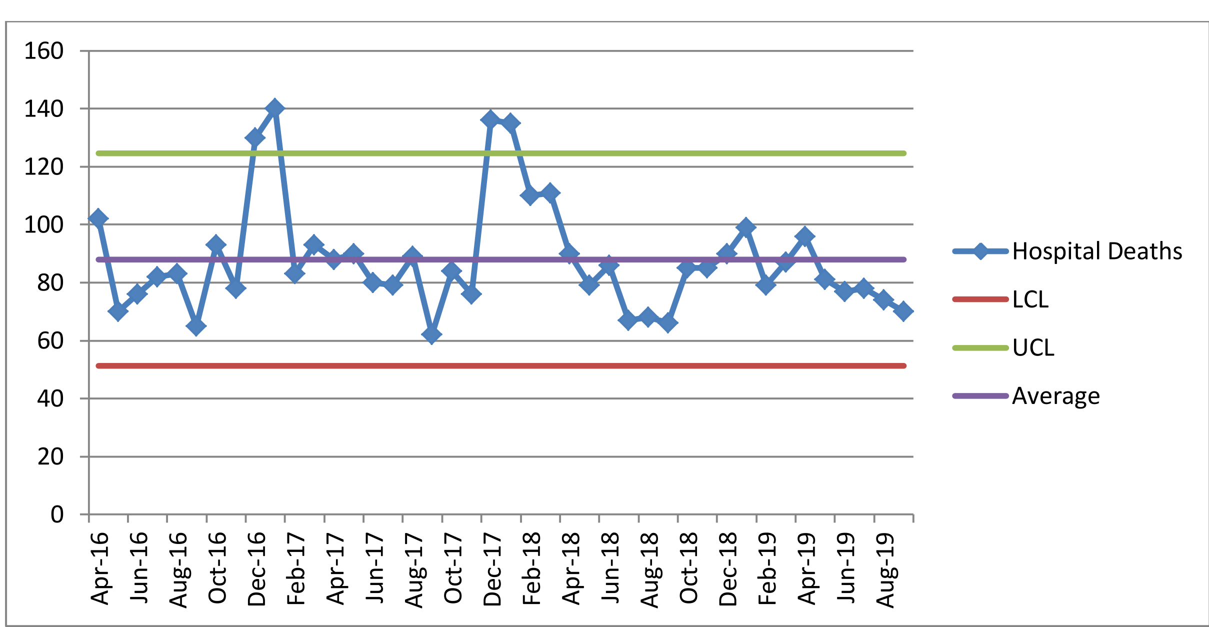
HSMR 2016 – 2019



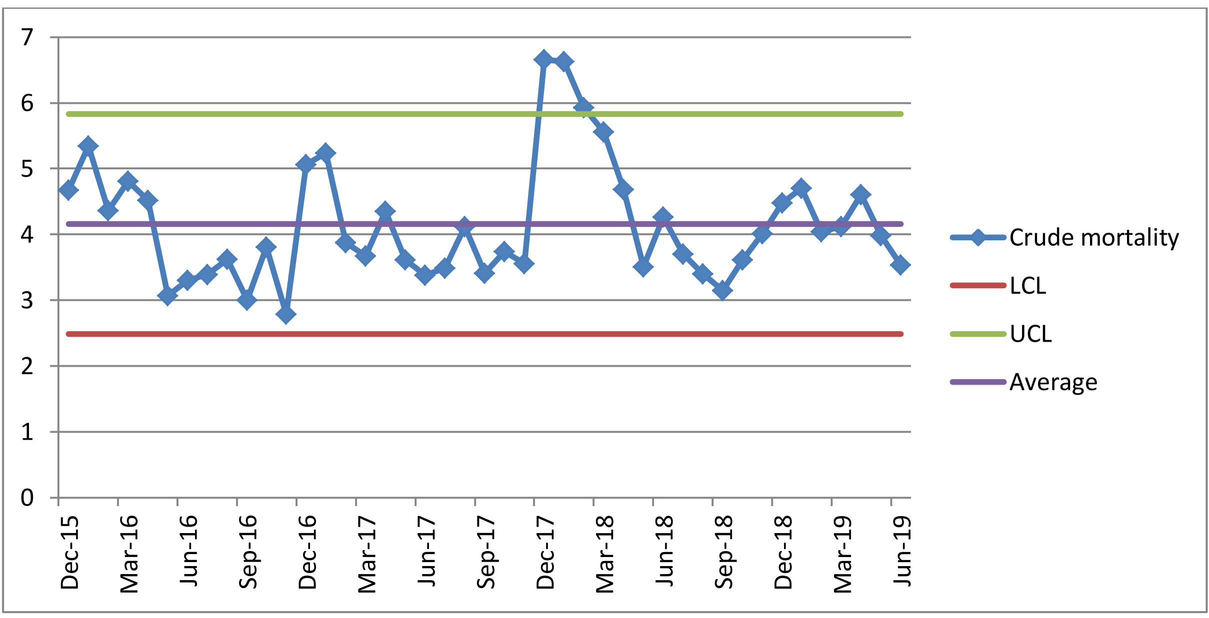
SHMI 2016 – 2019



In hospital deaths 2016 – 2019



Crude Mortality 2015 – 2019



Process for reviewing deaths in hospital
The Trust has aspired to review the majority of deaths based on the application of the NQB triggers, local trends, national alerts and triggers identified from SHMI and HSMR and using the SJR tool.

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

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

- All deaths where a bereaved family, carer or staff have raised a concern
- Patient deaths of those with a learning disability
- Patient deaths of those with a mental illness
- Unexpected deaths, such as following an elective procedure
- Particular groups where an alarm has been raised for example via HSMR, SHMI or CQC
- Deaths where learning will inform the providers quality improvement work
- All maternal deaths
- All child deaths, over 16 years of age
- All perinatal and still birth deaths.

Following recruitment to dedicated administrative support, a renewed focus has been implemented to ensure the backlog of reviews is facilitated.

The trust commissioned a National Mortality Case Record Review (NMCRR) workshop for all specialty mortality leads in the use of the Royal College of Physicians (RCP) Structured Judgement Review (SJR) tool. This was attended by 24 clinicians on 14th October 2019. The SJR tool will be used for all adult deaths.

The Division of Women and Children are currently implementing the revised national child death review processes and the perinatal mortality review tool which align to the national learning from death principles.

Top 10 causes of death derived from HSMR for a 12 month rolling period

Diagnosis groups		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Running Total
122 - Pneumonia (except that caused by tuberculosis or	Deaths	14	10	9	18	19	21	21	16	19	17	9	14	187
	HSMR	126.84	101.15	102.26	105.07	132.08	115.54	103.30	103.95	135.23	114.29	85.25	120.92	
2 - Septicemia (except in labor)	Deaths	5	3	6	9	11	7	12	7	9	13	9	9	100
	HSMR	52.19	24.34	73.91	76.52	90.26	57.64	94.39	51.07	68.04	80.76	67.01	94.46	
157 - Acute and Unspecified Renal Failure	Deaths	6	7	4	3	6	6	9	9	4	1	3	3	61
	HSMR	132.82	218.28	159.67	145.41	162.15	107.90	204.70	217.99	123.30	36.74	62.73	194.19	
108 - Congestive heart failure; nonhypertensive	Deaths	5	5	6	3	4	4	5	5	3	7	6	5	58
	HSMR	193.67	110.88	143.74	76.04	85.19	143.20	165.29	106.65	72.56	150.10	188.50	139.55	
129 - Aspiration pneumonitis; food/vomitus	Deaths	5	6	4	4	5	5	1	1	4	8	8	6	57
	HSMR	213.19	155.29	111.89	63.54	126.98	103.61	71.14	36.89	100.11	180.27	154.00	111.15	
127 - Chronic obstructive pulmonary disease and	Deaths	1	3	2	3	1	8	2	3	4	4	4	3	38
	HSMR	55.55	82.07	122.97	117.51	52.03	300.32	47.80	97.68	149.59	149.89	151.22	106.06	
131 - Respiratory failure; insufficiency; arrest (adult)	Deaths	1	3	3	3	3	6	5	2	3	4	1	0	34
	HSMR	97.36	127.59	248.24	137.38	151.16	331.66	325.35	124.49	344.29	242.83	41.55		
226 - Fracture of neck of femur (hip)	Deaths	2	0	1	2	2	4	5	6	4	3	3	1	33
	HSMR	152.11		133.43	130.43	123.11	211.23	151.77	387.14	129.60	265.24	202.56	82.80	
159 - Urinary Tract Infections	Deaths	1	3	0	0	5	4	1	2	3	2	2	3	26
	HSMR	73.28	139.26			183.41	245.14	58.67	136.86	145.85	145.24	128.56	161.21	
19 - Cancer of bronchus; kung	Deaths	3	2	1	0	0	1	2	0	3	2	2	3	19
	HSMR	183.06	169.91	77.51			44.86	333.04		142.20	105.14	98.10	96.45	

Top causes of death with elevated HSMR

From July 18 2018 to June 2019, HSMR has reported 33 diagnostic groups with a HSMR above 100. Seven of these groups have recorded greater than 30 deaths in the period (highlighted in yellow).

Diagnostic Group (CCS)	Expected number of deaths	Observed number of deaths	HSMR	Observed - Expected
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	166.2	187	112.52	21
157 - Acute and unspecified renal failure	42.37	61	143.96	19
108 - Congestive heart failure; non hypertensive	45.98	58	126.15	12
129 - Aspiration pneumonitis; food/vomitus	47.99	57	118.79	9
127 - Chronic obstructive pulmonary disease and bronchiectasis	32.29	38	117.67	6
131 - Respiratory failure; insufficiency; arrest (adult)	18.77	34	181.16	15
226 - Fracture of neck of femur (hip)	20.2	33	163.35	13
159 - Urinary tract infections	22.3	26	116.59	4
151 - Other liver diseases	6.73	13	193.26	6
155 - Other gastrointestinal disorders	10.34	13	125.72	3
224 - Other perinatal conditions	8.26	12	145.36	4

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109 - Acute cerebrovascular disease	9.45	12	127.04	3
149 - Biliary tract disease	6.28	11	175.15	5
130 - Pleurisy; pneumothorax; pulmonary collapse	7.11	11	154.68	4
43 - Malignant neoplasm without specification of site	5.43	10	184.23	5
114 - Peripheral and visceral atherosclerosis	4.47	9	201.25	5
55 - Fluid and electrolyte disorders	8.07	9	111.46	1
133 - Other lower respiratory disease	6.27	8	127.56	2
199 - Chronic ulcer of skin	3.59	7	194.97	3
14 - Cancer of colon	5.3	7	131.98	2
197 - Skin and subcutaneous tissue infections	6.45	7	108.48	1
15 - Cancer of rectum and anus	4.06	6	147.88	2
237 - Complication of device; implant or graft	3.26	5	153.47	2
103 - Pulmonary heart disease	4.41	5	113.29	1
59 - Deficiency and other anaemia	4.59	5	109.05	0
13 - Cancer of stomach	2.15	4	185.97	2
134 - Other upper respiratory disease	1.3	3	229.94	2
29 - Cancer of prostate	1.67	3	179.5	1
117 - Other circulatory disease	2.07	3	144.62	1
115 - Aortic; peripheral; and visceral artery aneurysms	2.5	3	119.93	0
251 - Abdominal pain	0.88	2	226.57	1
154 - Non-infectious gastroenteritis	0.55	1	181.41	0
245 - Syncope	0.72	1	137.95	0

A suite of SPC charts has been developed to demonstrate performance relating to HSMR for the top causes of death. Appendix 6

Cause of Death	Number of Deaths (rolling 12 month period)	HSMR
Pneumonia	191	112.20
Septicaemia	95	65.54
Acute and unspecified renal failure	62	139.76
Congestive heart failure	56	122.47
Aspiration pneumonia	52	112.76
COPD	39	119.28
Fracture neck of femur	38	179.78
Respiratory failure	34	178.94

KEY AREAS FOR ATTENTION

Deaths of patients with a learning disability

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

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

Of those 3 deaths, one death, following discussion at the Divisional Safety Huddle and the Serious Incident meeting, was not considered a serious incident but it was recognised that there are learning points; a multidisciplinary concise table top review has subsequently been undertaken with a number of areas for concern:

- Application of the DNAR and MCA process
- Communication with relatives regarding the plan of care
- Multiple patient ward moves
- LD nurse not notified of the patients admission

There have been 2 further deaths in patients with LD in June and both have been recorded within safeguarding as incidents.

- 1 case relates to a possible HCAI (Healthcare Associated Infection) and is being managed as a serious incident; an SJR has been requested to be undertaken by the lead clinician and the learning disability team.
- 1 case has undergone formal SJR by the lead clinician and the lead nurse for adult safeguarding and has been reported as an incident in safeguarding. This has since been determined as not being an SI and will be discussed at divisional huddle.

Following a discussion at the Regional Mortality Meeting, and after liaising with the trust LD lead, a request has been made for feedback from LeDeR to provide themes and learning points identified from LeDeR reviews of patients with LD who have died at the trust.

The Lead Nurse for Safeguarding in Adults presented at the trust wide ‘audit’ session in September to improve awareness of the LeDeR processes.

Deaths where there may have been an issue in care, system or process

Serious Incidents

There have been six serious incidents and one incident not deemed to be a serious incident:

1. An elective trauma and orthopaedic patient, as outlined in the quality improvement action log. This incident will be managed through the Safeguarding Framework.

   Key learning points relate to the provision of quality documentation, ward round standards, escalation procedures for a deteriorating patient, and provision of appropriate clinical review at weekends and development of clear standardised pathways for elective patients.

2. A patient who sustained a fall whilst an inpatient on Ward 3 and suffered a fractured neck of femur. The case was reviewed by the coroner who advised that the case was an accidental death but would be taking note of all other deaths relating to falls over the next 6 months.

   Key learning points relate to undertaking risk of falls assessments, ensuring appropriate staffing levels for wards where there are cohorts of patients who require a higher level of supervision, reducing the number of times patients with dementia are transferred and improving communication and handover of patients on transfer. The incident will be managed through the Safeguarding Framework, refer to the quality improvement log.

3. This case involves a HCAI serious incident; the patient also had a learning disability.

4. This case is pending the outcome of an independent coronial review.

5. This case is pending an RCA (Root Cause Analysis) during the week commencing 21 October 2019.

6. This case is pending RCA.

7. This case was determined not to be a serious incident but lessons were learnt as the patient died following a procedure (please refer to action log).

SJR Care Scores

During the period January to date 9 deaths have been recorded with an overall score of 2 ('poor care').

- 1 case has undergone a second review identifying adequate care, with no factors contributing to the patient's death.
- 8 cases continue to be investigated.
    1) Incident reported and reviewed at the divisional safety huddle. The case has not been determined as an SI. A concise review has been undertaken by the elderly care team. *Learning points*: to ensure use of oxygen prescription on medication charts. An audit is to be undertaken on the elderly care wards. A re review has been requested following discussion at Mortality Surveillance Group (MSG).
    2) Case reported via safeguard, lead clinician advised. Also, under review by PALs following a complaint from the family. Investigation of level of care received will be presented via the PALs processes.
    3) Case following review at divisional huddle and the serious incident meeting has been identified as a serious incident and will be managed via the safeguarding framework. The root cause has been determined as lack of early definitive investigations. *Key learning points* relate to: timely admission to critical care, timely and appropriate investigations are requested and reported, contemporaneous documentation, specialty team ownership of patient in ED (refer to RCA in action log).
    4) Clinical incident has been recorded relating to care and outcome; the case has been reviewed by the clinical teams and determined as no harm.
    5) Case was reported as an incident (SI status pending); this case has subsequently been determined not to be an SI and is referred to in the LD section of this paper; final review by the ED nursing team is pending.
    6) Patient care identified as inadequate via SJR, pending review at divisional huddle.
    7) The patient care was recorded as poor; this case is pending review at the divisional safety huddle.
    8) This case relates to an on-going formal complaint by the patient's family; formal SJR and specialty review has been undertaken and the case is being overseen by PALs.

A further case was identified following SJR (as part of a review into deaths due to 'acute and unspecified renal failure' for January and February). The case did not trigger for an SJR originally based on local or NQB indicators. This case has been reported as an incident and has subsequently been determined as no harm. Following a concise review of the case by the elderly care team lessons learnt in relation to documentation and accurate death certification have been noted for action by the team.

Cases pending decision as Serious Incident

a) Case pending decision following a family concern, awaiting a date for an inquest. This has not been identified as a clinical incident, awaiting inquest.
b) Case subsequently determined not to be a serious incident and described as an accident following coronial review.
c) Case determined as an SI due to a possible HCAI; this patient will also have a formal SJR and has been recorded on the LeDeR data base
d) Case reported as an incident in safeguarding due to a possible HCAI, to be discussed at MLTC safety huddle to clarify cause of death. A formal SJR has been requested and completed.
e) Case reported as an SI following death after a procedure, determined as not an SI, concise review to be undertaken by the clinical team.
f) Case reported as an SI relating to management of haematological condition. Incident reported following the unexpected death of a surgical patient PALS also supporting. SI confirmed

Alerts and Notifications

CuSum, Cumulative Sum Control Chart, identifies significant changes and persistent deviation from the expected (Appendix 4 describes the methodology).

a) For January and February 2019 the Trust noted a CuSum trigger for **Acute and unspecified renal failure**. It should be noted that the refreshed HSMR data has not identified a trigger although triangulation against other data sets shows a rise in deaths for this diagnosis, identifying 18 patients for the 2 months. An initial review of this group of patients has identified:

- One patient demonstrated a data quality issue
- One patient to be recoded
- Of the remaining 16 cases, 4 patients did not trigger an initial National Quality Board or local trigger. Preliminary findings identified:
    - 12 patients where no issues were identified with adequate, good and excellent care;
    - 3 cases where actions are continuing to secure reviews; this has been delayed to difficulties in locating the clinical records;
    - 1 patient who did not trigger for a review but has since been identified as having received inadequate care; now been recorded as an incident through the safeguarding framework.

This supports the importance of implementing the Medical Examiner process to determine the need for further investigation based on clinical overview, in contrast to predetermined indicators alone.

b) For March 2019 a further CuSum trigger was noted relating to **Respiratory failure, insufficiency and arrest,** noting 3 deaths against an expected of 0.87. Initial review of the three patients has identified that two of the patients had a history of significant deteriorating respiratory disease and other long

term conditions; both patients died shortly after admission following a decision to enact a DNAR. The third patient was admitted to ICU following deterioration relating to a long term respiratory condition, a review of care was undertaken following death and identified as of a good standard.

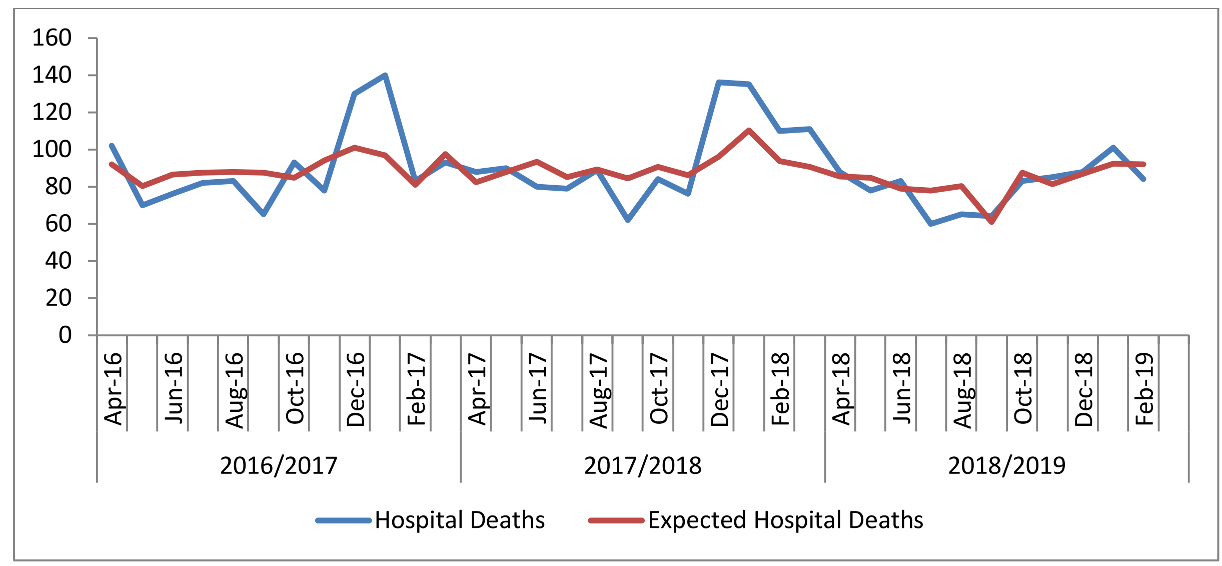
There have been no further CuSum alerts

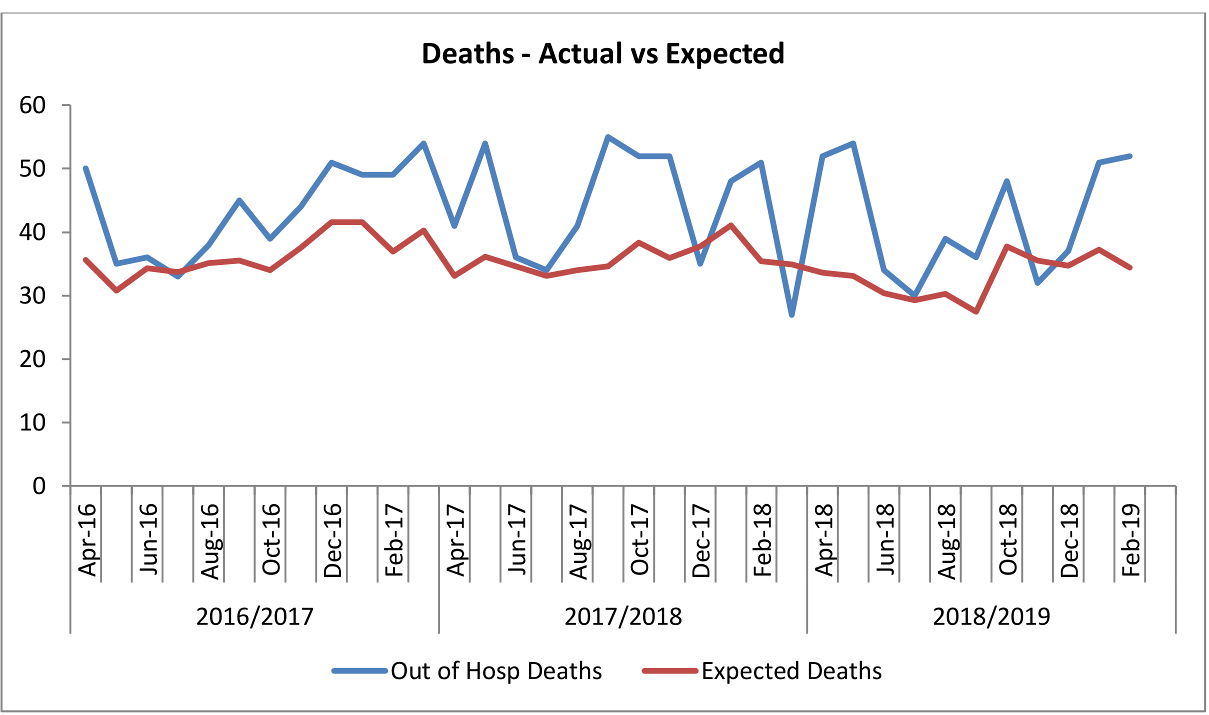
National Outlier Notification

- August 2019: the trust has received notification from the Royal College of Physicians of a National Hip Fracture Database alert as the trust is an outlier for patients admitted with a **fractured neck of femur (**dying in the hospital or following discharge within 30 days of admission). A comprehensive multidisciplinary review will be undertaken of this cohort (totalling 34 patients). The initial findings were presented at the October 2019 MSG. A comprehensive action plan has been completed (refer action log), and a further presentation of the remaining patients will be presented in November 2019. Key learning points relate to review of the fracture neck of femur pathway, 7 day respiratory physiotherapy, consultant led procedures, assessments of dementia and frailty.

Local Press Inquiry

- August 2019: the trust received a press enquiry regarding the disparity between the number of expected deaths and those seen within the trust between March 2018 and February 2019. Data analysis identifies a fall in the disparity so far for the year 18/19 compared to that of the previous year. The charts below demonstrate the variance for those deaths occurring at the trust and in the community.

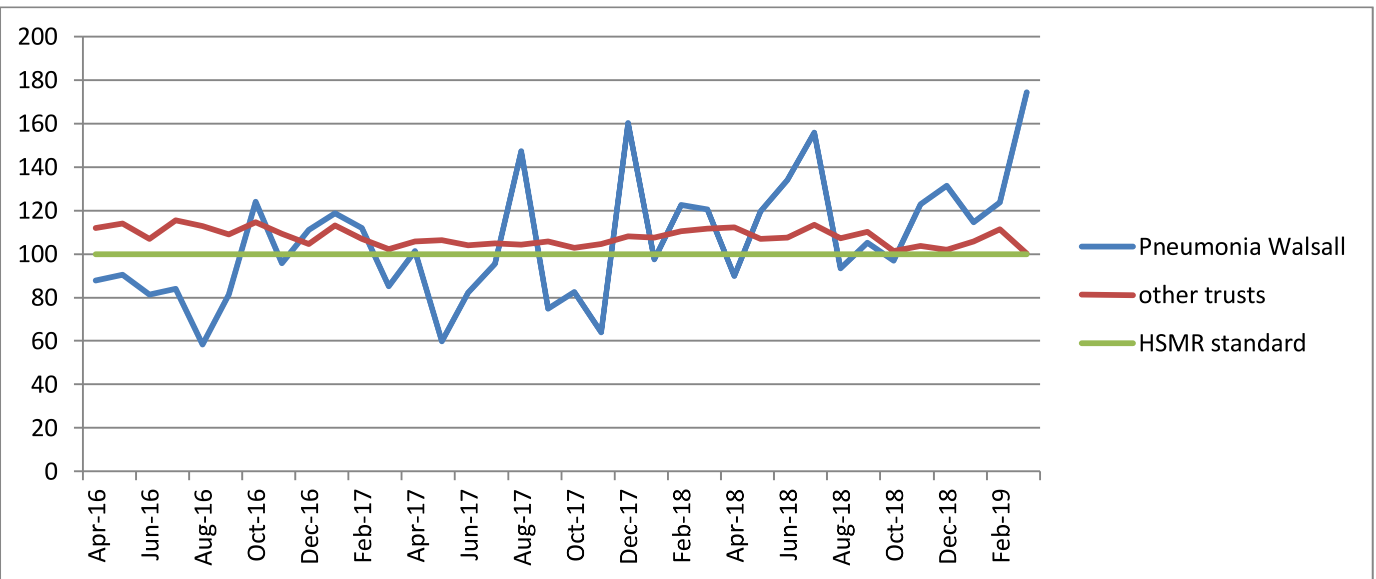




A review of this group of patients was undertaken and presented at the October 2019 MSG. Key learning points identified that in excess of 80% of the patients died in their chosen place of death and a number of patients were not known to the community services; this group of patients will be assessed further to identify additional learning points. Involvement of the palliative care team, use of the ReSPECT tool and end of life (EoL) pathways appear to be inconsistent. In respect of the final point, it was suggested that the presentation be taken to the Walsall Together End of Life Strategy Delivery Group to consider supporting the use of the Gold Standard Framework.

HSMR prevalence

Pneumonia has been a prevalent diagnostic code, with a raised HSMR for eleven of the past twelve months and the highest proportion of deaths. The chart below demonstrates the value of the HSMR for pneumonia at Walsall.



A review of a cohort of patients falling into this demographic is being undertaken, focussing on those patients who were also coded as Hospital Acquired Pneumonia (HAP). During the review, the coding applied to this group of patients will be scoped in addition to the patient care and pathways. Findings and recommendations will be presented at MSG potentially in January 2020.

Since April 2017, a total of 1174 patients had a clinical code relating to HAP recorded (including 359 deaths). A cohort of 42 patients will be reviewed who had a length of stay between 2 and 10 days and were a readmitted within 30 days of a previous discharge. An initial clinical coding review has been undertaken which did not identify any anomalies. A clinical review will now be undertaken of this cohort of patients, which will be presented in January 2020 along with an EoL presentation relating to the care of the dying patient with respiratory disease.

Risks

- A significant risk existed in respect of undertaking the **administrative processes** to support the Learning from Deaths requirements. This risk contributed in delays in facilitating SJR, data collection and analysis, reporting of incidents and associated safeguarding processes. The process has lacked support since May 2019. In the event of an issue in care being identified this can result in a significant impact in the ability to address issues in care system or process in a timely manner. An appointment has since been made to the administrative support post.

- Priority is being given to those cases where the patient has been identified as having a learning disability or a clinical incident has been raised outside of the SJR process.
- This risk is being reduced by focussing on the backlog of SJRs and additional support for the admin processes.
- A revised business case will be developed to seek additional resources for the MEO and administrative posts, above those agreed for this financial year, with reference to pilot sites and the evolving ME and LFD agenda.

- The lack of robust structured **care group governance**. Discussions are taking place between the Medical Director and Director of Governance to determine the support required by the care groups to deliver the quality and safety framework for identifying, learning and sharing lessons following ME and SJR processes, as identified by the CQC. A governance proposal has been developed and presented at MSG and will be presented at the trust wide audit day during September. Clinical leads have been identified and requested to consider their team processes and involvement of their MDTS in SJR and subsequent M&M discussions.

- Availability of accommodation for the Medical Examiner Office and supporting teams. Discussions with the patient liaison team regarding shared accommodation have progressed and a suitable option is currently being considered including collocating members of the general office, PALS and bereavement team to support with a streamlined ME process. The appointment to the MEO role continues to prove challenging. A bid for accommodation in the vacated pathology department will be presented at the trust utilisation group in November 2019

- Availability of a consistent bereavement service. The trust currently employs a single handed bereavement officer. National guidelines propose a consistent approach to the availability and resources available for all bereaved relatives and carers.

FUTURE ACTIONS

Medical Examiner

Four MEs have been recruited so far. Recruits are currently in the process of undertaking the mandatory e-learning and face to face training delivered by the Royal College of Pathologists. Recruitment to administrative support has been undertaken. The ME scrutiny process will commence in November 2019. Recruitment to the MEO posts continues with a second national advert and interviews planned for 15 November 2019

Revised Learning from Death Processes

Reporting to identify the number of deaths receiving a score of 3a, 2 or 1, and also LD deaths has been implemented. This tool will be amended to align with the Medical Examiner process (requiring scrutiny of all deaths, with SJR based on the review outcomes or reference to the National Quality Board minimum criteria).

An end to end data file is currently being developed to capture data for the purpose of reporting and analysis from death, through the ME and LFD processes.

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

ME and LFD principles and processes will be presented at the trust wide audit meeting including proposed governance flow charts (appendix 5). A revised governance process has been presented at the October MSG.

An interim data collection solution is currently being developed to support the ME and LFD processes pending the implementation of the national digital solution platform to support standardised national reporting.

The update of the **Trust Learning from Death Policy** will be completed in December 2019 to encompass the revised processes, governance, reporting and auditing including national developments relating to Child Death Overview Panels (CDOP) and Perinatal Mortality Review Form (PMRT).

A multi-agency, health economy mortality forum will be reconvened in November 2019 to address shared issues relating to premature deaths in the borough of Walsall.

Quality Improvements Presentations and Action Log

Date	Specialty	Presenter	Summary/Learning Points	Actions	Progress	Owner	Target Date	RAG
April 2019	All specialties	Miss R Joshi (retrospective)	A review of 7 patients was undertaken as part of the Well Led CQC inspection Key Learning Points 1.Poor documentation using the sepsis tool 2.Innaccurate cause of death recorded on medical certification 3.Improved use of a ceiling of care and advanced care pathway	To be presented at the June MSG	To be presented in August. Pending feedback from CQC To be presented in September 2019 The presentation identified issues in documentation, recognising the dying patient, use of DNRMCA, use of the sepsis tool.RJ has been requested to complete the standard action format , addressing local ED issues with the team and sharing wider issues for action at October MSG. Issue relating to inaccurate MCCD was identified. Ths will be addressed through the implementation of the ME	RJ and TBC	August 2019 Oct 2019	
10 May 2019	All specialties		Following a CuSuM alert in April 2018 and a subsequent CQC request to review a group of patients whose cause of death was recorded as fluid and electrolyte imbalance management of hyperkalaemia was noted as an issue but not contributory to the death of patients. An action point was allocated to the clinical lead in ED.A subsequent NPSSA alert was received relating to an update of clinical guidelines in the management of hyperkalaemia	1. The CD for ED is to undertake communication and awareness sessions with her team. 2. The hyperkalaemia guideline is to be updated and training and awareness session to be delivered through junior doctor training, grand round and clinical team meetings.	The CD for ED have discussed the issues at departmental board rounds and team meetings. The hyperkalaemia guideline has been updated as per the national guidance and is currently in the awareness and training phase. The guideline will be presented at DQB week commencing 27 May and during junior doctor training	UI	30 June 2019	

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					and grand round during June. UPDATE: 13/6/19 – awaiting confirmation from Emergency & Acute Medicine Care Groups of internal dissemination. RJ has confirmed the actions required in respect of disseminating information within the ED have been undertaken			
10 May 2019	Acute Medicin e	Dr Ali	A review of 20 patients was presented. Key Learning Points 17 out of 20 patients DNAR was put in place Incomplete MCA documentation Poor documentation in the patient record A medication error was noted	1.To review the 17 patients with a DNAR put in place and represent at the June MSG to identify any pathway themes 2. General documentation and MCA completeness to be discussed at team meetings. 3.Performance relating to DNAR and MCA to be addressed through the deteriorating patient and sepsis group chaired by the DDDN 4. Medication error to be reported through the safeguarding framework	Cases represented at June MSG. Issues relating lack of MCA and community DNAR discussed. Actions to be undertaken to improve MCA documentation , DNAR to align to community work focussing on GSF A further presentation was made at MSG in September 2019. The clinical lead has been requested to present findings and actions using the standard format. Key issues identified lack of escalation and intervention, poor use of DNA and MCA tools. Issues to be escalated to the resuscitation committee	MA/S R	30 June 2019 Septe mber 2019	

10 May 2019	Anaesthetics	Dr Garg	A retrospective review of the quality of verification of death and associated documentation was undertaken Key learning points Poor documentation Varied degrees of application of the national standards Disparity in time of death and verification leading to anomalies in subsequent death certification alignment QIP Death Verification Garg.pdf	1.Review of the Trust Verification of death Policy 2.implementation of a standard verification proforma	Presentation at grand round 24/5 Revised proforma communicated and available on the intranet To be presented at junior doctor induction in august Reaudit will take place as part of the QIP cycle	AG/DR		July 2019 Sept 2019
July 2019	T&O	Mr Selzer	A retrospective presentation of mortality following repair of # NOF	1 improve post-operative chest physiotherapy resources 2 address issues relating to prolonged LOS	A further review following a outlier alert is being under taken			
2 July 2019	Community	Dr S Harlin	A presentation by SH demonstrating opportunities and actions for the trust sepsis and deteriorating patient to adapt to community services, opportunities to reduce conveyance to hospital and to develop a whole systems approach to managing the deteriorating patient Deterioration Sepsis.pptx	1.Implemtnation of advanced care plans 2.Improved identification of dying or deteriorating 3. Improved navigation of community systems	Work to continue through the community task and finish groups and supported by Walsall together	SH	on-going	
July 2019	MLTC	Patient EF LD patient	LD patient incident submitted, not considered SI. Divisional concise review undertaken. Learning points identified	1.Implementation of DNAR/MCA 2.Communication with relatives relating to the plan of care 3.Multiple ward moves 4.Notification of admission to the LD nurse	Action plan and formal report to be developed	DH		
July 2019	T&O Incident 95114 RC	NT	A patient died 12/09/18 following an elective procedure There should be a robust elective surgery pathway for patients that should be followed to ensure that they are supported to discharge in a timely manner Staff should be made aware that where a medical emergency requires the presence of	Serious Incident report for 2019-879	Progress against actions will be monitored through PSG	NT	30/09 /2019	

			an anaesthetist this should be communicated by identifying the emergency as a cardiac arrest. Where an anaesthetist is not required the call should state that they are requesting the attendance of the medical emergency team. Critical Care outreach/at night team will be live from the 24th of June 2019 which should be also called if a patient is deteriorating. For the transfusion advice/policy to be reviewed to ensure it clearly identifies when patients should receive transfusion for post-operative drops in Hb. For ward round standards to be reaffirmed to every ward in the hospital, to ensure that all tests that are undertaken on patients are reviewed as part of the ward rounds When requesting tests such as blood tests, whoever requests the tests should review the outcome and put a plan in place On a weekend patients should be reviewed by the parent team either by the consultant or the Registrar. There should be no variations in the care and treatment for patients being seen on a ward round on a weekday or a weekend When doctors are undertaking a review of a patient, the results should be clearly documented					
August 2019	MLTC incident LC	NR	The patient died following a fall. The coroner recorded the death as an accident .Key actions relate to undertaking falls risk assessments, communicating effectively on handover, appropriate staffing levels for cohorts of patients with a higher need of observation, reduce the number of moves for patients	PDF Final Report LC 2019-8458 - 104700	Progress against actions will be monitored through PSG, JA chased DH 18/9		31/08 /2019	
August 2019	Community	SH/KG	A review of those deaths occurring in the community in January and February will be undertaken		The cohort of patients is currently being reviewed and will be presented at MSG October	SH/KG	31/10 /2019	

August 2019	T&O	TM	A review of the deaths with a mortality within 30 days of patients who have undergone a repair of a fractured neck of femur will be undertaken following an alert from the Royal college of Physicians		A MDT review is being arranged to take place in September 2019 Provisional update October MSG	TM	31/10 /2019	
August 2019	MLTC/ Respiratory	KI/JA	A review of patients with a diagnosis of pneumonia and specifically HAP will be undertaken		A report has been developed identifying all patient deaths relating to pneumonia with a coding for HAP. The methodology and cohort are to be determined.	KI	January 2020	
September 2019	MLTC/ Gastro	NG	Review of processes following the death of a patient post procedure	Review of consent and process relating to abdominal parasenthesis. Use of the DNA MCA policies Timely involvement of the palliative care team. Involvement of families	The ward will be undertaking team meetings and discussions to develop a SOP for the procedure and implement formal written consent. The team are scoping options of using an alternative piece of equipment to reduce the risk of reoccurrence	NG	Nov 2019	
October 2019	T&O	TM/LP	Review of #NoF deaths following a national alert	#NOF MORTALITY & BPT action plan .do	Review to continue, re present December 2019	TM/LP	Dec 2019	
October 2019	Community	KG/SH	Review of out of hospital deaths Dec/Jan 2018/19	Community Mortality report 2019.docx	To review patients not known to CC, present at Walsall Together EOL Strategic Delivery Group	KG/SH	December 2019	
October 2019	Elderly Care		Review of deaths within the elderly care wards	Specialty Elderly Care Presentation T	1 case to be referred to divisional huddle for further discussion in respect of oxygen and opiate management Lessons to be learnt and education to be undertaken relating to EOL care	VS	January 2019	

Glossary of Terms

HSMR Hospital Standard Mortality Rate
SHMI Standard Hospital Mortality Index
NQB National Quality Board
CQC Care Quality Commission
NHSI NHS Improvement
SJR Structured Judgement Review
ME Medical Examiner
MEO Medical Examiner Officer
LeDeR Learning Disability Mortality Review Programme
LD Learning Disability
DNAR Do not attempt resuscitation
MCA Mental Capacity Act
SI Serious Incident
RCA Root Cause Analysis
MTLC Medicine and Long Term Conditions division
LFD Learning from Death
CuSuM Cumulative Summary, a performance indicator demonstrating persistent deviation from the mean
PALS Patient Advisory and Liaison Services
CCG Clinical Commissioning Group
MSG Mortality Surveillance Group
MDT Multidisciplinary Team

Appendix 1: Clinical Mortality Leads Key Responsibilities

Clinical Mortality
Leads Key Responsibi

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

Acorns Closure
Letter.pdf

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

MAC Mortality
Review Turnaround F

Appendix 4: CuSuM methodology

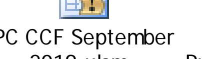
2018-04-30_RBK (3)
ICL alert.pdf

Appendix 5 ME and LFD Governance Flow Charts

Proposed Process for
ME and LFD v3.docx

Appendix 6

Specialty SPC HSMR performance


SPC CCF September 2019.xlsm

SPC Aspiration Pneumonitis Septemb

SPC UTI September 2019.xlsm

SPC Septicamia September 2019.xlsm

SPC Respiratory September 2019.xlsm

SPC Pneumonia September 2019.xlsm

SPC FNOF September 2019.xlsm

SPC COPD September 2019.xlsm

SPC Renal September 2019.xlsm

BAF Risk- S05
Risk Owner; Director of People and Organisational Development
Date of Review; 22nd October 2019

Strategic Objective; **Value our Colleagues -** so they recommend us as a place to work through the development of professional leadership, enhanced engagement, embedding clinical leadership and accountability in the way we operate our services	**Risk Appetite;** Risk Appetite; The Trust aspires to having a zero risk appetite for any behaviours or actions that damage or compromise our Trust values. Specifically working to reduce the current areas of risk such as bullying and harassment, improving inclusion, staff engagement and experience and confidence to speak up. The Trust will have a moderate risk appetite for risks associated with building new workforce models for future.	Initial Risk Rating 4 (L) x 4 (I) =16, Moderate Current Risk Rating 4 (L) x 4 (I) = 16, Moderate Target Risk Rating 2 (L) x 3 (I) = 6, low
Risk; Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care	**Rationale for current score** • Freedom to speak up guardians in place • NHS Interim People Plan published, action plan awaited • Staff survey results some improvement, needs to be sustain • New EDI lead recruited • Committed to implement 'just culture'	**Future risks** • Failure to meet EDI requirements • Failure to approve revised policy framework • Capacity within the HR and OD team
Controls / Assurance • Values launched • Behaviour Framework in place • Values based appraisal process being piloted and launched through the leadership conference • Increased engagement through engagagents and EDI champions	**Gaps in controls / assurance** • Current Policy framework not fit for purpose • EDI strategy requires further development	**Future Opportunities** • Embed 'Just Culture' • Further opportunity to build partnerships with community groups and local stakeholders including 'Walsall Local Integration Partnership'

MEETING OF THE PUBLIC TRUST BOARD – 7th NOVEMBER 2019			
UPDATE ON LEADERSHIP AND TALENT MANAGEMENT – VALUING COLLEAGUES IMPROVEMENT PROGRAMME			**AGENDA ITEM: 12**
Report Author and Job Title:	Catherine Griffiths – Director of People and Culture	**Responsible Director:**	Catherine Griffiths – Director of People and Culture
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The purpose of this report is to provide the Trust Board with an update on the Trust's Leadership, Culture and OD work-stream, relating to Leadership Development and Talent Management. This work is part of the implementation plan for Valuing Colleagues within the Trust Improvement Programme which aims to achieve a CQC outstanding rating for patients by 2022. The Trust worked in partnership with the NHS Leadership Academy over Summer 2019 and with the top 100 leaders within the Trust, to complete a leadership diagnostic (appreciative inquiry). This report contains a summary of the key themes arising from this, the People and OD Committee considered the detailed report and taken recommendations on next steps for engaging with the Divisions. The messages correlate with the most recent Pulse Survey and the qualitative focus groups on the Trust Values, already considered by Trust Board. One key and immediate action has been taken relating to Talent Management and Development with a refreshed approach and cycle for appraisal out to consultation within the Trust with a proposed Trust-wide launch in January 2020. This aims to address key indicators raised by the national staff survey.		
Recommendation	Members of the Trust Board are asked to: 1. Note the key themes coming from the Leadership Diagnostic work with the NHS Leadership Academy and the next steps on engaging Divisions in planning a response to the issues raised. 2. Note that the new appraisal process and PDR paperwork incorporates an approach to talent management within the		

<table>
<tr><td></td><td colspan="2">Trust and that consultation will complete in December.

3. Note that the People and Organisation Development Committee has resolved to receive the Trust Organisation Development Plan at its November meeting for consideration at Trust Board in December.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="2">The work programme described within this report will provide positive assurance to the committee on the following BAF risk:

Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.</td></tr>
<tr><td>Resource implications</td><td colspan="2">There are no cost implications associated with following this programme of work, all resource will be re-aligned through existing budgets.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">The data from the NHS Leadership Academy report does indicate Equality, Diversity and Inclusion as a key development need.

The new appraisal process introduces the NHS Leadership approach to Talent Management and maximising potential and includes career progression as well as development planning. The outcomes will form part of the staff ESR record, which will enable assurance reports to be drawn relating to access to career progression and development opportunities. The national Staff Survey provides evidence that black and minority ethnic staff report a less favourable experience relating to career progression and access to progression.

Any further implications evidenced will be reported within the quarterly progress report to People and OD Committee and following actions assurance to Trust Board.</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td>Safe, high quality care ☒</td><td>Care at home ☐</td></tr>
<tr><td>Partners ☐</td><td>Value colleagues ☒</td></tr>
<tr><td>Resources ☐</td><td></td></tr>
</table>

Valuing Colleagues Improvement Programme – Leadership and Talent Management

1. PURPOSE OF REPORT

The purpose of this report is to provide an update on the Trust's Leadership, Culture and OD work-stream, specifically to update on Leadership and Talent Management. This work is part of the implementation plan for Valuing Colleagues within the Trust Improvement Programme which aims to achieve a CQC outstanding rating for the Trust by 2022. The Board are asked to note the joint work with the NHS Leadership Academy is complete. The Board are also asked to note next steps towards engaging colleagues within the Divisions to design interventions for the Trust Organisation Development plan due to be considered by the People and OD Committee in November.

The Board are asked to note that one of the actions relating to Talent Management, appraisal and development has been "fast-tracked" and a new process, supported by refreshed appraisal paperwork was launched at the Leadership Conference held in October. This is out for a 2 month consultation period, with a view to launching a new approach to underpin talent management within the Trust to be launched in the new-year January 2020.

2. BACKGROUND

The Trust worked in partnership with the NHS Leadership Academy and the Trust's 100 top leaders to complete a leadership diagnostic within the Trust in order to achieve an inclusive view of the development required.

3. DETAILS

Leadership Diagnostic – Top 100 Leaders:

The Trust and NHS Leadership Academy completed a diagnostic (appreciative inquiry) which covered:

a. Working in the trust
b. The culture of the trust
c. Behaviours being exhibited
d. Development needs
e. Strengths
f. Issues and challenges

High level messages were considered at the Leadership conference held in October 2019. The themes and messages:

a. This is a valuable approach, it is good to be heard, expectations high now for action.
b. Leadership – lots of managers not enough leaders, Executive vision can get lost, need to grow and develop leaders.
c. Accountability – not clear, micro-management, complex governance, not consistent between staff groups
d. Frustration – empowerment variable, clarity on innovation, finances.
e. Equality Diversity and Inclusion – not fully understood.
f. Talent and Development – poor experience of appraisal, staff development and career progression.
g. Values and Behaviours – pockets of excellence however some poor practice too.

These messages correlate with the most recent Pulse Survey and the focus groups on Trust Values already considered by the Trust Board.

The next steps will be to consider the Leadership Diagnostic through TMB and the Divisional Meetings with a view to co-designing an Organisation Development plan (including a Leadership and Management Development offer) capable of empowering Trust leaders at all levels, to achieve the Trust ambition of being outstanding for patients by 2022.

Talent Management and Development

The action relating to Talent and Development has been 'fast tracked' to address the immediate issues highlighted and those that are evident within the NHS National Staff Survey. These are in particular that the appraisal is a 'tick box exercise' lacking in quality conversation and there is not a consistent approach across the Trust.

This has been taken as an area for action since it is a vital cornerstone in determining staff engagement, staff morale and the general sense of how valued people feel. It is therefore by definition the biggest difference and contribution those in leadership positions can make towards making the Trust a place all would recommend as a place to work and as a place to be treated.

There is an evidenced differential experience reported through the NHS staff survey 2018, relating to the following question: Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Staff from a black and minority ethnic background report a less favourable experience.

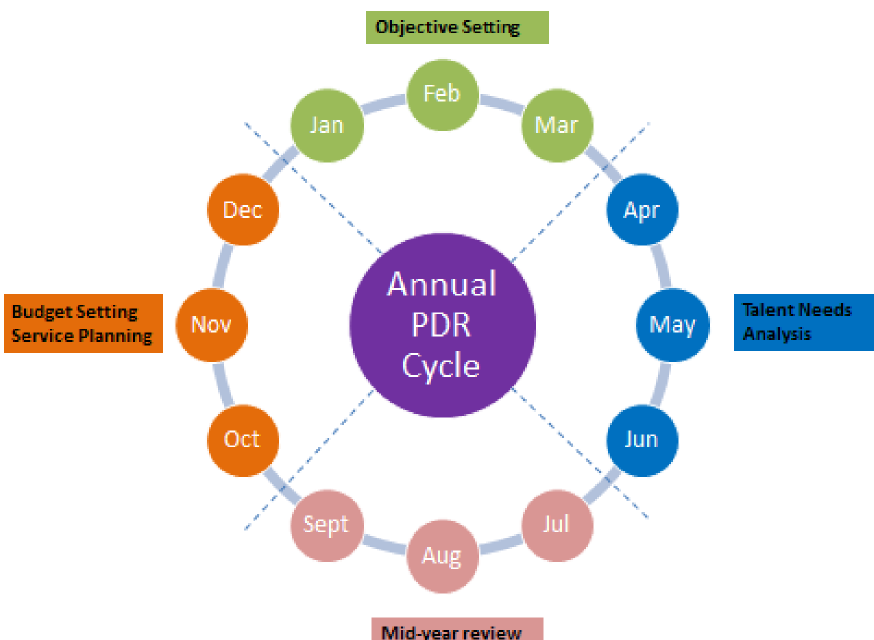
The proposed process introduces the NHS Leadership approach to Talent Management and maximising potential talent management conversations and includes career progression as well as development planning. The outcomes will form part of the staff ESR record, which will enable assurance reports to be drawn relating to access to career progression, promotion and development opportunities. This will enable the Trust Board to seek

assurance from a robust evidence base relating to how inclusively the Trust is managing, developing and retaining talent.

The proposed approach to annual appraisal cycle includes:

- Golden Thread – Board to Ward [link to the strategic spheres]
- Common Objective on Trust Values and Behaviours
- Common Objective for Managers/Leaders [clear expectations]
- Link to ESR in order to evaluate access to career progression/promotion and development opportunities
- Introduction of Improvement Objectives
- Talent Management Maximising Potential [in all appraisals]
- Career Development needs recorded and monitored for equality of access
- Structured Individual Development Plan [supported by development offer]
- Core compliance with mandatory, statutory and essential training [time/access]

The changes to the processes are supported by a proposed Trust wide approach to planning for appraisal, objective setting, talent management and delivery of individual development plans, summarised below:



The attendees of the Leadership Conference held in October have already received a link to the proposed appraisal process to test the approach. Those completing PDRs during November will be asked to pilot the new paperwork and following evaluation and re-design in December; the new process will be launched in January 2020.

RECOMMENDATION

For Trust Board to note the work in progress and resolve to receive an update from People and Organisation Development Committee on the OD Organisation Development Plan in December.

BAF Risk- S06 **Risk Owner; Director of Finance** **Date of Review; 22nd October 2019**		
Strategic Objective; **Use Resources** well to ensure we are sustainable - through the alignment of the overall Trust-wide improvement programme to ensure financial sustainability and sustainable benefits.	**Risk Appetite;** Risk Appetite; The Trust is prepared to accept a moderate risk appetite on finance where this would impact on patient safety. The Trust will accept a low appetite for enhancing quality or patient safety beyond safe levels to the detriment of its financial stability. The Trust will ensure all decisions taken are aligned to our principle of ensuring good use of resources.	Initial Risk Rating 5 (L) x 5 (I) = 25, High Current Risk Rating 5 (L) x 4 (I) = 20, High Target Risk Rating 2 (L) x 3 (I) = 6, low
Risk; Failure to improve our financial health results in regulatory action	**Rationale for current score** • High Level LTFTM developed and presented to the Board in March 2019 • Trust has attained plan in month 6 • Cost Improvement Programme delivery remains on plan (though is not attaining the stretch targets) • Income is below plan	**Future risks** • management of cash flow • Failure to deliver further run rate mitigation plans.
Controls / Assurance • Performance Management regime in place and performance reports to the board. • Contract monitoring process • Finance & Performance Committee in place, • CIP Governance processes In place	**Gaps in controls / assurance** • Gaps in current Demand and Capacity Model • Temporary workforce spend is not decreasing at the levels expected • Business planning processes require strengthening	**Future Opportunities** • Further Development of LTFM • Efficiency saving in relation to collaboration • Further alignment of corporate financial support to the divisions • GIRFT and Model Hospital

Performance Report

October 2019
(September 2019 Results)

Author: Performance & Information team
Lead Director: Russell Caldicott – Director of Finance and Performance

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Walsall Healthcare NHS
NHS Trust

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Quality, Patient Experience and Safety Committee

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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: Pamela Bradbury

Key Areas of Success

- The number of falls reduced in month as focused effort continues to identify the root causes and putting a range of actions in place to address the issues. This effort will continue until practice is embedded.
- The number of hospital and community acquired pressure ulcers continues to improve and requires ongoing sustained effort to maintain this position.
- The number of open complaints and response rates within 30 and 45 days have all improved.
- Dementia screening has seen this month improvement and continued effort to maintain this position continues.

Key Areas of Concern

- Dementia screening (although improved) continues to be under performing and required sustained effort to ensure this becomes part of usual business for patients
- The birth to midwife ratio has moved to 1:32 in September. Factors contributing to this were related to the cap level for deliveries, insufficient planning with the roster to ensure all shifts were covered with the correct staffing level which was actioned mid-month. In addition there was a sickness level of 6.15% and low uptake of bank requests. The acuity level was 59% which was the lowest it has been for some time
- Complaints trajectory will show a continued concerted effort is required to ensure performance is achieved by year end, this require all Divisions to take responsibility for this trajectory.

Key Focus for Next Committee

- Efforts on reduction of falls as well as reduction in harm from falls in hospital continues until changes in practice are embedded so the Committee remains sighted on this for the foreseeable future.
- VTE continues to be a focus for the committee until practice changes take effect

Walsall Healthcare 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

C Difficile

HSMR

Narrative (supplied by Director of Nursing)

In September there were 2 C Diff cases attributed to the Trust.

The Trust has had a total of 14 cases YTD against a target of 26 cases for the year this is 1 case over the trajectory for this point in the year.

Narrative (Supplied by Medical Director)

- HSMR for the May is 107.28 and 109.73 respectively (YTD 111.62).
- SHMI for May 2019 is 97.59 (YTD 96.69).
- Alerts have identified potential concerns for Acute and unspecified renal failure, Respiratory failure, Fracture neck of femur and Pneumonia which have prompted further actions.
- Extensive advice sought to improve the processes and reporting of mortality in the trust. A broad paper has been submitted to QPES.
- Medical Examiner role is expected to start in December 2019.

Walsall Healthcare NHS
NHS Trust

Quality, Patient Experience and Safety Committee

SPC Key: Mean; Process limits - 3σ; High or low point; Special cause - improvement; Special cause - concern; Target; 0

Pressure Ulcers

Falls

Narrative (supplied by Director of Nursing)

Across the Trust in September 2019 there was a total of 15 acquired pressure ulcers reported for the hospital and community compared to 18 reported in the previous month; effort continues to identify root causes and put relevant actions into place.

Narrative (supplied by Director of Nursing)

The number of falls decreased in September 2019 with 70 falls reported, an improvement from the 89 falls reported in August 2019. In September 2019 the ratio of falls per 1000 bed days decreased to 4.47 from the 6.18 ratio reported in August 2019. Focused effort continues to apply practice changes, until these changes are embedded.

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE 2019-2020

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no..	HSMR (HED) nationally published in arrears	117.55	107.28	109.73				111.62	100.00		N
no..	SHMI (HED) nationally published in arrears	95.88	97.59					96.69	100.00		BP
no	MRSA - No. of Cases	0	0	0	0	0	1	1	0	2	N
no	Clostridium Difficile - No. of cases	3	3	3	2	1	2	14	26	19	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.82	0.93	0.56	0.80	1.09	0.58				
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.31	0.59	0.21	0.55	0.14	0.21				
no..	Falls - Rate per 1000 Beddays	5.02	5.17	6.05	5.01	6.18	4.47		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	4	1	0	0	4	3	12	0	13	BP
%..	VTE Risk Assessment	91.01%	92.02%	92.29%	93.20%	93.83%	93.42%	92.64%	95.00%	94.90%	N
no	National Never Events	0	0	0	0	0	0	0	0	17	N
no..	Midwife to Birth Ratio	1:24.2	1:26.9	1:27.3	1:31.5	1:27.5	1:32.1		1:28	1:28.1	N
%..	C-Section Rates	29.20%	27.55%	28.01%	34.77%	33.45%	26.24%	29.87%	30.00%	28.46%	BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.12%	12.22%	10.13%	11.21%	12.70%			10.00%	10.73%	L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	85.23%	85.72%	85.04%	83.65%	85.49%	87.87%	85.48%	100.00%	84.47%	N/L
%..	Compliance with MCA 2 Stage Tracking	68.97%	59.26%	69.57%	61.76%	56.00%	62.50%	63.21%	100.00%	62.44%	BP
%..	Friends and Family Test - Inpatient (% Recommended)	96.00%	96.00%	96.00%	96.00%	93.00%	95.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	93.72%	92.69%	93.28%	92.73%	91.94%	91.71%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	89.12%	85.74%	84.92%	85.11%	85.69%	86.12%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	97.04%	96.21%	96.32%	96.65%	96.56%	96.33%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	92.67%	92.85%	93.10%	91.61%	90.04%	89.17%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	89.16%	84.75%	85.68%	87.37%	87.05%	86.56%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	95.37%	95.08%	95.45%	94.26%	93.68%	92.05%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	83.38%	85.12%	89.64%	90.89%	89.91%	89.20%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	88.98%	90.37%	89.96%	90.24%	89.46%	88.06%		85.00%		L

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):

The SPA is set to continue as a Winter SPA with a new triage tool as a pilot with a B4 Clinical Assistant Practitioner, there will be oversight of a Qualified senior Nurse in Rapid Response. There will be a detailed analysis of the pilot in November/December

Clinical Intervention Team *:* Pilot Project for 24 hr IV antibiotic infusion/ administration in the community in progress with launch dates predicted for October, the Team currently provide daily or twice daily therapy, this enhanced model will support care at home for patients who currently need IV therapy greater than twice daily for conditions such as bacterial endocarditis, osteomyelitis. The SOP has been agreed at Community Divisional Board and a pilot patient is receiving IV intervention through this device at home with daily attendance / review at Hollybank House clinic.

Key Actions Taken

Quality and assurance team for care homes: Lead appointed to as secondment until end of March 2020, start date 21st October, recruitment ongoing for all other new posts, start dates to follow shortly. This pilot is focussed on replicating the success that has been seen with the nursing homes

Points to Note

The next page shows the first working version of an operational dashboard for Walsall Together. Over the coming months this board will be refined from feedback and will include more high-level information relating to the flow of patients through the different areas of the system.

The headline dashboard is current broken down into four columns.

Resilient Communities – This shows the activity of the newly deployed social prescribers within 3 areas of the borough. The data in this part of the dashboard will highlight the work that teams are undertaking to keep the population healthy at home

Complex MDT's – The recruitment of the formal GP posts is underway. Once this is complete this areas will show how the teams are integrating to manage complex patients in the community

Community Contacts – This area of the dashboard highlights the headline activity for the community teams and where the demand and capacity challenges exist.

Intermediate Care Services - Finally this area shows the discharge part of the partnership and how continuing care is effective in the system. Again this area will develop over future months.

Walsall Healthcare
NHS Trust

Resilient Communities

Complex MDT's
Not yet ready for reporting

Community Contacts

Intermediate Care Service

Referrals by Pilot Area (April - June 2019)

Referrals by Referring Practitioner (April - June 2019)

Prevelance of Presenting Issues (April - June 2019)

Community Activity- starting 01/04/15

Rapid Response

Number of patients case managed in care homes

Medically Fit For Discharge-Average days per person starting 01/03/18

Medically Fit For Discharge-Total Patients MFFD starting 01/03/18

Average Length of Stay (Bed v Home)

This is the first set of data which has been validated shows active referrals in two of the localities and developing work within the partnerships discharge pathways. Referrals can come from any part of the partnership but the focus is anticipated to be around the resilient community and integrated health and care teams. Once the MDT's are fully deployed the link between the work streams should be definable.

Community activity and case load continues to grow as outlined in the top graph. The district nursing caseload in particular is above contracted activity and demonstrates that more is being managed within the community teams. Rapid response activity continues to follow the same trend. Avoided admissions in this area continue to average between 88 - 92%. Finally there continues to be a steady increase in the complex case load of our nursing home teams. More complex cases are being managed at home for longer rather than being referred. The last two teams are running at capacity.

The average length of stay for patients considered fit for discharge shows continued improvement in the borough. However the data overall shows huge variability in the Length of Stay (LOS) largely due to complex out of area patients. The teams are now working on how to deliver the same improvements that have been delivered within Walsall. The bottom table shows consistency in the home pathway LOS but variability in bed based care within the community. This is being targeted by the teams including therapy input.

INTEGRATION
2019-2020

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.12%	12.22%	10.13%	11.21%	12.70%		11.47%	10.00%	10.73%	L
no	Rapid Response Team - Total Referrals	273	276	269	270	253	240				L
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	226	239	235	244	222	205				L
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours	71.08%	66.28%	63.44%	72.73%	73.10%	68.40%				L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.18%	7.79%	7.89%	7.84%	8.37%	7.07%	7.71%	7.00%	7.43%	BP
	RESOURCES										
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only (Mon&Thurs)	36	31	35	31	34	35				
no	Average Number of Medically Fit Patients - Trust (Mon&Thurs)	25	30	32	25	24	22				
	PARTNERS										
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	37.88	36.26	35.94	37.25	33.03	35.71				L
no	Nursing Contacts per Locality - Total	18619	19182	18447	19638	19370	18433	113689		205571	L
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	2.16	2.03	2.09	2.30	2.07	1.90				L
no	No. of patients on stroke pathway in partnership with Wolverhampton (one month in arrears)	3	4	6	7	3					L

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

- Appraisals compliance rising above 83% average.
- Mandatory training 5 competencies are above 91%, with IG compliance peaking at 93%.
- Sickness absence shows reduction in short-term absences
- Retention - improved to 10.38% in September just short of the 10% target.

Key Areas of Concern

- Sickness Absence - increased to 5.79% from 5.30%. With a 26% spike in Stress/Anxiety-related absence,
- Mandatory Training –.although some areas are showing improvements the overall performance achieved 88.79% in September.

Key Actions Taken

- Following an invitation to join the NHSI facilitated Retention Direct Support Programme (Cohort 5); the Trust will increase its role in the national retention programme, gaining and sharing insight regarding best practice.
- A Cessation of Smoking project group has been established, with a remit to implement a no smoking campaign before the national No Smoking Day. Several events were held in and around the Health & Wellbeing Hub, including a survey of male colleagues to ascertain any gender-specific support needs.
- The Flu Prevention Campaign has commenced, with a target of 80% immunisation amongst the workforce
- Mandatory training packages continue to be streamlined, with Infection Control training set be included within future Trust Induction programmes
- Additional PDR workshops will be scheduled in early 2020. Two E-learning packages for IPDR Training are being developed, one for staff and one for managers

Value colleagues

Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee

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

Retention (24 Months)-Walsall Healthcare NHS Trust starting 01/10/17

Sickness Absence (In Month)-Walsall Healthcare NHS Trust starting 01/10/17

The retention of AHP & Scientific colleagues remains a challenge. Retention high amongst Admin (89.1%) & Estates (88.9%) colleagues.

A 26% spike in Stress/Anxiety-related absence. Reductions in MSK-related absence.

Respect
Compassion
Professionalism
Teamwork

Walsall Healthcare NHS Trust

People and Organisational Development Committee

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

Mandatory Training Compliance-Walsall Healthcare NHS Trust starting 01/10/17

Mean — Process limits - 3σ — High or low point — Special cause - improvement — Special cause - concern — Target — Mandatory Training Compliance

Appraisal Compliance-Walsall Healthcare NHS Trust starting 01/10/17

Mean — Process limits - 3σ — High or low point — Special cause - improvement — Special cause - concern — Target — Appraisal Compliance

5 Competencies are above 91%, with IG compliance peaking at 93%. Continued deterioration in Clinical Update and Safeguarding compliance.

Compliance rising above 83% average.
Completion continues to be low within Corporate directorates.

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE 2019-2020

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	% of RN staffing Vacancies	8.52%	9.65%	10.84%	11.28%	8.66%	9.83%				BP
%..	Mandatory Training Compliance	86.62%	86.84%	87.60%	89.09%	89.25%	88.79%		90.00%	86.67%	L
%..	PREVENT Training - Level 1 & 2 Compliance	93.72%	92.69%	93.28%	92.73%	91.94%	91.71%		85.00%		L
%..	PREVENT Training - Level 3 Compliance	89.12%	85.74%	84.92%	85.11%	85.69%	86.12%		85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	97.04%	96.21%	96.32%	96.65%	96.56%	96.33%		95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	92.67%	92.85%	93.10%	91.61%	90.04%	89.17%		85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	89.16%	84.75%	85.68%	87.37%	87.05%	86.56%		85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	95.37%	95.08%	95.45%	94.26%	93.68%	92.05%		95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	83.38%	85.12%	89.64%	90.89%	89.91%	89.20%		85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	88.98%	90.37%	89.96%	90.24%	89.46%	88.06%		85.00%		L
	VALUE COLLEAGUES										
%..	Sickness Absence	6.00%	5.47%	5.63%	5.38%	5.30%	5.79%		3.39%	6.04%	L
%..	PDRs	80.67%	81.60%	81.73%	82.20%	81.93%	83.47%		90.00%	83.66%	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	4.61%	7.37%	7.96%	6.97%	8.26%	7.84%		6.30%	9.14%	L
%..	Agency expenditure as % of Paybill	2.76%	4.83%	4.49%	4.41%	5.29%	5.50%		2.75%	4.90%	L
no	Staff in post (Budgeted Establishment FTE)	3871	3905	4022	4033	3978	3966				L
%..	Turnover (Normalised)	11.65%	11.92%	11.68%	11.07%	11.04%	10.38%		10.00%		

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

- September saw continued improvement in EAS performance compared to the Q1 mean and met the submitted trajectory (83%) despite Type 1 ED attendances being 10.4% higher than September 2018. The DM01 standard was met for the third consecutive month achieving performance of 0.10% service users waiting over 6 weeks meeting the 1% national target .
- Trust has attained plan at a £5.4m deficit at month 6, though has an operational deficit of £1.8m 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

- As forecast, due to taking increased Breast referrals from Wolverhampton to support RWT, both Cancer 2 week metrics saw deterioration. Cancer 62 RTT and Cancer 62 Day Upgrade also deteriorated, contributed to by the record number of suspected cancer referrals in July. RTT performance also represents a further month of deterioration, which is now 4 consecutive months of deteriorating performance.
- September saw continued high ED attendances, with Type 1 attendances having risen by 9.2% Apr- Sept 2019 compared to the same period of 2018/19.
- The Trust has a £1.8m operational deficit to plan at month 6 (attaining plan through a movement in reserves). The Trust will need to mitigate the adverse operational deficit through continued focus being placed upon improvements within medically stable, closure of additional capacity, reductions in sickness and reducing temporary workforce, alongside grip and control measures and 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 this has been partially mitigated, though additional emergency admissions requiring additional capacity has introduced further costs, the risk to delivery of the outturn currently £5m based on run rate modelling (£7m deficit with lost quarter 4 Provider Sustainability Funding)

Key Actions Taken

- ED Medical workforce review near completion which will produce a rota matching staffing to peak times of demand. Nursing workforce review undertaken and presented to JNC (Aug). RTT; 120 pain referrals transferred to another provider, ENT substantive consultant commenced in September.
- Implementation of the Executive led measures to improve run rate, with further reviews on-going to improve current 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 MLTC Division recovery plans.
- The Trust Board formation of 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 to monitor and provide mitigation to the risk to delivery of the financial plan

Key Focus for Next Committee

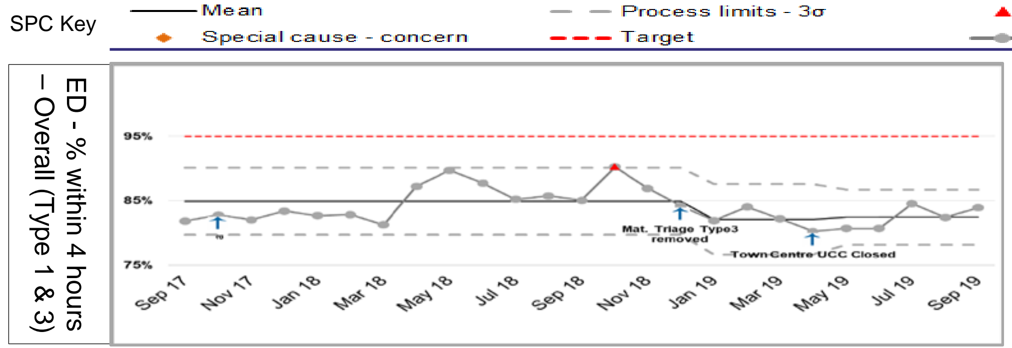
- Review of run rate to actual delivery (including winter expenditure plans) with an assessment of risk regarding the central mitigations with a view to development of a forecast for close of the financial year

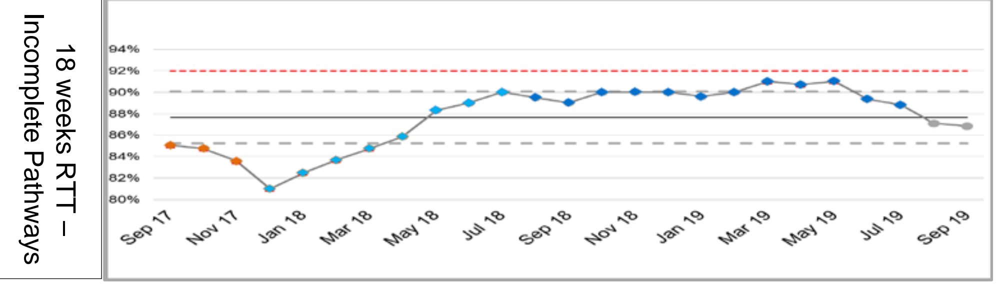
Value colleagues

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

SPC Key — Mean; Process limits - 3σ; High or low point; Special cause - improvement; Special cause - concern; Target; 0





Cancer 62 Day RTT

95%
80%
65%

Aug 17, Oct 17, Dec 17, Feb 18, Apr 18, Jun 18, Aug 18, Oct 18, Dec 18, Feb 19, Apr 19, Jun 19, Aug 19

Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

Type 1 attendances remained high in September, with attendances 10.4% up on September 2018. This was particularly notable on 16th September with attendances of 305 and 286 on 23rd September. In spite of this, this is now the 2nd month of the past three months (July and September) that we have met the trajectory of four-hour emergency access standard agreed with NHS Improvement.

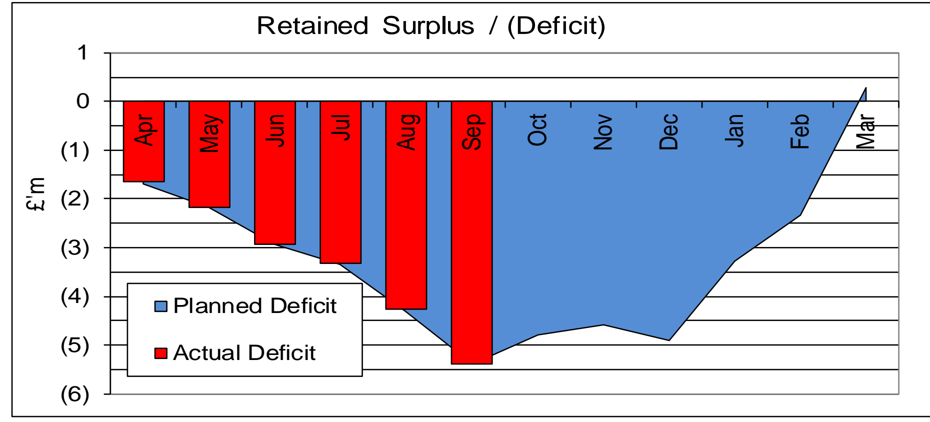
RTT

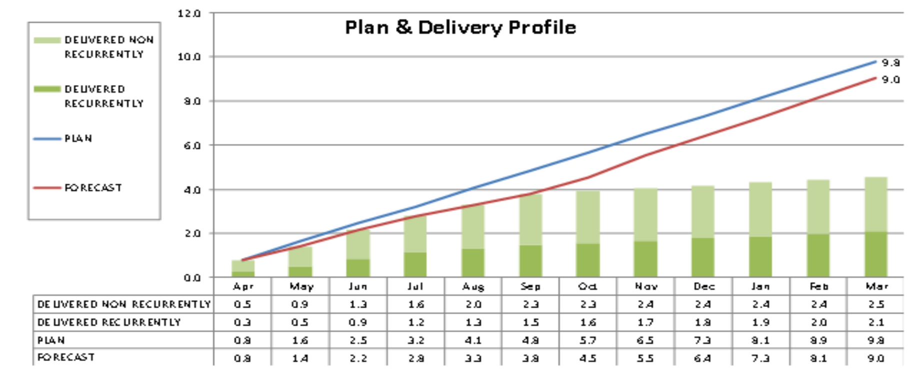
The Trust RTT incomplete pathway performance for September is 86.86%. The overall number of patients on the PTL increased from the August position by circa 300, which indicates a stabilisation in terms of growth for incomplete pathways. RTT recovery plans are developed and will begin to reduce the incomplete numbers during October and November, with the focus on long waits.

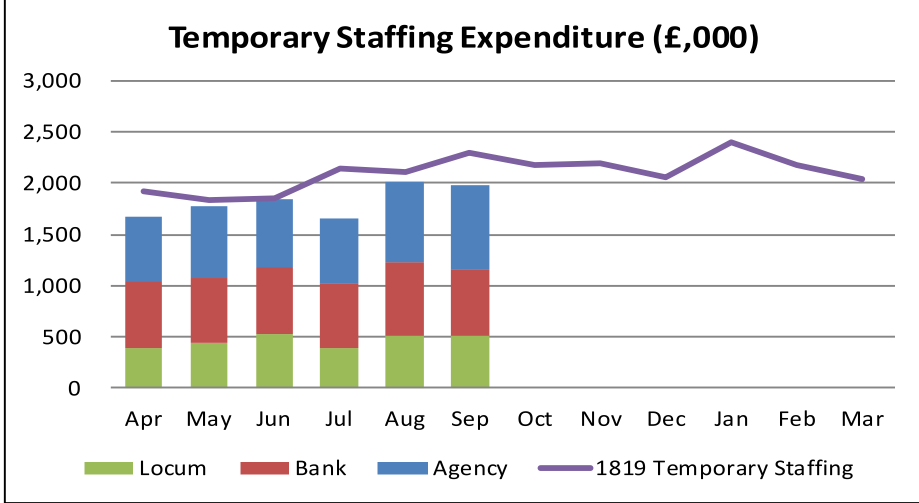
Cancer

The Trust failed to achieved the constitutional measure for Cancer 2 week waits with a performance of 84.73% and 62 day RTT with a performance of 77.5%. Increasing Breast referrals from RWT are highly likely to result not only in non-compliance of Breast Symptomatic 2WW standard, but also of Trust suspected cancer 2WW standard. The Trust changed Diversion arrangements on the 10/10/2019 due to RWT and WHT booking days equalised. The Trust continues to achieve Cancer 31 Day measures and have also achieved cancer 62 days referral to treatment from screening in August.

Financial Performance to September 2019 (Month 6)







Financial Performance

- Trust has an operational deficit of £1.79m (behind plan), though has attained plan following a movement in reserves
- Overspending on pay is reflective of the cost overruns within Medical & Long Term Conditions (MLTC) drivers being sickness and servicing of unfunded capacity
- Income is below plan (against CCG contracts), largely as a consequence of reduced births, ED coding underperformance and elective underperformance in month
- The Executive have endorsed improved run rate measures (endorsed at Extra-ordinary Trust Board) to mitigate run rate risks and further reviews are ongoing to assure full mitigation

CIP Delivery

- The Trust's Cost Improvement Programme requirement is £8.5m (£10.5m stretch) .
- The CIP has delivered £3.8m YTD, behind on plan (£0.2m) and below the stretch target of £4.8m (£1m behind stretch). In addition, £2.3m 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 for the month is £1.7m.
- 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 30th September 2019

Description	Annual Budget	Budget to Date	Actual to Date	Variance
	£'000	£'000	£'000	£'000
Income				
CCGs	211,305	105,705	104,883	(822)
NHS England	18,110	9,029	9,297	268
Local Authorities	8,865	4,447	4,492	46
DoH and Social Care	18,380	6,641	6,806	165
NHS Trusts/FTs	1,008	494	523	29
Non NHS Clinical Revenue (RTA Etc)	1,060	530	560	30
Education and Training Income	6,840	3,429	3,457	28
Other Operating Income (Incl Non Rec)	7,666	4,111	4,513	402
Total Income	**273,233**	**134,386**	**134,532**	**146**
Expenditure				
Employee Benefits Expense	(177,757)	(88,102)	(88,962)	(860)
Drug Expense	(11,174)	(8,632)	(8,812)	(180)
Clinical Supplies	(15,365)	(8,009)	(8,714)	(705)
Non Clinical Supplies	(17,763)	(9,061)	(8,976)	85
PFI Operating Expenses	(5,444)	(2,722)	(2,777)	(55)
Other Operating Expense	(28,894)	(14,837)	(13,131)	1,706
Sub - Total Operating Expenses	**(256,397)**	**(131,363)**	**(131,373)**	**(10)**
Earnings before Interest & Depreciation	**16,836**	**3,023**	**3,159**	**136**
Interest expense on Working Capital	51	26	40	15
Interest Expense on Loans and leases	(10,387)	(5,193)	(5,394)	(201)
Depreciation and Amortisation	(6,500)	(3,250)	(3,027)	223
PDC Dividend	0	0	0	0
Losses/Gains on Asset Disposals	0	0	0	0
Sub-Total Non Operating Exps	**(16,836)**	**(8,418)**	**(8,381)**	**37**
Total Expenses	**(273,233)**	**(139,781)**	**(139,754)**	**27**
Less Prior Year PSF			(165)	(165)
RETAINED SURPLUS/(DEFICIT)	**0**	**(5,395)**	**(5,387)**	**8**

Use of Resources Ratings (M6)

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

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending September 2019	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	132
Depreciation and Amortisation	3,027
(Increase)/Decrease in Trade and Other Receivables	(7,812)
Increase/(Decrease) in Trade and Other Payables	(6,448)
Increase/(Decrease) in Stock	10
Increase/(Decrease) in Provisions	1,714
Other movementss in operating cash flows	165
Interest Paid	(5,394)
Net Cash Inflow/(Outflow) from Operating Activities	**(14,606)**
Cash Flows from Investing Activities	
Interest received	**41**
(Payments) for Property, Plant and Equipment	**(3,192)**
Net Cash Inflow/(Outflow)from Investing Activities	**(3,151)**
Net Cash Inflow/(Outflow) before Financing	**(17,757)**
Cash Flows from Financing Activities	15,235
Net Increase/(Decrease) in Cash	**(2,522)**
Cash at the Beginning of the Year 2018/19	4,186
Cash at the End of the September	**1,664**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending September 2019	Balance as at 31/03/19	Balance as at 30/09/19	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Total Non-Current Assets	**141,208**	**140,263**	**(945)**
Current Assets			
Receivables & pre-payments less than one Year	16,532	24,619	8,087
Cash (Citi and Other)	4,186	1,664	(2,522)
Inventories	2,362	2,352	(10)
Total Current Assets	**23,080**	**28,635**	**5,555**
Current Liabilities			
NHS & Trade Payables less than one year	(29,461)	(21,746)	7,715
Other Liabilities	(1,445)	(2,047)	(602)
Borrowings less than one year	(15,590)	(17,631)	(2,041)
Provisions less than one year	(117)	(1,831)	(1,714)
Total Current Liabilities	**(46,613)**	**(43,255)**	**3,358**
Net Current Assets less Liabilities	**(23,533)**	**(14,620)**	**8,913**
Non-current liabilities			
Borrowings greater than one year	(202,939)	(215,267)	(12,328)
Total Assets less Total Liabilities	**(85,264)**	**(89,624)**	**(4,360)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	64,190	65,052	862
Revaluation	15,925	15,925	-
Income and Expenditure	(165,379)	(165,379)	-
In Year Income & Expenditure	-	(5,222)	(5,222)
Total TAXPAYERS' EQUITY	**(85,264)**	**(89,624)**	**(4,360)**

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE 2019-2020

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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)	80.22%	80.68%	80.68%	84.57%	82.38%	83.92%	82.05%	95.00%	85.90%	N
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	62.49%	66.92%	60.93%	63.65%	62.49%	59.46%	62.48%	100.00%	72.20%	BP
no	Ambulance Handover - No. of Handovers completed over 60mins	35	16	21	5	12	27	135	0	155	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	82.46%	94.48%	95.61%	90.81%	84.73%	84.35%	88.80%	93.00%	93.59%	N
%..	Cancer - 62 day referral to treatment of all cancers	80.90%	67.71%	90.10%	86.21%	77.53%	79.31%	80.00%	85.00%	85.35%	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	90.72%	91.04%	89.37%	88.83%	87.11%	86.86%		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	3.15%	6.50%	4.13%	0.33%	0.22%	0.10%	2.58%	1.00%	0.32%	N
no	No. of Open Contract Performance Notices	10	11	11	11	11	11	11	0	9	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	7.18%	7.79%	7.89%	7.84%	8.37%	7.07%	7.71%	7.00%	7.43%	BP
	RESOURCES										
%..	Outpatient DNA Rate (Hospital and Community)	10.63%	10.35%	9.93%	10.57%	11.34%	9.88%	10.44%	8.00%	10.44%	L
%..	Theatre Utilisation - Touch Time Utilisation (%)	89.54%	86.70%	86.99%	86.94%	85.57%	89.59%		75.00%		L
%..	Delayed transfers of care (one month in arrears)	3.51%	2.65%	3.27%	3.45%	3.43%			2.50%	3.46%	L
no	Average Number of Medically Fit Patients (Mon&Thurs)	85	80	87	75	77	81				
no	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	12.34	10.46	12.57	11.23	9.51	11.02				
£	Surplus or Deficit (year to date) (000's)	£45	£3	£4	£14	£35	£8	£8		-£27,669	L
£	Variance from plan (year to date) (000's)	£45	£3	£4	£14	£35	£8	£8		-£17,038	L
£	CIP Plan (YTD) (000s)	£900	£1,600	£2,500	£3,200	£3,300	£4,800	£4,800		£15,500	L
£	CIP Delivery (YTD) (000s)	£800	£1,400	£2,200	£2,800	£3,300	£3,800	£3,800		£11,100	L
£	Temporary Workforce Plan (YTD) (000s)	£1,300	£2,700	£4,200	£6,000	£7,600	£9,400	£9,400		£19,400	L
£	Temporary Workforce Delivery (YTD) (000s)	£1,700	£3,500	£5,300	£6,900	£8,900	£10,900	£10,900		£25,200	L
£	Capital Spend Plan (YTD) (000s)	£500	£800	£1,600	£2,400	£3,200	£4,100	£4,100		£12,200	L
£	Capital Spend Delivery (YTD) (000s)	£700	£1,200	£1,300	£1,700	£2,000	£2,500	£2,500		£13,100	L

Walsall Healthcare NHS Trust

Glossary

Glossary

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

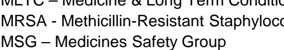
Always Event® - those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system

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



Partners

Walsall Healthcare NHS
NHS Trust

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

BAF Risk- S03
Risk Owner; Interim Director of Walsall Together
Date of Review; 22nd October 2019

Strategic Objective; **Care at Home**– by delivering services within the scope of Walsall Together; having a clear set of plans for joined up working with voluntary and housing partners; integrated secondary care pathways and social care collaboration	**Risk Appetite;** The Board is prepared to accept a high risk appetite on the development of integrated pathways across partner organisations to deliver sustainability. It has a moderate risk appetite on development of technology driven improvements and on sustainability to deliver the Trust vision.	Initial Risk Rating 4 (L) x 5 (I) =20, Major Current Risk Rating 4 (L) x 4 (I) = 16, Moderate Target Risk Rating 2 (L) x 3 (I) = 6, low
Risk; Failure to develop effective partnerships within the Walsall Together Partnership may result in the Trust being unable to deliver integrated secondary care pathways and social care collaboration	**Rationale for current score** • Continuation of engagement with PCNs; • Advancing Place-Based Care – self assessment; • Recruitment in progress to appoint a Communications Lead; • System operational performance – application of 'Making Data Count'; • Staff engagement; • Development of better working relationships across the system	**Future risks** • the future requirements for operational leadership; • Estates – ability to fund the full business case offering (4 Health & Wellbeing Centres) • Financial model – funding for pump priming and ability to invest in preventative services and ability to build capacity and resource in the voluntary sector
Controls / Assurance • Executive lead for Walsall Together in place • Non-Executive Director for Walsall Together appointed • Business case approved by Partners • Alliance agreement signed by Partners	**Gaps in controls / assurance** • Current leadership post Interim • Lack of investment across the health economy impacts on the delivery of the Partnership • Commissioner contracts to be aligned to Walsall Together	**Future Opportunities** • Further development of the Governance • S75 Development

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th November 2019			
Walsall Together Report			AGENDA ITEM: 16
Report Author and Job Title:	Michelle McManus Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Interim Executive Director of Walsall Together
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This paper updates the Board Members on the key Walsall Together work undertaken this month: • Continuation of engagement with PCNs; • Advancing Place-Based Care – self assessment; • Recruitment in progress to appoint a Communications Lead; • System operational performance – application of 'Making Data Count'; • Staff engagement; • Consideration of the future requirements for operational leadership; • Development of better working relationships across the system. To provide assurance on delivery of the transformation, the programme office produces a suite of documents to the WTP Board on a monthly basis. The update this month is included in section 10 of this update. Overall good progress is being made on the whole programme. Areas of slower progress or regression are reported in this short section and the attachment. All recovery actions are being coordinated by the Walsall Together SMT and the Walsall Together Board		
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
OCTOBER 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

A Highlight Report from the Walsall Together Partnership (WTP) Board is included in the Committee section of the Board papers.

The Clinical Operating Model (COM) Group met on 7th October 19 and was well attended. Each of the agreed priority pathways has now been reviewed by the respective leadership teams and areas for improvement have been identified. The Group will continue to monitor the ongoing work in each area and will identify key recommendations for the Walsall Together Partnership Board to take forward.

3. PCN ENGAGEMENT

Each of the 4 localities in Walsall has nominated a PCN Lead to engage in Walsall Together across the governance/decision-making forums and the wider programme of transformation activities. GPs to support MDTs across each of the 7 place-based teams have also been identified. The PCN leads are now actively engaging with the Walsall Together governance meeting which is a significant step forward.

Discussions are ongoing with PCN Nominated Leads to develop a proposal to make use of the resource available to support governance and the wider programme. There are 10 sessions per month allocated to formal governance meetings and 6 sessions per month remaining to support the wider programme. The areas that have been identified as a priority in respect of having primary care leadership indicate that 10 sessions per month would be required to ensure full coverage. An interim proposal within the 6-session envelope is being developed with the PCN Leads and the WTP Board is considering how full coverage of the programme can be achieved in the context of future funding.

4. ADVANCING PLACE BASED CARE – BLACK COUNTRY STP

The Strategy Unit, on behalf of the Black Country and West Birmingham STP, has produced an analysis of the current state of place-based care. The document 'Advancing Place Based Care' establishes 7 evidence-based characteristics of effective place-based care and provides a framework for shaping the accelerated development

of local models. Going forwards, there is commitment to “deepening and extending cross-STP collaboration in relation to place-based care”. In other words there will be a formal ‘place’ workstream established across the STP with the first meeting taking place last month.

There is detailed analysis for each of the 5 places across the Black Country and West Birmingham along with some general recommendations that will be considered at a system workshop in the future. The document has been shared with the Walsall Together Senior Management Team (SMT) and a self-assessment has been undertaken that will be presented to the WTP Board in November.

Feedback at a Black Country STP workshop suggests that the progress made in Walsall has been recognised and other areas of the system will be looking to replicate parts of the Walsall Together model in their areas. Walsall is the only borough in the Black Country that has maintained a credible balance between operational delivery, future state governance/ shape and programme management. We therefore need to continue to build on this and maintain updates into the STP to build further confidence in the place based model.

5. COMMUNICATIONS

As previously reported Walsall Together is looking to recruit a communications lead to link with all partners and start to communicate a clear and transparent message across the partnership. SMT has agreed a job description and the post is out to advert. The opportunity has been discussed with communications leads through the STP group to seek suitable candidates from any of the partner organisations. An appointment is expected to be made in mid-November. This post will work with the communications teams across the organisations to dovetail into current processes but will also focus on getting positive coverage on progress made so far.

6. SYSTEM OPERATIONAL PERFORMANCE – MAKING DATA COUNT

Reporting has been continued to be discussed at SMT where the Operational Service Leads have been given responsibility of identifying report requirements in support of Operational Services in scope of Walsall Together. There is a robust approach in place where the results will be seen over the next couple of months. Additional data analytic capacity is now in place. This will be completed with the use of techniques and the approach of ‘Making Data Count’.

Programme metrics and Benefits dashboard are being developed in conjunction with the Programme Definition and Operating Model linking to overall Aims of Walsall Together. As programmes are defined this will be present within the documentation including any interdependencies. A first version of the work being coordinated is included in this month’s performance report

The Outcomes Framework is being co-produced with commissioners to ensure the overall programme is aligned as system reform. This was received by the Walsall Together Board this month but will need more work before it is fully adopted.

7. STAFF CONVERSATIONS

SMT has discussed a formal engagement programme with wider staff groups to update on Walsall Together to date and serve as a wider engagement vehicle for staff to share initial experiences and opportunities as we commence planning for the next year. This is considered critical given it has been noted in multiple work streams that staff are limiting transformation ambition based on the lack of funding in the system. There is a concern that such limited ambition will prevent the partnership from leading the bold changes required for the future. It is hoped that these sessions that will be both informative and developmental in nature, will be part of a rolling programme to promote shared thinking and future opportunities for working as one system.

The first of these conversations took place a few weeks ago with East Locality staff and that ideas are now being reviewed.

8. OPERATIONAL LEADERSHIP

As the teams develop integrated working and more importantly, colocation, it has become clear that a future leadership model should be developed. This model will go through a series of transitions, aligning the roles present in each organisation initially and over a period of time, explore whether roles can be merged or undertake joint organisational responsibilities. Initial thinking is being developed into a draft for further discussion through SMT in October and November with a paper scheduled to come to the WTP Board in December.

9. DEVELOPMENT OF BETTER WORKING RELATIONSHIPS

At the end of September, the Walsall Together Programme Office held a joint meeting with CCG commissioning colleagues to explore ways of developing better working relationships. The conversation focussed initially on alignment of the Walsall Together programme with that of other system plans including Right Care, the A&E Delivery Board and the Joint Commissioning Committee. In future, agendas will be focussed on identifying the key priorities across the system and where mutual support can be provided to secure engagement in or mitigate risk to programme delivery.

With support from the CEO of One Walsall an early conversation has started to explore how we undertake development on co-production and asset based approaches with the WTP Board, the SMT and the wider leadership teams for the services in scope. The development will include an overview from the programme team along with expert speakers across a small number of pertinent themes.

10. 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 Overview for Horizon 1	A high-level view of the programme including a Gantt for all live projects, highlights from the month and priorities for the next month.
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:

- Within Tiers 0 and 1, the accommodation for place based teams (PBTs) remains ‘amber’ rated as there is a short-term risk associated with securing suitable premises to enable co-location of PBTs. Mitigation has been identified to address the short-term challenges and solutions for co-location of all PBTs have been identified.
- The ICS Improvement Plan remains ‘amber’ rated due to the risks associated with achieving the commissioned model (therapies establishment and funding).
- The Stroke/Neuro Rehab Pathways project has been downgraded from ‘red’ to ‘amber’ as the outline proposal has been approved and the final proposal will be considered in November.
- The mobilisation project has been upgraded to ‘amber’ due to the risks associated with securing engagement in the project. However, commitment has since been shown to implement the project and it is expected that this will be down-graded in advance of the November WTP Board.
- The data and business intelligence project has been upgraded to ‘amber’ due to delays in the production of a system-wide operational performance dashboard. There are specific challenges associated with agreeing a set of metrics and facilitating the collection of a community data set. The SMT is supporting with an action plan to recover this project and an update is expected at the November WTP Board.
- The Communications and Workforce & OD enabling workstreams remain ‘amber’ rated following discussions with the SMT regarding their significance in the context of delivering the programme and the level of resource allocated to these areas to date. Mitigation has been identified: resource has been allocated from the Programme Office to mobilise these workstreams and ensure adequate focus is given during the next reporting period.

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

- Workstream Plan for Tier 0: Resilient Communities;
- Workstream Plan for Digital.

11. RECOMMENDATIONS

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

Respect
Compassion
Professionalism
Teamwork

ENC – Walsall Together Programme Overview

Improve the health and wellbeing outcomes of the Walsall population	**A healthy population**	Living longer lives; living healthy, happy, fulfilling lives; the best possible start in life; greater equality in health outcomes across Walsall	Walsall Healthcare NHS Trust Walsall Council (Social Care and Public Health)
Increase the quality of care provided	**Accessible, coordinated and responsive care**	Good experience of care; health & care services that work together; access to right care, right place, right time; best possible care for people with long-term and complex needs; best possible end of life	Dudley & Walsall Mental Health NHS Trust Walsall Clinical Commissioning Group
Provide long term financial sustainability for the system	**Strong, active communities**	People feel in control of health and wellbeing; people actively engaged in communities; families and friends providing informal care well-supported; making a difference to the wider aspects of	One Walsall (Council for Voluntary Services) Walsall Housing Group (rep the housing sector)

Clinical Operating Model (COM)

Tier 1 – Integrated Primary, Long term condition management, Social and Community Services
Tier 2 – Specialist Community Services
Tier 3 – Intermediate, Unplanned and Crisis Services
Tier 4 – Acute Hospital Services
Walsall Together Tier 0 – Resilient Communities
Single Point of Access (SPA)

Single Point of Access	Care access, navigation and coordination including clinical triage
Tier 0 (T0)	Resilient Communities - an integrated prevention and early intervention offer to all Walsall citizens
Tier 1 (T1)	Primary Care at scale and integrated health and care teams working through a hub and spoke model across each locality
Tier 2 (T2)	Outpatients and diagnostic services delivered from locality based Health & Wellbeing (H&WB) Centres or the home
Tier 3 (T3)	Network of specialist care delivered from Health & Wellbeing (H&WB) Centres preventing unnecessary hospital admissions and facilitating timely discharge from hospital
Tier 4 (T4)	Access to high quality acute hospital services for patients when they need specialist intervention provided a) locally and b) at a Black Country, regional or national level where necessary
Digital (DIG)	Integrated health and care record, data reporting & business intelligence, population health management
Enablers	Communications, Estates, Patient & Public Engagement, Workforce & Organisational Development

Governance		Key Programme Risks	Mitigation	RAG
WTP Board	Decision making and strategic direction including delivery of the Business Case. Responsibility for oversight of service integration	Suitable premises to deliver 4 H&WB centres	Space Use Group, Local Est Forum, One Public Estate	
		Funding to provides the estates model in the Bus C	Rev how estates £ is released and moved around	
Senior Man Team	(SMT) Provide assurance to WTP Board. Responsible for delivery of system integration and transformation as per the COM	Partner Engagement at all staff levels	Comms group in place. Recruitment of Lead post.	
		Primary Care Network engagement and alignment	PCN funding agreed. Engagement in progress.	
COM Group	Provide clinical and professional input to the work of Walsall Together	Ability to invest in prevention/pump priming	Commissioner reps in governance	
WTPO	Drive the programme forwards and manage relationships through to delive	Resource capacity to delivery the transformation	Review of priorities. Recruitment to prog office	
Projects	Delivery of the integration and realisation of programme benefits	Organisational culture re integrated working	Org Dev plan at 3 levels: Board, SMT and operatio	

Latest Update: key actions completed and key priorities for the next period		Milestones
Gov	Initial session and 'Place' workstream established within the Black Country Sustainability & Transformation Plan/Partnership (STP) - enable learning from other parts of the Black Country	Sep-19
	Alliance Agreement approved at partner Governing Bodies	Oct-19
	Scoping for Horizon 2 including children's and Public Health	Oct-19
SPA	Workshop with key stakeholders across the system to review wider SPA	Aug-19
	Evaluation of pilot SPA. Pilot engaged WMAS - improved relations, referral protocols and referral confidence. Has contributed to non-conveyance	Oct-19
	Further workshop re wider SPA defining in/out of scope and specific actions - outputs to be developed into a plan and drafted to present to SMT/WTPB Nov 2019	Oct-19
Tier 0	Workshop 1 undertaken with key stakeholders - define context, concept, vision	Aug-19
	Second workshop completed - vision set, priorities identified, implementation plan in development. Proposals to WTP Board October 2019.	Sep-19
Tier 1	Multi Disciplinary Team Coordinator recruited - candidate will be in post from Nov-19	[illegible]
	Workshop to develop plan for establishing robust Multi Disciplinary Team meetings that are self sustainable has taken place with key stakeholders	[illegible]
	North and South Localities to be co-located by the end of Oct-19	[illegible]
	Locality workshops are being developed in relation to workforce and OD to support managers & teams with integration. Workshops scheduled for Oct-19	[illegible]
Tier 2	Scoping for Tier 2 has commenced - the focus will be on moving Dermatology and Cardiology Clinics into a community site.	[illegible]
Tier 4	Establishment of steering group for the Patient Mobilisation project and initial engagement undertaken with senior nursing to secure support for implementation	Sep-19
	Approval of the outline business case for the transfer of stroke rehab services from Manor Hospital to Holly Bank House (community inpatient facility)	Sep-19
	Exemplar Ward rollout to Ward 14 at Manor Hospital	Oct-19
Workforce	Funding secured Skills4Care/BCF to deliver Strengths Based training to workforce. Discussions underway to align wider-workforce plans under WT umbrella. Update Nov 19.	Aug-19
Digital & Technology	Draft PID for Shared Cared Record and EPACCS (End of Life) ready for initial circulation	Sep-19
PPE	First draft patient and public engagement (PPE) strategy for review by SMT (in development)	Oct-19

Tiers	Pre September 19	September 19	October 19	November 19	December 19	January 20	February 20	March 20

SPA
- Pilot SPA (Delivery)
- SPA Winter (Design)
- SPA Winter (Delivery)
- SPA Winter (Closedown)
- SPA Future (Define)
- SPA Future (Design)
- SPA Future (Delivery)

Tier 0
- Integrated plan for commissioning ResCom - Analysis Define)
- Integrated plan for commissioning ResCom - Vision (Design)
- (Delivery)
- Building capacity VCS (Define)
- Building capacity VCS (Design)
- (Delivery)
- Social Prescribing PCN (Define)
- Social Prescribing PCN (Design)
- Social Prescribing PCN (Delivery)
- Social Prescribing OW (Delivery)
- Social Prescribing MCW (Delivery)
- Social Prescribing across all tiers (Define)
- Social Prescribing across all tiers (Design)
- Coproduction (Define)
- Coproduction (Design)
- Coproduction (Delivery) (SBA)

Tier 1
- Co Location of Place Based Teams (Delivery)
- Co Location of Place Based Teams (close down)
- Multi Disciplinary Team Plan (Design)
- Multi Disciplinary Team Plan (Delivery)
- Multi Disciplinary Team Plan (Close down)
- Family Safeguarding (Define)
- Family Safeguarding (Design)
- Family Safeguarding (Delivery)
- Integration of Specialist Services in Place Based Team (Delivery)
- Integration of SS(Close down)

Tier 2
- Outpatients in Community - Cardiology & Dermatology (Define)
- Outpatients in Community - Cardiology & Dermatology (Design)
- Outpatients in Community - Cardiology & Dermatology (Delivery)
- OP in Com - Cardio & Derm (Close down)
- Outpatients in Community - Phase 2 (Define)
- Outpatients in Community - Phase 2 (Design)

Tier 3
- Intermediate Care Service Improvement Plan (Delivery)
- Falls (Define)
- Falls (Design)
- Integration Rapid Response (Define)

Tier 4
- Exemplar Ward (Delivery)
- Exemplar Ward
- Mobilisation (Define)
- Mobilisation (Design)
- Mobilisation (Delivery)
- Mobilisation (Closedown)
- Therapies (Define)
- Therapies (Design)
- Therapies (Delivery)
- Therapies (Closedown)
- Stroke Rehab (Design)
- Stroke Rehab (Delivery)
- Stroke Rehab (Closedown)

Digital & Technology
- Development of Walsall Together Digital Strategy with Operational Plan (Delivery)
- Digital Strategy & Operational Plan (Closedown)
- Shared Care Record (Define)
- Shared Cared Record (Design)
- Shared Cared Record (Delivery)
- EPACCS (End of Life Pathway) (Define)
- EPACCS (End of Life Pathway) (Design)
- EPACCS (End of Life Pathway) (Delivery)
- Data Reporting Requirements (Design)
- Initial Reporting Requirements (Delivery)
- Benefits & Outcomes Framework (Delivery)
- (Closedown)

Enablers
- PPE (Define)
- PPE (Design)
- PPE (Delivery)
- Workforce (Define)
- Workforce (Design)
- Workforce (Delivery)
- Estates (Define)
- Estates (Design)

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC TRUST BOARD – 7th NOVEMBER 2019</td></tr>
<tr><td colspan="3">Walsall Healthcare Trust Enforcement Undertaking</td><td>AGENDA ITEM: 17</td></tr>
<tr><td>Report Author and Job Title:</td><td>Jenna Davies
Director of Governance</td><td>Responsible Director:</td><td>Richard Beeken
Chief Executive Officer</td></tr>
<tr><td>Action Required</td><td colspan="3">Approve ☐ Discuss ☐ Inform ☒ Assure ☐</td></tr>
<tr><td>Executive Summary</td><td colspan="3">NHS Improvement accepted enforcement undertakings from the Trust on 19 December 2017 in relation to Quality, Operational performance and Financial issues after the Trust was placed into special measures for quality.

In July 2019, the Trust exited special measures and NHS England and NHS Improvement accordingly issued a compliance certificate in respect of paragraph 1 (Quality), 4 (Buddy trust and other partnerships) and 5 (Leadership and governance) of the December 2017 undertakings.

The Revised undertakings presented have been issued to the Trust, as NHS England and NHS Improvement continue to have concerns about the Trust's finances and our operational performance in relation to sustained performance against the A&E 4-hour and diagnostics targets. These undertakings commit the Trust Board to demonstrating that there are clear plans which lead to improvements in performance on key priorities which the Board has already identified.</td></tr>
<tr><td>Recommendation</td><td colspan="3">Members of the Trust Board are asked to note the revised undertakings issued to the Trust</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3">Failure to demonstrate improvements aligned to Financial and operational performance will result in het Trust being place back in special measures</td></tr>
<tr><td>Resource implications</td><td colspan="3">There are no resource implications associated with this report.</td></tr>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="3">There are no legal or equality & diversity implications associated with this paper.</td></tr>
</table>

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

GENERAL GUIDANCE

Overall, the paper/report as a whole should not exceed 4 pages.

Text should be in Arial 12 and left justified (i.e. have a ragged right margin) as this is easier to read and therefore more accessible.

Margins should be set to 1.8cm top, bottom, left and right to maximise the use of the page.

Paragraphs and pages should be numbered.

If abbreviating to an acronym, write out the name in full once and provide the acronym in brackets. Then use the acronym throughout the remainder of the document.

The next section identifies the format which should be used when a report is being written:

[Insert Title of report]

1. PURPOSE OF REPORT

The purpose of the reports is to…….

The purpose of a report is to be clear on what the reader needs to do as a result of reading your report, ideally in only one or two sentences. Moreover, your purpose informs all the other aspects of the report, including background, details and recommendations.

2. BACKGROUND

The background summary provides the background information for the reader who may not be familiar with the details. You should explain the background to the issue / proposal so that the reader can quickly grasp what is being presented, the context in which it is being presented and why.

You should keep it brief and refer members to links to other information, for example appendices or further reading in the reading room section of Board pad etc.

3. DETAILS

This is the main substance of your report. This section should clearly set out the main points the key issues raised by the report, and outline the evidence for and against any proposed actions and the solution.

4. RECOMMENDATIONS

Clearly set out the recommendations and proposed actions arising from the conclusions reached by the report.

The recommendation should match the action required on the front sheet of the report.

APPENDICES
(List any appendices)

Rebecca Farmer
Acting Director of Strategic Transformation, West Midlands

St Chad's Court
213 Hagley Road
Birmingham
B16 9RG

T: 0300 123 2620
E: Rebecca.farmer3@nhs.net
W: www.england.nhs.uk and www.improvement.nhs.uk

Richard Beeken
Chief Executive
Walsall Healthcare NHS Trust

By email

8 October 2019

Dear Richard

Walsall Healthcare NHS Trust ("the Trust"): Enforcement Action under the Health and Social Care Act 2012

1. As you will be aware NHS England and NHS Improvement recently formally re-assessed the status of the Enforcement Undertakings in place with the Trust. The Regional Support Group, held on 22 July 2019, agreed that the Trust had met requirements of quality and improvement plan, buddy trust and other organisations and leadership.
2. Therefore, I am pleased to enclose a signed compliance certificate in respect of these Enforcement Undertakings. We will shortly be publishing this on our website.
3. As you are aware from recent discussions the Trust's Single Oversight Framework segmentation has now changed from 4 to a 3 as a result of the Trust exiting Quality Special Measures.
4. In respect of the Enforcement Undertakings not fully complied with, replacement undertakings have been developed for operational performance, finance and recovery, programme management, access and meetings and reports. In addition, as per the requirement of the exit of quality special measures, revised quality Enforcement Undertakings have been developed regarding the support package.
5. I also enclose a signed copy of the revised Enforcement Undertakings by NHS England and NHS Improvement, which we will also publish on our website.
6. It is expected that the Trust will share a copy of the signed Enforcement Undertakings with the Trust Board.
7. We will continue to hold a bi-monthly system review meetings with the Trust and CCG to formally review progress with the financial position, performance and quality matters.
8. If you have any questions in relation to the matters set out in this letter, please contact either me or Katrina Boffey on 07900300180 or by email at Katrina.boffey@nhs.net.

Yours sincerely

Rebecca Farmer
Acting Director of Strategic Transformation, West Midlands
NHS England and NHS Improvement

cc: Danielle Oum, Chair, Walsall Healthcare NHS Trust
Katrina Boffey, Senior Delivery and Improvement Lead, NHS England and NHS Improvement

ENFORCEMENT UNDERTAKINGS

NHS TRUST:

Walsall Healthcare NHS Trust ("the Trust")
Moat Road,
Walsall,
West Midlands,
WS2 9PS

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS England and NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS England and NHS Improvement has decided to accept undertakings from the Trust.

BACKGROUND:

NHS Improvement accepted enforcement undertakings from the Trust on 19 December 2017 in relation to Quality, Operational performance and Financial issues after the Trust was placed into special measures for quality.

In July 2019, the Trust exited special measures and NHS England and NHS Improvement accordingly issued a compliance certificate in respect of paragraph 1 (Quality), 4 (Buddy trust and other partnerships) and 5 (Leadership and governance) of the December 2017 undertakings.

Although the Trust made some progress against the remaining parts of the December 2017 undertakings, NHS England and NHS Improvement continues to have concerns about the Trust's finances and its operational performance in relation to sustained performance against the A&E 4-hour and diagnostics targets.

NHS England and NHS Improvement is now taking regulatory action in the form of these updated undertakings which replace and supersede the outstanding December 2017 undertakings.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS England and NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

“NHS England and NHS Improvement” means the National Health Service Trust Development Authority;

“TDA Directions” means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

The Trust is an NHS trust all or most of whose hospitals, facilities and establishment are situated in England.

2. Issues and need for action

NHS England and NHS Improvement has reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following conditions of the Licence FT4(5)(a) to (g), and FT4(6)(a)to (f).

In particular:

Quality Improvement

2.1. The Trust was placed into Special Measures in February 2016 following its comprehensive CQC inspection in September 2015 where the Trust was rated ‘Inadequate’ overall.

2.2. The Trust exited Special Measures in July 2019 following a further announced core services and well-led inspection in February and March 2019. The Trust was rated overall as ‘Requires Improvement.’ The CQC’s report of 25 July 2019 sets out the outstanding concerns on the Trust’s performance on quality issues.

2.3. A requirement of the Trust exiting Special Measures is that there is a comprehensive exit support plan in place which addresses the outstanding CQC areas of concern.

Financial issues

2.4. The Trust has reported a 2018/19 draft year-end deficit, before Provider Sustainability Fund (PSF) of £29.702m, which is £14.237m worse than planned. The year-end variance to plan is due to failure to control nursing and medical workforce pressures and some delays in outpatient productivity schemes. In particular, medical locum expenditure has not reduced as planned and ward nursing has overspent due to above plan fill rates, unfunded night posts and poor rota grip and control leading to high unpaid leave and sickness. The 2018/19 financial performance is a deterioration on the 2017/18 outturn deficit of £24.801m.

2.5. The Trust has submitted a control total compliant financial plan for 2019/20 which will deliver a deficit of £18.380m pre-PSF. The Trust remains in enhanced financial oversight led by the NHS England and NHS Improvement sub-regional finance team.

Operational performance

2.6. An urgent care system improvement plan has been developed and ECIST support has been provided, however there are ongoing challenges to deliver against the 4-hour emergency care standard and the improvement trajectory.

2.7. The impact of financial decisions made at the end of 2018/19 resulted in deterioration in the performance against the diagnostic standard.

2.8. During quarter 1 of 2019/20, the Trust saw deterioration against the 2-week wait, 2-week breast and 62-day cancer standards as a consequence of the diagnostic challenges.

3. Failures and need for action

These failings by the Trust demonstrate a failure of governance arrangements including, in particular:

3.1. Failure to establish and effectively implement systems or processes:

3.1.1. to ensure compliance with the Trust's duty to operate efficiently, economically and effectively;
3.1.2. for timely and effective scrutiny and oversight by the Board of the Trust's operations;
3.1.3. to ensure compliance with healthcare standards binding on the Trust.

3.2. Need for action:

NHS England and NHS Improvement believes that the action which the Trust has undertaken to take pursuant to these undertakings, is action required to secure that the governance failures in question do not continue or recur.

UNDERTAKINGS

NHS England and NHS Improvement has agreed to accept and the Trust has agreed to give the following undertakings.

4. Quality Improvement (post Special Measures)

4.1 The Trust will work with NHS England and NHS Improvement to ensure that the post Special Measures exit support plan as agreed with NHS England and NHS Improvement is fully implemented within 12 months of the date of these undertakings.

4.2 The Trust will provide progress updates against the exit support plan as part of the NHS England and NHS Improvement regular oversight arrangements.

4.3 The Trust should continue to develop and take all reasonable steps to implement Quality Improvement Plans to address the concerns identified in, but not limited to, CQC reports. The Trust will provide progress updates on the progress with their

plans, advising NHS England and NHS Improvement of any matters that materially affect their ability to deliver the plans within agreed timelines.

4.4 The Trust will ensure that it has sufficient capacity at both executive and other levels of management to enable delivery of quality improvements, and ensure that these measures do not compromise its overall financial position.

5. Finance Performance

2019/20 Performance

5.1. The Licensee will ensure that robust financial plans are in place to:
 5.1.1. deliver the 2019/20 control total and planned CIPs; and
 5.1.2. minimise the revenue cash support requirement.

5.2. The Licensee will take all reasonable steps to ensure that 2019/20 CIP plan, as set out in plans submitted to NHS England and NHS Improvement in May 2019, are fully delivered with full assessment being completed on the impact of schemes on quality and the Licensee's underlying financial position.

5.3. The Licensee will comply with planning guidance issued by NHS England and NHS Improvement in January 2019 and June 2019 related to receipt of the financial recovery fund in 2019/20. The Licensee will have in place financial recovery plans as part of the five-year system level strategic plans by December 2019. These plans will demonstrate recurrent financial improvement as measured by I&E run-rate and planned financial outturn, and which return the Licensee to sustainable financial balance.

5.4. The Licensee will develop a long-term financial model (LTFM) to achieve a sustainable financial position that aligns with the Black Country and West Birmingham Sustainability and Transformation Plan (the STP); the Licensee's strategic direction and the STP strategic and financial context. The Licensee will work constructively with STP partners to develop a long-term plan in line with guidance issued by NHS England and NHS Improvement in June 2019. The Licensee will agree the long-term plan with system leads and partners by mid-November 2019 and publish the plan in December 2019.

Governance

5.5. The Trust should ensure that appropriate governance arrangements are in place to deliver both the submitted 2019/20 plan and the medium-term financial strategy. These structures will be reviewed and approved by the NHS England and NHS Improvement regional team.

6. Operational Performance

6.1 The Trust will take all reasonable steps to recover operational performance to meet national standards in relation to the 4 hour Urgent and Emergency care standard and the diagnostic standard, including but not limited to those set out in paragraphs 6.2 to 6.4, below.

6.2 The Trust will ensure that there are robust improvement plans in place to meet the requirements of paragraph 6.1, which has been agreed with NHS England and NHS Improvement.

6.3 The improvement plans will, in particular:

6.3.1 include the actions required to meet the requirements of paragraph 6.1, with appropriate timescales, key performance indicators and resourcing;
6.3.2 describe the key risks to meeting the requirements of paragraph 6.1 and mitigating actions being taken;
6.3.3 be based on realistic assumptions;
6.3.4 reflect collaborative working with key system partners and other stakeholders;
6.3.5 set out the key performance indicators which the Trust will use to measure progress.

6.4 The Trust will keep the improvement plans and their delivery under review and provide appropriate assurance to its Board regarding progress towards meeting the requirements of paragraph 6.1, such assurance to be provided to NHS England and NHS Improvement on request. Where matters are identified which materially affect the Trust's ability to meet the requirements of paragraph 6.1, whether identified by the Trust or another party, the Trust will notify NHS England and NHS Improvement as soon as practicable and update and resubmit the performance plan within a timeframe to be agreed with NHS England and NHS Improvement.

7. Programme management

7.1 The Trust will develop and implement or where appropriate, strengthen, Trust-wide governance and programme management processes to manage and deliver sustained performance covered by these enforcement undertakings. Such programme management and governance arrangements must enable the board to:

7.1.1 obtain clear oversight over the process in delivering these undertakings;
7.1.2 obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
7.1.3 hold individuals to account for the delivery of the undertakings.

7.2 In the event that successful delivery of the financial and operational improvement plans do not result in corresponding sustained improvements, the Trust will consult with NHS England and NHS Improvement and other stakeholders on alternative course of actions.

8. Access

8.1. The Trust will provide to NHS England and NHS Improvement direct access to its advisors, programme leads and the Trust's board members as needed in relation to the matters covered by these undertakings.

9. Meetings and reports

9.1. In addition to the action in paragraph 4.2 (reporting in relation to the special measures exit plan) the Trust will:

9.1.1 attend meetings or, if NHS England and NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England and NHS Improvement; and

9.1.2 provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

Any failure to comply with the above undertakings may result in the NHS England and NHS Improvement taking further formal action. This could include giving directions to the Trust under section 8 of the National Health Service Act 2006.

THE TRUST

Richard Beeken
Chief Executive

4th October 2019

NHS ENGLAND AND NHS IMPROVEMENT

Signed (Acting Director of Strategic Transformation (West Midlands) and member of the Midlands Regional Support Group)

Dated 8/10/2019

COMPLIANCE CERTIFICATE

TRUST:
Walsall Healthcare NHS Trust ("the Trust")
Moat Road,
Walsall,
West Midlands,
WS2 9PS

In this certificate, "NHS Improvement" means the National Health Service Trust Development Authority.

NHS Improvement hereby certifies that it is satisfied that the Trust has complied with paragraph 1 (1.1-1.6), 4 (4.1-4.2) and 5 (5.1-5.2) of the Trust's Enforcement Undertakings accepted by NHS Improvement on 19 December 2017.

Signed:

Position: Acting Director of Strategic Transformation (West Midlands) and member of the Regional Support Group (Midlands)

Date: 8\10\2019

MEETING OF THE PUBLIC TRUST BOARD – 7th NOVEMBER 2019			
Quality, Patient Experience and Safety Committee Highlight Report			**AGENDA ITEM: 18**
Report Author and Job Title:	Karen Dunderdale Director of Nursing	**Responsible Director:**	Pam Bradbury - Non Executive Director.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report provides highlights from the Quality Patient Experience & Safety committee.		
Items for escalation	The committee wish to highlight; • The first MRSA case of the year • Continued lack of compliance with MCA • First annual chaplaincy and spiritual care team report • Improvements in the diagnostic reporting backlog • Reassurance in the mortality surveillance process • Reassurance in the use the SPC trend charting for information		
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 ☐		

Quality Patient Experience & Safety Committee: October 2019
Highlight Report to the Trust Board

Report for Trust Board meeting on:	7 November 2019
Report From:	31 October 2019

Highlight Report:

Hospital Acquired Infections

At the date of the committee meeting there has been a total of 14 hospital acquired C. Diff infections and 1 MRSA bacteraemia to September 2019.

Compliance with Mental Capacity Act

The committee received a report outlining the issues and action in place to address a consistently poor performance. The committee were reassured about the action being taken and asked for a further update in 4 months.

Annual Chaplaincy & Spiritual Care Team report

The committee received the first annual report from the lead chaplain which highlighted a number of key achievements the most notable being the positive impact the reinstated and extended on call chaplaincy arrangements have had and how this has addressed the diversity of religious needs in an inclusive way.

Diagnostic Backlog

The committee received assurance that the previous reporting back log is now at the correct time of 2weeks and was delivered in line with the divisional trajectory.

Hospital mortality

The committee received a comprehensive report on the review of the mortality surveillance process and the assessment against national indicators and changes that have been undertaken.

Performance reporting

Subsequent to previous highlight reports to Trust board regarding the format of data, the committee saw the first reports using SPC trending data

Action Required by the Trust Board:

The Trust Board is asked to note the report and support any further action required.

Pam Bradbury, Non-Executive Director and Dr Karen Dunderdale, Director of Nursing/Deputy Chief Executive

October 2019

<table>
<tr><td colspan="4">MEETING OF THE PUBLIC TRUST BOARD – 7th November 2019</td></tr>
<tr><td colspan="3">Performance, Finance & Investment Committee (PFIC) Highlight report</td><td>AGENDA ITEM: 19</td></tr>
<tr><td>Report Author and Job Title:</td><td>Mr D Mortiboys –
Operational Director of Finance</td><td>Responsible Director: Mr R Caldicott, Director of Finance and Performance</td><td>Mr J Dunn – Chair of PFIC (Non-Executive)</td></tr>
<tr><td>Action Req</td><td colspan="3">Approve ☐ Discuss ☒ Inform ☒ Assure ☒</td></tr>
<tr><td>Executive Summary</td><td colspan="3">The report indicates the key messages from PFIC meeting in October 2019 for escalation to the Trust Board, namely;
An update on the Trust Financial position. This included the position at Month 6, details of risks for the financial year, an update on further central mitigations, analysis of CIP performance, details on current run rate shared with financial cabinet and details of NHSI control totals for future years. Oversight of the position continues through regular performance reviews, financial cabinet, Trust Management Board and PFIC.
Members received a report on performance against constitutional standards;
Members received a report on performance and quality metrics.
Members received an update on Use of Resources
The Committee received a report on delivery of the Electronic Patient Record, requesting further reports for future Committee meetings
Members endorsed the business cases for Trust Secretary and ED Development support. This was agreed through Chairs action with the support of the executive.</td></tr>
<tr><td>Recommendation</td><td colspan="3">Members of the Board are asked to note the increased ED activity and the risk to delivery of the financial plan</td></tr>
<tr><td>BAF or Trust Risk Register</td><td colspan="3">This report aligns to the BAF risk associated with delivery of the financial plan, with the risk rated as red at present</td></tr>
<tr><td>Resource implications</td><td colspan="3">The implications are lost financial support resulting in additional borrowings (interest charges) and the effect on ‘use of resources’ rating. Alongside performance risks.</td></tr>
<tr><td>Legal, Equality & Diversity</td><td colspan="3">There are no legal or equality & diversity implications associated with this paper</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td colspan="2">Safe, high quality care ☒</td><td>Care at home ☐</td></tr>
<tr><td colspan="2">Partners ☐</td><td>Value colleagues ☐</td></tr>
<tr><td colspan="2">Resources ☒</td><td></td></tr>
</table>

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FINANCE PERFORMANCE AND INVESTMENT COMMITTEE (PFIC)

HIGHLIGHT REPORT

KEY AREAS FOR CONSIDERATION BY THE BOARD

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting, this report covering the key issues from the meeting.

2. KEY ISSUES

2.1 The meeting was Chaired by Mr Dunn, Non-executive Director, Vice Chair of the Trust and Committee Chair. The meeting was not quorate.

2.2 Financial performance

The report indicates the key messages from PFIC meeting in October 2019 for escalation to the Trust Board, namely;

- Trust attained a £5.4m deficit for month 6 (in line with plan). However, delivered £1.8m operational overspends that requires mitigation to attain plan, drivers being;
    - Emergency Department (ED) increased demand (attendances and admissions)
    - High sickness (in particular at commencement of the financial year)
    - High temporary workforce costs, largely a consequence of the above
    - Clinical income below plan (births/elective/outpatients & ED coding depth)

The Trust Executive has initiated and continued the following actions to mitigate the financial risk;

- Continuing escalation of the Division of MLTC using the Accountability Framework
- Enhanced focus on controls associated with temporary workforce
- Initiation of a number of grip and control measures to reduce costs
- WC&CSS births income mitigation plan (paper presented to members at September PFIC)
- Increased productivity

- A greater focus on ED Coding which executives advised was resolvable with plans in place. The Chief Operating Officer had chaired a performance meeting with the Medicine & Long Term Conditions Division which discussed the root causes of the coding issues and confirmed new coders had been appointed to commence on 4th November 2019 with an expectation of a material improvement from November. At the start of the year the number of coders had been reduced as part of the Division's expenditure reduction plan.

The risk to delivery post implementation of the above mitigations totals c£5m on current run rates (c£8m deficit with lost Provider Sustainability Funding) further is therefore needed to assure attainment of the plan, action being;

- Divisions to secure further benefits equating to 1% of current monthly run rates
- Trust to implement central mitigation schemes, that include for example receipt of IM&T income allocations

Delivery of improved Divisional run rates and further central mitigations are essential to mitigate risks to attainment of plan. Oversight provided through bi-weekly performance meetings, the financial cabinet, Trust Management Board and PFIC.

2.3 Trust performance against constitutional standards

Members received a detailed report on the performance against constitutional standards;

The Chief Operating Officer presented a report against Constitutional Standards;

- September saw continued improvement in EAS performance compared to the Q1 average performance and met the submitted trajectory (83%) despite Type 1 ED attendances being 10.4% higher than September 2018
- As forecast due to taking increased breast referrals from Wolverhampton to support Royal Wolverhampton Trust the following standards were not met; Cancer 2 week GP referral to 1st outpatient appointment national target and breast symptomatic and Cancer 62 day referral for all cancers and consultants upgrade.
- All other cancer standards were delivered
- 6 week diagnostic target demonstrated continued excellent performance
- Deterioration of the 18-week RTT standard was noted as a concern, with further scrutiny being applied to Divisional recovery plans.

2.4 Business cases

The committee supported the following business cases;

- Trust Secretary
- ED Development

As the committee was not quorate, the Chair approved these as a Chairs action. This was supported by executives in attendance.

2.5 Use of Resources

An update on Use of Resources (UOR) was received by members. It was agreed due to the detailed nature of the report and the importance of UOR that board would receive a more detailed briefing.

2.6 Electronic Patient Record

An update report was received by members regarding implementation and progress to date on delivery of the new Electronic Patient Record (EPR).

The report summarised:

- The project is running to plan
- The future plan for implementation is robust
- This will create huge organisational change which needs to be managed

The Chair requested that PFIC will receive a detailed progress report at every future meeting while the project progresses.

3. RECOMMENDATION

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

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MEETING OF THE PUBLIC TRUST BOARD – Thursday 7th November 2019			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 20**
Report Author and Job Title:	Catherine Griffiths, Director of People and Culture	**Responsible Director:**	Philip Gayle, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This report details Board Assurance and the Annual Cycle of Business and to: 1. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care. 2. The processes adopted to support optimum employee performance in line with the Trust values. 3. The delivery of the Trust's legal and regulatory duties in relation to its employees. **4.** The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.		
Recommendation	Members of the Trust Board are asked to note the content of the report for information.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	**BAF Risks:** The work programme described within this report will provide positive assurance to the committee on the following BAF risks: *Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.* *National staff shortages amongst a number of professions impacts on the Trust's ability to provide safe and high quality care, and*		

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	impacts on the morale and robustness of the Trust's current workforce.	
Resource implications	There are no specific resource implications associated with this report, however the annual cycle of committee business is scheduled to provide oversight and seek assurance on behalf of the Trust Board that people resources are managed within the Trust in a way that is sustainable and that supports the financial health of the Trust.	
Legal and Equality and Diversity implications	The Board Assurance Framework reports to People and Organisational Development Committee to identify current implications. The annual cycle of committee business is scheduled to provide oversight and seek assurance on behalf of the Trust Board that legal, equality and diversity implications are considered and effectively managed within the Trust in a way that promotes inclusion and supports the Equality Objectives contained within the Trust Equality, Diversity and Inclusion Strategy.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

People and Organisational Development Committee Highlight Report.

1. PURPOSE OF REPORT

The purpose of this report is to inform the Board of key issues discussed at People and Organisation Development Committee and of key actions identified.

2. BACKGROUND

The People and Organisation Development Committee is a sub-committee of Trust Board and has an annual programme of business that is developed to provide assurance to the Trust Board on:

5. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care.

6. The processes adopted to support optimum employee performance in line with the Trust values.

7. The delivery of the Trust's legal and regulatory duties in relation to its employees.

8. The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.

3. DETAILS

NHS Leadership Academy Diagnostic Updte

The report provided an update on the Trust's Leadership, Culture and OD work-stream, which is part of the implementation plan for Valuing Colleagues within the Trust so outstanding patient care can be achieved.

The NHS Leadership Academy worked in partnership with the Trust to complete a leadership diagnostic based on an appreciative inquiry approach, covering values, behaviours, culture, leadership development needs, strengths, issues and challenges.

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The committee heard the key themes emerging from the diagnostic work as follows:

1. This is a valuable approach, good to be heard.
2. Leadership – lots of managers not enough leaders, Executive vision can get lost.
3. Accountability – not clear, micro-management, complex governance, not consistent between staff groups.
4. Frustration – empowerment variable, clarity on innovation, finances.
5. Equality Diversity and Inclusion – not fully understood.
6. Talent and Development – poor experience of appraisal, staff development and career progression.
7. Values and Behaviours – pockets of excellence however some poor practice too.

The report highlighted next steps which are to engage within the divisions for priority actions and to bring together an Organisation Development plan drawing together all strands of diagnostic work in order for PODC to consider in November for Trust Board in December.

Health and Wellbeing – Update Report

The Committee received a report updating on the approach to staff health and wellbeing and considered three recent case studies relating to Sleep Pods, Weight Management and Flu Campaign. The report updated on plans to provide Health and Wellbeing branding so the offer to staff to support physical health, mental health, spiritual health, financial health and family life. The committee resolved to receive a more detailed report on sleep pods following consideration at other Trust forums, noted that NHSi will be working with the Trust Health and Wellbeing Steering Group. The report was received.

The Workforce Performance Data and Metrics

The workforce metric report was received by the committee commented that the SPC charts had improved the analysis of workforce trends and welcomed the ongoing work in this regard. The work taking place within Midwifery and Nursing is to be included in next months report as a qualitative report on best practice, agreed that the approach to workforce analytics can help highlight improvement and shared best practice. The report was accepted and noted that the highlights will be included within the Trust Board Performance Report.

Update on Medical Workforce Programme

The Medical Workforce Programme update report was well received and commended by the committee, progress was noted and discussion took place on the following key programme aims:

- Reviewing staffing levels in key clinical areas
- Creating a structure for effective job planning
- Realising the potential benefits of implementing Allocate
- Building a sustainable workforce model.

The committee noted how the foundation work is nearing completion and how the use of new and adapted roles presented a good opportunity for the Trust in the approach to Workforce planning.

Update on Just Culture

The committee received a presentation and outline of the approach being taken to introduce the concept of a just and learning culture within people practices and processes at the Trust.

The committee were supportive of the approach and heard how staff-side are supportive and working in partnership to achieve this. It was noted by the committee that this is a whole system change and resolved to hear back from a specially convened task group who will work on a joint governance/HR/organisation wide approach on developing the approach.

OD and Talent Management Update

The Committee noted that one of the actions relating to Talent Management, appraisal and development has been taken and a new process, supported by refreshed appraisal paperwork was launched at the Leadership Conference in October for a 2 month consultation period, with a view to launching in the new-year January 2020. The committee noted the proposed approach, the paperwork and the proposed cycle and resolved to receive a further report.

Sub-committees and groups of People and OD Committee

The committee received the minutes of JNCC, LNC, Health and Wellbeing Steering Group and Equality, Diversity and Inclusion Group.

Matters to bring to the attention of the Board

1. There is new national FTSU guidance, this was reviewed by committee who resolved to receive a further update within the FTSU Guardians' report.

2. The committee received assurance on the Flu Campaign and reviewed the self-assessment completed in line with national requirements.

3. The EU Exit Assessment report was presented for assurance on arrangements relating to the workforce.

4. The committee heard that the Electronic STP Workforce Plan submission had been completed and submitted, the operational plan has been completed for submission by 4th November.

5. The committee received a report for assurance on the actions recommended in Baroness Dido's letter to Trusts on 'Learning Lessons to Improve our People Practices' .

RECOMMENDATIONS

The recommendation to Board is to note the content of the report for information.

MEETING OF THE PUBLIC TRUST BOARD			
Walsall Together Partnership (WTP) Board Highlight Report			**AGENDA ITEM: 21**
Report Author and Job Title:		**Responsible Director:**	Daren Fradgley Interim Executive Director of Walsall
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		

Executive Summary	This report provides the key messages from the Walsall Together Partnership (WTP) Board October 2019:
	
	• Patient story from Dudley and Walsall Mental Health Partnership Trust, which demonstrated significant progress using engagement from internal and external colleagues, to redesign the service provided.
	• The Directors report outlined the following updates;
	  o Advancing Place Based Care – Black Country STP
	  o PCN Engagement
	  o System Operational Performance – Making Data Count
	  o Communications Lead Recruitment
	  o Staff Conversations
	  o Operational leadership
	  o One Public Sector Estate
	  o Development of Better Working Relationships
	  o Family Safeguarding Model
	• WTP Board reviewed the programme structure, RAG and status report
	• WTP Board reviewed workstream plans for tier 0 and Digital.
	• WTP Board received an update on quality in care homes.
	• WTP Board reviewed and challenged the outcomes framework.
	• Clinical Operating Model (COM) Group highlight report was received and taken as read.
	• SMT action log was received and noted.		

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 ☐	

WALSALL TOGETHER PARTNERSHIP BOARD HIGHLIGHT REPORT
OCTOBER 2019

1. INTRODUCTION

The Walsall Together Partnership (WTP) Board, formally Integrated Care Partnership Board, met in October 2019. The WTP Board will continue to meet monthly in line with the Terms of Reference.

This report provides an overview of the key items discussed at the meeting held in October 2019.

2. BACKGROUND

The WTP Board has been established to oversee the integration and transformation of in scope services. The Board is responsible for decision making and strategic direction in the context of the Walsall Together Business Plan.

3. DETAIL

3.1. Attendance, Apologies and Quorum

The Board was chaired by Mrs Anne Baines, Trust Chair, Walsall Healthcare NHS Trust. The meeting was declared quorate and apologies were received from:

- Mr Mark Axcell, Chief Executive, Dudley and Walsall Mental Health Partnership Trust
- Mr Richard Beeken, Chief Executive, Walsall Healthcare NHS Trust
- Mr Daren Fradgley, Interim Executive Director of Walsall Together
- 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. 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. Members acknowledged the positive work undertaken at Dudley and Walsall Mental Health Partnership Trust, highlighting that the key to success was through engagement with external colleagues.

3.4. Walsall Together Director Report

A report from the Interim Executive Director of Walsall Together was received, outlining the subjects named above. The report was taken as read and members were asked for any comments or queries.

Mrs Furnival commented that the family safeguarding money was based on best practice to understand cause of concerns within the family, rather than taking a child away, supporting the family.

The Chair asked for staff conversation dates to be shared with members, advising that it would be positive engagement to show support if colleagues from the Board were able to attend some of these sessions.

3.5. Programme Overview

Programme structure, RAG & status report
A report outlining the programme structure including RAG rating and status update was received by WTP Board. WTP Board members thanked Mr Botfield for the report provided and noted the updates provided.

Board members confirmed that they were happy with the progress made and actions agreed. The requirement to clarify engagement and communication plans was reiterated by members and acknowledged as a priority.

Workstream plan: Tier 0 & Digital
WTP Board members endorsed plans for the approach for tier 0 and Digital, with challenges noted regarding timescales provided for Digital.

The Chair acknowledged concerns raised with regards to Digital and the requirement to understand the journey, therefore agreed more details was requested ahead of approval from the Board. WTP Board members asked for Digital to be discussed at COM Group ahead of taking back a revised document to WTP Board for approval.

3.6. Quality in care homes

WTP Board members noted the updates presented by Mr Dodd and agreed there was a very positive opportunity to take a Walsall Together approach with peer support and challenge from the Partnership Trusts.

3.7. Outcomes framework

The Chair advised that more time was required to review the information provided and identify outcomes for the next meeting. Members agreed for the outcomes framework to be discussed at SMT ahead of providing an update to the Board.

3.8. Clinical Operating Model (COM) Group

WTP Board received a report on COM Group, which was taken as read and supported by WTP Board members.

Members were advised that DWMHPT would be added to future meetings.

3.9. SMT Action Log

The SMT action log was received and taken as read. No comments or queries were raised.

3.10. 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.