Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD TO BE HELD IN PUBLIC ON THURSDAY 1ST FEBRUARY 2018 AT 10.00 A.M. IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL

For access to Board Reports in alternative accessible formats, please contact the Interim Trust Secretary via 01922 721172 Ext. 7775 or linda.storey@walsallhealthcare.nhs.uk

A G E N D A

The Board of Walsall Healthcare NHS Trust has committed to undertake its Board Meetings in accordance with an etiquette that all Members have confirmed their agreement to. The purpose of the Etiquette is to enable the Board to make well-informed and high quality decisions based on a clear line of sight into the organisation.

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIMING
1.	Patient Story	Learning	Director of Nursing		**10.00**
CHAIR'S BUSINESS					
2.	Apologies for Absence	Information	Chair	Verbal	**10.20**
3.	Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held In Public 7th December 2017	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	
6.	Chair's Report	Information	Chair	ENC 4	
7.	Chief Executive's Report	Information	Chief Executive	ENC 5	
QUALITY AND RISK					
8.	Patient Care Improvement Programme and Quality Commitment	Discussion	Director of Nursing	ENC 6	**10.35**
9.	Safe Nurse Staffing	Discussion	Director of Nursing	ENC 7	**11.00**
10.	Independent Patient Care Review: Susan Hearsey	Discussion	Director of Nursing	ENC 8	**11.10**
11.	Serious Incident Report	Information	Director of Nursing	ENC 9	**11.25**
12.	Mortality Report	Information	Medical Director	ENC 10	**11.35**
13.	Quality & Safety Committee Highlight Report and Minutes	Discussion	Committee Chair	ENC 11	**11.45**

ITEM		PURPOSE	BOARD LEAD R Beale	FORMAT	TIMING
BREAK – TEA/COFFEE PROVIDED					**11.50**
STRATEGY AND PLANNING					
14.	Black Country Pathology Service Full Business Case Update	Approval	Medical Director	ENC 12	**12.00**
PEOPLE AND CULTURE					
15.	People and OD Committee Highlight Report and Minutes	Discussion	Non-executive Director P Gayle	ENC 13	**12.10**
16.	Interim Director of Organisational Development and Human Resources Reflections Update	Discussion	Interim Director of OD & HR	ENC 14	**12.20**
PERFORMANCE AND FINANCE					
17.	Financial Performance Month 9	Discussion	Director of Finance & Performance	ENC 15	**12.30**
18.	Performance and Quality Report Month 9	Discussion	Director of Finance & Performance	ENC 16	**12.40**
19.	Winter Update	Discussion	Chief Operating Officer	ENC 17	**12.50**
20.	Performance, Finance & Investment Committee Highlight Report & Minutes	Discussion	Committee Chair J Dunn	ENC 18	**13.00**

21. **QUESTIONS FROM THE PUBLIC**

22. **DATE OF NEXT MEETING**
Public meeting on **Thursday 8th March 2018** at 10.00 a.m. at the Manor Learning and Conference Centre, Manor Hospital

23. **Exclusion to the Public** – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 1st February 2018
Report Title	Declarations of Interest			**Agenda Item: 3** **Enclosure No.: 1**
Lead Director to Present Report	Chair of Trust Board, Ms Danielle Oum			
Report Author(s)	Trust Secretary, Ms Linda Storey			
Executive Summary	The report presents an updated Register of Directors' interests to reflect updated interests of the Chair of the Trust Board, Ms Danielle Oum, and Associate Non-executive Director, Ms Paula Furnival. 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.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	To NOTE the updated Register of Directors' interests.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Board Assurance Framework Risk Statement No. 11 ‘That our governance remains “inadequate” as assessed under the CQC Well-Led standard.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications highlighted in the detail of the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with NHS Code of Conduct and Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Last update to the Board received in at the Public Board Meeting on 7th December 2017.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Declarations will be reported to the Board as the interests of individual Directors change throughout the course of the year. The next scheduled report to Board will be in June 2018 at the submission of the 2017/2018 Annual Report.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Register of Directors Interests at January 2018

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Ms Danielle Oum	Chair	Chair - Healthwatch Birmingham
		Committee Member – Healthwatch England
		Board Member – Wrekin Housing
		Board Member – WM Housing
Professor Russell Beale	Non-executive Director	Director, shareholder: CloudTomo- security company – pre commercial.
		Founder & minority shareholder: BeCrypt – computer security company.
		Director, owner: Azureindigo – health & behaviour change company, working in the health (physical & mental) domains; producer of educational courses for various organisations including in the health domain. .
		Academic, University of Birmingham: research into health & technology – non-commercial.
		Spouse: Dr Tina Newton, is a consultant in Paediatric A&E at Birmingham Children's Hospital & co-director of Azureindigo.
		Journal Editor, Interacting with Computers.
		Governor, Hodnet Primary School.
		Honorary Race Coach, Worcester Schools Sailing Association.
		Non-executive Director for Birmingham and Solihull Mental Health Trust with effect from January 2017.
Ms Deborah Carrington	Associate Non-executive Director	No interests to declare.
Mr John Dunn	Non-executive Director	No Interests to declare.
Ms Paula Furnival	Associate Non-executive Director	Executive Director of Adult Social Care, Walsall Council.
		Governing Body Member, Walsall Clinical Commissioning Group.
		Director of North Staffordshire Rentals Ltd
Mrs Victoria Harris	Non-executive Director	Social Care Manager, Walsall Metropolitan Borough Council
		Governor, All Saints CE Primary School Trysull
		Husband, (Dean Harris) Deputy Director of IT at Sandwell & West Birmingham Hospital from March 2017

Name	Position/Role at Walsall Healthcare NHS Trust	Interest Declared
Mr Sukhbinder Heer	Non-executive Director	Non-executive Director of Hadley Industries PLC (Manufacturing)
		Partner of Qualitas LLP (Property Consultancy).
		Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity).
		Chair of Mayfair Capital (Financial Advisory).
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision).
Mr Richard Kirby	Chief Executive	Steward (Trustee) Selly Oak Methodist Church
Ms Barbara Beal	Interim Director of Nursing	Non-executive Director at University Hospital Coventry and Warwickshire.
		Owner of Consultancy – Griffis-Beal Healthcare Company Ltd.
Mr Russell Caldicott	Director of Finance and Performance	Executive Member of the Branch of the West Midlands Healthcare Financial Management Association
Mr Daren Fradgley	Director of Strategy and Transformation	Director of Oaklands Management Company
		Clinical Adviser NHS 111/Out of Hours
Mr Amir Khan	Medical Director	Trustee of UK Rehabilitation Trust International
		Trustee of Dow Graduates Association of Northern Europe
Mrs Louise Ludgrove	Interim Director of Organisational Development & Human Resources	Director of Ludgrove Consultancy Services Ltd.
Mr Philip Thomas-Hands	Chief Operating Officer	Non-executive Director, Aspire Housing Association, Stoke-on-Trent.
		Spouse, Nicola Woodward is a senior manager in Specialised Surgery at University Hospital North Midlands.

Walsall Healthcare NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 7TH DECEMBER 2017 AT 10:00 a.m. IN THE LECTURE SUITE, MANOR LEARNING & CONFERENCE CENTRE, MANOR HOSPITAL, WALSALL

Present:

Ms D Oum	Chair of the Board of Directors
Mr J Silverwood	Non-Executive Director, People and Organisational Development Committee Chair
Mr J Dunn	Non-Executive Director, Performance, Finance and Investment Committee Chair. Chair and Champion for the Emergency Department
Mr S Heer	Non-Executive Director - Chair of Audit Committee and Champion for Improvement
Mrs V Harris	Non-Executive Director – Chair of Charitable Funds committee NED Champion for Maternity and Neonatal Services
Professor R Beale	Non-Executive Director – Quality and Safety Committee Chair and Champion for Information and Computer Technology
Mr P Gayle	Non-Executive Director Champion for Patient Experience (including Ethics) and for Equality, Diversity and Inclusion
Mr R Kirby	Chief Executive
Mr R Caldicott	Director of Finance & Performance
Mr P Thomas-Hands	Chief Operating Officer

In Attendance:

Mrs P Furnival	Associate Non-Executive Director – Adult Community Care
Mr D Fradgley	Director of Strategy & Transformation
Ms L Ludgrove	Interim Director of Organisational Development and Human Resources
Mrs L Storey	Trust Secretary
Mrs B Beal	Interim Director of Nursing
Miss J Wells	Senior Executive PA (Minutes)

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

199/17 Patient Story

Ms Oum welcomed members of the public and colleagues to the meeting.

Ms Oum welcomed Ms Marie Moore, accompanied by Richard Kus from the Patient Relations Team.

Ms Moore stated that she wrote to the Trust following her recent admission to the hospital. Ms Moore was under the care of the Dermatology Team and presented with multiple lesions on her legs. Following a biopsy, she attended clinic due to her worsening condition where she was referred to Accident and Emergency. The staff from Dermatology waited with her until she was seen and kept her calm. Ms Moore advised that she had experienced a severe allergic reaction to her medication. The staff recognised the symptoms and the need to take action. Ms Moore was admitted as an in-patient to AMU where she remained for three days. Ms Moore wanted to thank the staff for saving her life. The staff that cared for her throughout were polite and continually went above and beyond.

Ms Oum welcomed the feedback from Ms Moore's heart-warming story and extended her thanks to the teams involved.

Mrs Beal thanked Ms Moore for sharing her experience and was pleased that the staff recognised her symptoms and took swift action. Ms Beal would ensure that thanks were given to the staff.

Mr Khan thanked Ms Moore for attending and providing feedback, adding that he was pleased that Ms Moore received a good quality service while under the care of the hospital.

200/17 Apologies for Absence

Apologies were noted from:
Ms D Carrington – Associate Non-Executive Director, Champion for Improvement, Staff Experience (including Duty of Candour, Freedom to Speak Up and Junior Doctors).
Mrs Beal was welcomed to the meeting as the Interim Director of Nursing.

201/17 Declarations of Interest

Ms Oum asked the Board members and attendees if they had any declarations of interest to make in relation to any of the agenda items. There were no declarations made.

Ms Storey presented an updated Register of Director's interests for information.

Resolution

The Board noted that there were no declarations in respect of the agenda items and received the updated Register of Directors' Interests.

202/17 Minutes of the Board Meeting Held in Public 2nd November 2017

The minutes of the meeting held on the 2nd November 2017 were agreed as a correct record.

Resolution

The Board approved the minutes of the meeting held on the 2nd November 2017 as an accurate record.

203/17 Matters Arising and Action Sheet

The Board received the action sheet. It was noted that there were a

number of actions which had been deferred to the next Trust Board meeting and the following updates were provided:

147/17 07/09/2017 Quarterly Quality Commitment Report – As the Trust Board in January had been cancelled it was agreed that the report would be rescheduled to the Trust Board in February. The report would be circulated earlier if Mrs Beal considered it necessary. **BB**

150/17 07/09/2017 Emergency Preparedness Resilience Response – Compliance with Trauma Unit Standards. Mr Khan advised that all actions had been completed and the Trust was compliant. Evidence would be reviewed at the Quality and Safety Committee in December.

Resolution

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

204/17 Chair's Report

Ms Oum presented the report which was taken as read.

Resolution

The Board received and noted the Chair's update.

205/17 Chief Executive's Report

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

- Focus remained on the four main priorities for Quarter 3 and Quarter 4 which were;
  - Patient Care Improvement, particularly in the Maternity Department.
  - Emergency Care Improvement – Winter safety preparations.
  - Financial Recovery.
  - Culture Change.

Mr Kirby publically congratulated all winners of the Staff Awards, which had been a highlight of the year, evidencing the impressive work done for patients by staff. A full list of winners was included at the back of the report.

Progress on the development of an alliance contract with Community Health Services, Primary Care, Mental Health and Social Care was continuing at pace. Workshops with teams from each organisation had started. A proposal outlining the first steps in the structure would be completed by the end of January 2018.

Resolution

The Board received and noted the content of the report.

206/17 Risk Management

Ms Storey presented the report and highlighted the following key points;

- An update was given on the six strategic risk management

objectives.

- Work in the last quarter had focussed on the development of an electronic Board Assurance Framework (BAF) with a pilot framework to be tested in January 2018. This would enable linkage to the Corporate Risk Register risks.
- An updated BAF was presented together with narrative updates for each risk to support the current risk scoring.
- An updated Corporate Risk Register (CRR) was presented together with narrative updates for the risks, score movement, de-escalations and new and escalated risks.
- A mapping exercise had been undertaken to map each corporate risk to the relevant annual objective.
- Priorities for the next quarter were outlined as:
    - Pilot and launch of the electronic BAF.
    - Development of a short and simple Safeguard User risk training package.
    - A review of the CRR risk descriptions.
    - The Trust Board would develop its risk appetite.

Questions and Comments

Ms Oum advised that the work outlined was keeping the risk at the forefront, linking to operational realities and the delivery of strategic objectives.

Mr Heer welcomed the work undertaken to date and thanked Mrs Storey for her work. Mr Heer reflected whether the approach could be more dynamic and questioned whether the BAF scoring represented the depth of challenge facing the Trust and questioned whether the mitigations could be stronger. Mr Heer further questioned whether there was a sufficiently clear snapshot of the challenges and made reference to the Care Quality Commission, changes in leadership, sustainable CIP savings, finances and the change in leadership transition to a clinically led model.

Mr Gayle was encouraged by the report and questioned whether the BAF should include separate patient safety risks as opposed to the overarching quality risk.
In relation to the CRR Mr Dunn noted that it appeared to be collecting new risks but not seeing many de-escalated. The Trust appeared to be recognising the risks and documenting them properly but Mr Dunn queried whether enough action was being taken to sufficiently mitigate them. In response Ms Storey explained that a function of the Risk Management Committee was to review proposed risks and to ensure that sufficient risk assessments were completed. Mrs Storey explained that there was further work to do in terms of undertaking a detailed critique of the current risk descriptions and mitigations. In addition, Mrs Storey explained that the development of the Trust's risk appetite would be a critical step in the improvement of the Trust's risk management approach.

Ms Oum suggested that a risk appetite session as part of the next Board Development meeting would be beneficial in moving the prioritisation of risks forward.

Ms Oum queried whether training had been delivered effectively and widely and whether the process had been imbedded.
Mrs Storey replied that training had been undertaken including specific training with the divisions from an external provider, a module as part of the Effective Manager Programme and ongoing training provided by the Divisional and Corporate Governance Advisors who were imbedded within the divisions. Mrs Storey further explained that a training needs analysis was under way as it had been recognised that there was a requirement for a simplified training package for staff.
Mr Khan advised that the risks in relation to the Accident and Emergency Department were being managed but would likely rise during Quarter 4, adding that there were privacy and dignity issues within the A&E environment which would not be fully mitigated until the new build was completed.

Mr Fradgley reflected that departments were linked to their risks and there had been a change in operational thinking, but that the Trust had been on a journey in relation to its risk processes and some departments and teams were more embracing of the processes than others.

Mrs Beal observed that the imbedding of the governance teams in the divisions was strong and having a positive impact on divisional approach to risk. The Senior Nursing Advisory Group had utilised the Board Assurance Framework in a patient safety and quality workshop. In addition an internal review of workforce was under way. Mrs Beal added that there appeared to be a very clear understanding at a divisional level and that the training needs analysis would be beneficial.

Mrs Ludgrove acknowledged that the risk register needed to be updated regularly in order that it was kept dynamic to ensure it was reflective of a rapidly changing environment
Mr Caldicott welcomed the updates and noted the Trust's journey in relation to the development of its risk processes. Mr Caldicott confirmed that the three key risks of the financial position, including the cost improvement programme and the delivery of national standards were clearly reflected in the BAF.

Mr Kirby confirmed the big step forward in the ability to fully understand the risks and noted that whilst the leadership changes were reflected as a new risk on the CRR further consideration was required as to whether this should be reflected on the BAF as part of a BAF refresh in the New Year Mr Kirby questioned the executive team as to whether they were comfortable with the level of static risk on the CRR and cited a number including the generator risk and safe staffing and suggested that further consideration was required as to further mitigations as the team should not be content with the current level of risk

In summary the Chair noted the progress made in terms of understanding and managing risks and noted that the following

actions were required as a result of the discussion:

- The executive team would review the CRR to review the action required to address the large number of static risks. **Exec. Directors**
- The Trust Secretary would work with the Executive Team to review the number or risks on the CRR and to provide greater clarity on the risk descriptions. **Exec. Directors**
- A review of the Board Assurance Framework would be undertaken to ensure the right challenges were articulated with a view to there being fewer BAF risks. **LS/Board**
- The Board would complete a risk appetite survey which would feed into a Board Development session in January 2018. **LS/Board**

Resolution
The Board received and noted the content of the report.
Risk Appetite to be reviewed with Executive Directors and included on the Agenda at Board Development in January 2018.

207/17 Serious Incident Report

Mrs Beal presented the report and highlighted the following key points:

- There were 11 new Serious Incidents reported in October 2017.
- Pressure ulcer data still required further clarification and understanding. The report at the next Trust Board would provide more detail of findings together with actions to mitigate and next steps following work undertaken by the Deputy Director of Nursing and the Tissue Viability Team. A flash report comprising of one side of A4 would be developed to provide a more timely position statement. In addition, the new mattresses were starting to make a difference.

Questions and Comments

Mr Gayle noted that the Board did not see the detail of pressure ulcer grading and queried whether there were any pressure ulcer champions. Mrs Beal confirmed that the Trust did have pressure ulcer champions and she had requested a refresh with more focus. As a result, work was underway with teams on the wards and the Deputy Director of Nursing was reviewing the processes in order to understand the data more effectively. Mrs Beal added that there was also a Pressure Ulcer Working Group.

Ms Oum advised that the Board had previously asked whether guidance provided to people in the community about pressure relieving equipment was presented in a way that was understood by the different communities served by the Trust. Feedback had been requested through the Quality and Safety Committee but this had not yet been provided. Mrs Beal noted the action and agreed would progress it through the Quality and Safety Committee. **BB Q&S**

The importance of near miss reporting was discussed following a request from Mr Silverwood about the timescale to report back on work undertaken. Mrs Beal agreed to work up the timescale for **BB**

reporting through the Quality and Safety Committee. **Q&S**

Mr Heer made reference to recent news regarding national backlogs in radiology and asked what the Trust's position was and how any issues were being managed. Mr Khan explained that there had been delays in reporting within radiology which would be reviewed at the Quality and Safety Committee.

Mr Heer observed that one VTE incident related to 2016 and asked why it had taken so long to reach a resolution and queried whether lessons were being learnt and how the Board would receive assurance that learning was occurring. Mr Khan explained that the delay was due to awaiting outcomes from a number of audits that had been undertaken regarding VTE assessments. Mrs Beal explained that there was a requirement to get beneath the detail of incidents to ensure that changes made as a result were sustainable.

Mr Khan explained that there had been a Never Event in November within Maternity where a patient had been discharged with a retained swab. Mr Khan confirmed that there had been no harm to the patient and the Duty of Candour had been enacted.

Resolution
The Board:

- **Received and noted the content of the report.**
- **Noted that it would receive further information on the outcome of the review into the understanding of community guidance in relation to pressure ulcers and near miss reporting via the Quality and Safety Committee Highlight Report.**

208/17 Quality and Safety Committee Highlight Report and Minutes

Professor Beale presented the highlight report from the most recent meeting held on 30th November 2017, together with the approved minutes of the meeting held on 19th October 2017. The following key points were highlighted:

- VTE assessment compliance had dipped below the target trajectory but reassurance had been given that steps were in place to reach the 95% target in December.
- Good progress had been made on the CQC Section 29A Warning Notice actions.
- Actions and timelines in response to the independent review into the care and treatment of Miss Susan Hearsey had been reviewed and assurances provided that of the 12 actions recommended the majority were at a green or partially green/amber status.
- The division of medicine and long term conditions had delivered a presentation outlining the progress made following the CQC visit in 2015 and the current draft report received. The good work undertaken by the Rapid Response Team had been highlighted. The division had also discussed their areas of concern.

Questions and Comments

Ms Oum stated that it was encouraging that the committee had reviewed the action plan with regard to Miss Hearsey and that the actions were near complete. In addition, Ms Oum reiterated the importance of achieving the 95% target for VTE as its delivery was vital for patient care. Ms Oum explained that the Trust was specifically asked about VTE compliance at its most recent quarterly review with NHS Improvement.

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

209/17 Partnership Update

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

- Intensive work had been underway on the alliance approach. Workshops had been held the previous week and one to ones with providers were taking place to set the scene for future operating models.
- Benchmarking showed that the Trust was in a good position as it had most of the components in place that other organisations aspired to deliver. There was a requirement to link the components to further improve the position.
- The CCG were supporting the process moving forward.
- There were some issues which needed to be addressed as all partners operated different contractual mechanisms that could impact on how the organisations work together.
- Work continued with the design of the stroke service with the final case for approval to be submitted to the Board in February 2018. The pathway was under design and a clinical senate had been undertaken. There was good communication within the teams and further work was required with staff to ensure clarity on the proposed changes.
- Place based teams were moving forwards, albeit with not as much pace, which highlighted some of the difficulties faced.
- Work was underway with the Integrated Care Service. Some areas were moving forward on plans but others faced challenges in relation to how the service interfaced with the wards in relation to the discharge process.
- The development of the Black Country Pathology Services was a significant piece of partnership working and would be discussed as a separate item on the meeting's agenda.
- Feedback from Healthwatch Walsall surveys undertaken in relation to the review of stroke services was attached to the report. The public were broadly supportive of the proposed direction of travel, indicating a desire for accessibility of treatment for urgent cases and a local pathway for rehabilitation. It was noted that the design of the service aligned to the public need.

Questions and Comments

Ms Oum noted the solid progress made to date and requested Board

colleagues to provide their views on progress. The following views were given:

- Mrs Furnival stated that the work across the system with KPMG had been excellent with sessions sensitively led and engaging. GPs had been actively involved.

- With regard to Accountable Care, Mrs Furnival explained that there was emerging thinking that systems needed to be of a certain size and that Placed Based was not large enough, whilst there was the added complexity of understanding STP thinking.

- With regard to stroke services Mrs Furnival explained that the proposed changes to the stroke services had been to the Health Overview Scrutiny Committee and would go for a second time in January 2018. The clinical arguments had been convincing but there was concern about understanding the linkage of the community aspect of the services.

- In relation to intermediate care Mrs Furnival explained that there would be an update on this for the February Board.

- Mr Kirby noted that it would be helpful for the Board to spend some time in February to look at how Accountable Care in Walsall connected to Accountable Care in the Black Country and to explain what this would mean for business cases. Mr Heer requested that the work include a timeline for deliverables and to look at this through the lense of the patient. **DF/RK**

- Mr Kirby reiterated that work with providers regarding IT and accessing clinical records needed to continue together with maintaining the focus on stroke services, specifically in relation to making a strong case for the rehabilitation part of the pathway in Walsall.

- Mr Heer advised it was helpful to see a timeline and deliverables included in the report but would like to see a dynamic approach in terms of what it meant to patients and an alignment to the STP.

Ms Oum welcomed the progress made to date on the range of work and recognised the need for the Board to focus on the delays in transfer of care agenda through the Finance, Performance and Investment Committee and to work on developing Accountable Care and the wider context of change in the Black Country. Ms Oum suggested that the Board Seminar in February could be used for this.

Resolution

The Board:

- **Received and noted the content of the report.**
- **Proposed that Accountable Care be a topic for the Board Seminar in January.**

210/17 Black Country Pathology Services Business Case

The Black Country Pathology Services Business Case was presented for the Board's approval. Mr Khan introduced Dr Ye-Lin Hock, Histopathology Consultant and Clinical Director of Pathology Services for the Black Country Partnership.

Work on the Target Operating Model was underway with extensive engagement with laboratory leads and staff. Risks had been identified and were managed by clinical teams.

The following benefits of the business case were highlighted:

- Provision of sustainable services that delivered for patients. To do this a bigger service was required with a larger pool of consultants as currently there was a 25% consultant vacancy rate.
- A hub and spoke model was proposed with the hub based at Wolverhampton with spokes in the other hospitals providing emergency service laboratories for day to day work.
- The main principle was that the service would be as good as the current service and with a plan to improve the standard.
- Bigger laboratories for quicker test results.
- Improved GP access and delivery points.
- Improved cancer waiting times. Whilst Walsall Healthcare was performing well for cancer waiting times this was not the case across the Black Country. More histopathologists would result in improved reporting times.
- Locally based emergency laboratories with 24/7 access which did not have to work on elective pathology would result in improved response time to A&E with the overall impact of improving A&E waiting times.
- Robust IT services would be essential and further work was required to address this.
- A Financial benefit of £6.7m per year across all Black Country pathology services as a result of a reduction in pay and non-pay costs.

Mr Khan acknowledged that further work was required on staffing and commercial models including KPIs and also on I.T.

Mr Khan explained that the business case outlined best practice on clinical grounds for the benefit of patients and sought approval from the Board to approve the business case to move to the next stage of development.

<u>Questions and Comments</u>

Ms Oum stated that the Board had held detailed discussions with the developers of the business prior to the board and asked the Board for any questions and comments.

Mr Dunn suggested that whilst he was supportive of proceeding, this would be on the basis of the following caveats:

- A requirement to see the full commercial terms.
- A requirement for an improved understanding of the I.T. infrastructure and impact of integration which might result in further costs and remodelling.
- Inclusion of performance penalties should the changes not work for the people of Walsall together with mitigating actions to address any shortfall in performance.

Discussion was held about the clarity of the staffing numbers. It was noted that there would be a reduction of approximately 80 posts which was uniformly across all four organisations. The Board was advised that a level of detailed work remained to be finalised in the new year and whilst a higher number could not be ruled out at the present time, there was currently no reason to anticipate it being higher. The Board was advised that the current reduction in staffing did not include medical staff as there were a number of vacancies for medical staff and medical staffing was currently being modelled.

Clarity was requested on what the Board was was being asked to approve as the direction of travel was right but there were a number of risks including the I.T. systems where work was required to clearly understand and mitigate the issues.

A discussion was held about the requirement to see a detailed cash flow on a discounted cash flow basis in order to see the final 10 year cumulative benefit. Clarity was also sought on the benefits in Years 1 and 2. Mr Caldicott noted that further work was required on the commercial aspects of the case which would inform the financial model. Mr Caldicott explained that the service would not become operational for two years and additional cost would be incurred in that time – there was therefore a requirement for the financial modelling to show that cost. Mr Caldicott acknowledged that a discounted cash flow was not currently shown and explained that discussion was being held about that as the financial modelling was currently shown as an income and expenditure model. Mr Caldicott added that the cash model needed to be set out in the commercial terms.

Mr Kirby clarified that the Board was being asked to approve the business case as it stood to enable the teams to move forward to the next stage of work. Mr Kirby acknowledged that the next stage of work included working with staff and I.T. and the Partnership Board was seeking commitment to move forward, which could be made subject to commercial, I.T. and staffing issues being addressed.

Mr Heer sought clarification about the legal entity and was advised that the partnership would be an alliance.

Ms Oum summarised the position:

- There was a clear national strategic direction to collaborate for sustainability.
- The rationale for collaboration was understood.

- It was clear that there was not a sustainable workforce at Walsall and there was therefore a requirement to do something different.
- There was an understanding that the Trust would receive financial benefit from the proposals and there was a requirement to understand the detail.
- The most important driver was however an improved service to patients.

The Board moved to resolution with a number of caveats which would be circulated to the Board members.

Resolution
The Board:
Approved the business case as it stood in order that progression could be made to the next stage of the development of the service.

The approval was subject to the following caveats:

- That assurance be provided that the I.T. solutions for the new service were fit for purpose and that there would be a high level of clinical engagement in their development.
- That the detailed commercial terms for the Black Country Pathology Service included sufficient clarity about the approach to remedies and penalties in the event of under-performance by the service.
- Clarification of the cash flow benefits over 10 years.
- Clarification of the risks including mitigations.
- Clarification of the staffing model across the participating organisations and an agreed HR process that ensured all existing staff would be treated fairly in the change process.
- Clarity on the corporate governance with the proposal that once the Black Country Pathology Service was fully established its Board should be chaired by an independent chair.

211/17 Trust Objectives Update

Mr Fradgley presented the report and stated that the objectives had been presented in a new format following discussion about the assurance provided when the Board received the Quarter 1 report. Mr Fradgley and Mrs Storey had worked together to link the work to the risks in the Board Assurance Framework and the Corporate Risk Register.

The objectives had been presented and discussed at the three assurance committees and within the Executive Team meeting where there had been productive and challenging comment.

The report now comprised of a section on quarterly assessment update against each objectives with clarity on the assurance provided to reach that conclusion. The assurance had been provided against the three lines of scrutiny: internal, corporate and independent. This together with collective narrative would drive the

assessment for the RAG rating and aimed to partner the Board Assurance Framework assessments

The aim of the changes had been to better link the risk position to the status of the objectives.

Questions and Comments

Ms Oum thanked Mr Fradgley and Mrs Storey for their work to link the objectives to the risk position to provide a clearer status.

Mr Heer queried why completion dates were in March 2019 and how they would be monitored and managed with a completion date so far away. Mr Heer further questioned whether the Trust was mixing long term and short term objectives and questioned why there were some blank boxes for some of the assurance lines. Mr Fradgley explained that the objectives carried over for two years and that the deliverables were marked for when the plan was due. Mr Fradgley added that there were seven objectives in the plan which each had sub-objectives and that work was underway to outline progress dates which would give further assurance. Ms Storey explained that any blank box would be due to there not having been any assurance identified for that particular line of scrutiny. Mrs Beal confirmed that there had been independent oversight of maternity services and would provide an update to Mr Fradgley to update the report further. **BB**

Mr Kirby advised that the Emergency Care performance pressure was a big issue which had not surfaced as a result of the exercise, noting that the current status showed it at amber which was optimistic. Mr Kirby explained that on reflection it should be at red status. Mr Fradgley noted the comment and would amend the report. **DF**

Ms Oum thanked Mr Fradgley and Mrs Storey for the step forward with the reporting on Trust objectives and reiterated the importance of understanding the outcomes as well as the delivery. The report would be amended to reflect the discussion held and to ensure clear lines of assurance.

Resolution
The Board received and noted the content of the report which would be updated with the amendments proposed.

212/17 People and Organisational Development Committee Highlight Report and Minutes

Mr Silverwood presented the highlight report from the People and Organisational Development Committee meeting held on 20th November 2017 with the confirmed minutes of the meeting held on 23rd October 2017. The following key points were highlighted:

- Mr Simon Johnson had attended the meeting to share feedback from the staff engagement focus groups.
- It was noted that sickness figures had risen to 5.76%.

- Flu vaccinations were reported at 46%.
- The staff survey closed the previous week and the informal calculation of response rate was at 36%, which was less than the previous year at 40%

Mrs Ludgrove advised that the HR team had reviewed the sickness position and would feed back to the next committee. In addition the team were looking to see if there was a correlation between an increase in sickness and an increase in staff membership of bank. The initial indications were that there was some correlation and there was a requirement to consider the effect of this and how to manage it.

Questions and Comments

A discussion was held about the take up of flu vaccinations, the reasons why staff might not have yet had their jabs and the action being taken to improve the take up rate.
Mrs Ludgrove explained that staff had been asked why they had not taken up the jab and in response myth busting work had been undertaken. Mrs Ludgrove further explained that a key area of focus was peer vaccinators as there were insufficient numbers for the speed of the task required. Support had been sought from nursing colleagues to assist. Clarity was provided that there were a number of different measures in relation to the uptake of flu vaccinations with and the Trust targeting 100% of patient facing colleagues with a delivery point of the end of February whilst the CQUIN target for the year was 70%. Mrs Ludgrove stated she was confident the team was doing all it could but the confidence factor would depend on how many more peer vaccinators could be put into the clinical areas.

Professor Beale queried whether the Trust could implement an incentive such as 'get a jab, give a jab' to benefit the developing world.

Professor Beale suggested that some staff might be willing to have the vaccine but not in the form of a jab, querying whether the vaccine could be administered by another means. Mrs Beal explained that she was not aware of any other method of delivering the vaccine. Mrs Beal explained that she had sent out a joint letter setting out the response required from nursing teams and confirmed that the vaccination programme had the focus of the Senior Nursing and Midwifery Advisory Group.

The response to the national staff survey was discussed. Ms Oum emphasised the importance of the survey and reflected that the organisation had been pleased to have increased its response rate the previous year which made it disappointing that it had dropped for the current survey. Ms Oum acknowledged that there might have been a national context to the reduction in response rate but emphasised that staff engagement was a key priority area for the Board and there was therefore a requirement to renew The focus on participation for the next surveys Ludgrove reassured the Board that there had been great focus on encouraging staff to complete the survey with the help of Tom Johnson which included face to face

visiting and enabling staff to take time out to complete the survey.

Resolution
The Board received and noted the content of the report

213/17 Financial Performance Month 7

Mr Caldicott presented the Financial Performance report for Month 7 and highlighted the following key points:

- The Trust had attained a £14.9m deficit against plan of £12.8m giving an unfavourable variance of £2.1m.
- The position was largely driven by underperformance on clinical income in Obstetrics, Maternity and Outpatients and as a result of clinical divisions continuing to overspend.
- CIP delivery was behind plan at £5.2m and forward indicators for the savings schemes showed that it would be difficult for the Trust to deliver the plans.
- The opening of a ward during October that had previously been closed had led to increased agency costs in the month.
- The deterioration in the deficit position had reduced in month.
- The challenges to attain the £20.5m deficit plan were largely associated with productivity and managing patient flow, bed numbers and the temporary workforce.
- There was a requirement to deliver the requirements of the Letter of Undertakings including the submission of a three year sustainable financial plan by the end of January 2018.

Questions and Comments

Ms Oum noted the areas of challenge and questioned how the Board would approve the three year plan as its next meeting would not be until the beginning of February. Following discussion it was agreed that the plan would be signed off at the Performance, Finance and Investment Committee at the end of January but there needed to be a full board discussion at the early February Board for formal approval.

Mr Dunn advised that an Extraordinary Performance, Finance and Investment Committee was scheduled for the 4th January 2018 to look at ongoing support from KPMG in detail and to make a recommendation to the Trust Board.

Mr Heer suggested that as the next Board would not be until early February, a flash report be provided at the end of December and January to keep the Board up to date on the forecast monthly position including income and expenditure, cash flow and capital expenditure. Mr Caldicott agreed to circulate the information. **RC**

Mr Khan referenced the winter pressure and the impact on the financial position as a result of elective work reductions and asked whether the surgical teams were being closely engaged with the plans. Mr Caldicott confirmed that the Trust had been working closely with the teams and had planned for the reduction in elective work. Mr Caldicott further explained that plans to develop more sessions in Outpatients and an increase in day case work were

being considered.

Mr Kirby suggested that the Performance, Finance and Investment Committee look at whether the impact of action taken to manage the cash position such as delayed payment to suppliers, had resulted in operational difficulty. Mr Caldicott explained that a report had already gone to the Risk Management Committee on the subject and agreed to look at the issue again through the Performance, Finance and Investment Committee. **RC/ PFIC**

Ms Oum cautioned that delaying payment to suppliers could limit the choice of suppliers willing to work for the Trust

Resolution
The Board received and noted the content of the report and agreed that the Performance, Finance and Investment Committee would look at the impact of action taken to manage the cash position.

214/17 Performance and Quality Report Month 7

The Performance and Quality Report for October 2017 was received and the following key issues highlighted:

- All national cancer metrics achieved in September. The 62 day consultant upgrade local target failed to achieve, reporting 85.53% against a 91% target. Unvalidated performance for October shows achievement of all metrics with the exception of 62 day consultant upgrade.
- Diagnostics achieved a target of 99%.
- October RTT performance declined to 84.75%. There were 2 patients waiting more than 52 weeks in October on an incomplete pathway.
- A&E performance had improved to 82.75% in October but was below the trajectory of 90%.

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

215/17 Winter Plan

Mr Kirby presented the Winter Plan and highlighted the following key points:

- Actions had been planned across health and social care to ensure that there were 100 beds empty at Christmas Eve. The work included considerable work on rotas and in relation to on call rotas to ensure that the right people would available at critical points.
- Elective surgery scale back in January to free up surgical beds for emergency patients together work with the Deanery on what would be expected of surgical junior doctors.
- A plan was in place for extra bed capacity but this was being used earlier than intended. The plan included what other beds could be utilised and in what order.

- The work was supported by £500k from the Centre to put staff at the front door including an extra acute physician and an additional surgical physician. A further £1m from the budget allocation of money had been requested and was awaiting a response. Extra funding would assist with additional front door staffing.
- Partners were assisting where they were able to. The plan included extended access to primary care in Walsall and coordination with the Ambulance Service.

Mr Kirby advised that the Trust was very well prepared but that despite the planning the winter was a high risk point with A&E being very busy. The expectation was for a difficult operational period. If the winter was as busy as the previous year the plan would be sufficient, but if the Trust was busier it would face very difficult challenges.

Mr Kirby gave thanked Mr Thomas-Hands and his team for the work involved in the creation of the plan.

Questions and Comments

Mr Khan advised that the winter plan had been discussed at the Performance, Finance and Investment Committee. Clinical teams had input and were taking ownership to address winter performance.

Professor Beale suggested that in future the Board have earlier sight of the plan in order that it could contribute its areas of expertise to the planning.

Mrs Beal advised that NHSI had completed an assessment of how prepared the Trust was to keep patients safe during the winter period. The work had focused on the utilisation of the Discharge Lounge, more effective working between the Emergency Department, the Acute Medical Unit and the wards. Positive feedback had been received regarding staff engagement with an open working culture with a focus not just on the current position but looking at the future also. Clinical engagement was noted to have been different to previous years with good services around intermediate care and a good in-reach model. In addition, the Emergency Care Improvement Team would also assist with working with the multi-disciplinary teams.

Ms Oum thanked Mr Thomas-Hands and the teams involved for the helpful plan. Ms Oum advised that focus should not only be on risk but to reflect on the journey the trust had been on. Ms Oum noted Mr Kirby's concern to be realistic about the challenges faced.

Ms Furnival noted the difficult context and emphasised a number of positive steps that had been taken. These included alignment of the winter plans through the Accident and Emergency Board across the different organisations which had helped to prioritise work from the money received. There had been good cross system conversations about targeting money and the system had received a reasonable share of additional money.

Ms Oum noted the increase in delayed ambulance handovers in October and asked how the winter plan and its resources would impact on that area. Mr Kirby confirmed that teams were clear that any patient delayed in an ambulance was the Trust's responsibility to ensure safe care was provided. Mr Kirby further explained that the Trust had a relatively low number of delayed ambulance handovers compared to other sites. Delays were caused by A&E being at capacity and lack of physical space and the Trust did not as a matter of policy hold people in corridors. A set of actions had been designed to move patients through the Emergency Department swiftly and West Midlands Ambulance Service had been working with 111 in order to try to keep conveyance numbers down. The rate for Walsall was 60% which was middle of the pack.

Resolution
The Board received and approved the Winter Plan.

216/17 Performance, Finance and Investment Committee Highlight Report and Minutes

Mr Dunn presented the highlight report from the Performance, Finance and Investment Committee meeting held on 27th November 2017 with the confirmed minutes of the meeting held on 25th October 2017. Mr Dunn highlighted the good work done to stabilise the 4 hour performance.

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

217/17 Audit Committee Highlight Report

Mr Heer presented the highlight report from the Audit Committee meeting held on 20th November 2017 and highlighted the following key points:

- There was disappointing non-attendance of Executive Directors which resulted in restricted discussion of some agenda items. A further meeting to discuss the outstanding points had not been possible prior to the end of the year.
- The internal audit progress report had been received. The Committee asked internal audit to be more concise and unambiguous about the analysis of their work.
- Concern was raised that whilst good work had been achieved to reduce the number of outstanding internal audit recommendations, the numbers were beginning to creep up again.
- Concern was raised that the Counter Fraud Team appeared to have become involved with a number of matters outside of their remit and which should have been managed by Human Resources.
- The Committee requested the Nominations and Remuneration Committee to review the decision making process for the appointment of the recruitment agency relating to the Executive team vacancies.

Ms Oum reiterated the importance of executive director attendance at the committee to ensure that agenda items had sufficient representatives.

218/17 Questions from the Public

No members of the public were in attendance and no questions had been raised in advance of the meeting.

Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 1st February 2018 at 10:00 a.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

Resolution:

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

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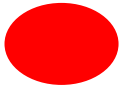
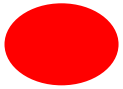
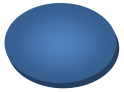
Walsall Healthcare NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
118/17 06/07/2017 OD & HR Initial Reflections	People and Organisational Development Committee to review findings of the report following which the Board would receive a statement about monitoring improvements.	LL/JS	~~02/11/2017~~ ~~07/12/2017~~ 01/02/2018	**Update** On agenda for Board Meeting 1st February	
147/17 07/09/2017 Quarterly Quality Commitment Report	Summary of actions relating to red rated areas to be included in the next version of the Quality Commitment report.	BB	~~07/12/2017~~ 01/02/2018	**Update** Quality Commitment on agenda for Board Meeting 1st February	
150/17 07/09/2017 Emergency Preparedness Resilience Response	Compliance with Trauma Unit standards to be reviewed and reported through the Quality and Safety Committee.	AK	~~02/11/2017~~ ~~07/12/2017~~ ~~01/02/2018~~ 08/03/2018	**Update** Trauma Network Revisit due in January. Report on compliance to be provided to February Quality & Safety Committee.	
160/17 07/09/2017 Questions from the Public: Ward Closures	Workforce impact assessment to be undertaken in relation to ward closures and reported back through the People and Organisational Development Committee.	PTH	~~02/11/2017~~ ~~18/12/2017~~ 19/02/2018	**Update** Re-scheduled to February meeting.	
169/17 05/10/2017 Quality & Safety Committee Highlight Report	Feedback from a number of external reviews regarding Maternity would be due in two months and would be reviewed at the December Quality & Safety Committee.	RK	~~21/12/2017~~	**Update** Re-scheduled to February meeting to enable inclusion of RCOG report.	

Walsall Healthcare NHS
NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
190/17 02/11/2017 Serious Incident Report	Revisit the statistics for near misses and no/low harm to provide assurance to the Board through the Quality & Safety Committee.	BB (L Pascall)	01/02/2018	**Update** Written update provided in the Serious Incident report to the Board.	
	Next report to the Quality & Safety Committee to provide an update on progress in relation to community understanding of guidance for pressure relieving equipment. (Clarification provided at December Board that the action related to whether the guidance provided to people in the community about pressure relieving equipment was presented in a way that was understood by the different communities served by the Trust).	BB (L Pascall)	01/02/2018	**Update** The Quality & Safety Committee received some clarification regarding equipment and advice provided to patients in the community at the November meeting.	
	Report to be developed to include benchmarking, a review of quantum vs actual activity lessons to be undertaken and building assurance over lessons learnt.	BB (L Pascall)	08/03/2018	**Update** Written update provided in the Serious Incident report and a further discussion to take place at the Q&S Committee to determine the content of reports going forward.	
	Develop a Business Intelligence strategy.	DF	June	**Update** Strategy already planned and due for delivery by the end of Q1 2018/2019 as part of the refresh of strategic documents. Strategy to go through PFIC. Scheduled on PFIC tracker for June	

Walsall Healthcare NHS
NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
				2018.	
195/17 02/11/2017 Performance & Quality Report Month 6	Mr Thomas-Hands to liaise with the Medical Director and report back outside of the meeting about concern raised in relation to the timely treatment of sepsis in emergency and acute areas.	PTH	07/12/2017	**Update**	
	The next report to show a clear distinction between patients on the Medically Fit for Discharge list that were awaiting Trust internal input and those that were waiting for external input.	Chief Operating Officer	01/02/2018	**Update**	
	Discuss with executive director colleagues an approach to including in the report those actions in place to deliver trajectories but which were not having the expected impact. Report back to the Performance, Finance & Investment Committee.	Chief Executive	01/02/2018	**Update**	
206/17 07/12/2017 Risk Management	Executive team to review the Corporate Risk Register to review the action required to address the large number of static risks.	Executive Directors	08/03/2018	**Update** Monthly review commenced at Executive Team.	
	Trust Secretary to work with the Executive Team to review the number of risks on the CRR and to provide greater clarity on the risk descriptions.	Executive Directors & Trust Secretary	08/03/2018	**Update** Review commenced. Monthly 1:1s to be used to provide guidance on reviewing risk descriptions.	
	Review Board Assurance Framework to ensure the right challenges were articulated with a view to there being fewer BAF risks.	Trust Secretary	08/03/2018	**Update** Review commenced.	

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Walsall Healthcare NHS
NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

Minute Reference/Date Item Title	Action Description	Assigned to	Deadline Date	Progress Update	Status
	Board to complete a risk appetite survey to feed into the Board Development session in January 2018.	Trust Secretary/ Board Members	29/02/2018	**Completed** Appetite survey circulated December 2017. Risk appetite session scheduled for 29/01/2018.	
209/17 07/12/2017 Partnership Update	Board to look at how Accountable Care in Walsall connected to Accountable Care in the Black Country. Explain what this would mean for business cases. A timeline was required for deliverables. Accountable Care to be looked at through the lense of the patient.	Director of Strategy & Transformation & Chief Executive	29/01/2017	**Completed** Accountable Care scheduled for Board Seminar 29/01/2018 & Public Board 01/02/2018.	
211/17 07/12/2017 Trust Objectives Update	Mrs Beal to provide Mr Fradgley with independent oversight assurance evidence in relation to maternity services to update and strengthen the report.	Director of Nursing	08/03/2019	**Completed** Information required shared with Mr Fradgley.	
211/17 07/12/2017 Trust Objectives Update	Objective relating to emergency care to be updated to a red status from amber, as the current report did not sufficiently surface the emergency care performance pressure.	Director of Strategy & Transformation	01/02/2018	**Completed** Report Amended to show red status.	
213/17 07/12/2017 Financial Performance Month 7	Provide a flash report at the end of December and January to keep the Board up to date on the forecast monthly position including income and expenditure, cash flow and capital expenditure.	Director of Finance & Performance	29/12/2017 & end January 2018	**Update**	
	Performance Finance and Investment Committee to look at whether the impact of action taken to manage the cash position such as delayed payment to suppliers had resulted in operational difficulty.	Director of Finance & Performance	28/02/2018	**Update**	

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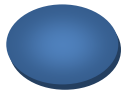
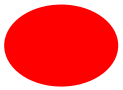
Walsall Healthcare NHS
NHS Trust

PUBLIC TRUST BOARD ACTION SHEET

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

Key to RAG rating

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

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting		**Date: 1st February 2018**
Report Title	Chair's Report		**Agenda Item: 6 Enclosure No.: 4**
Lead Director to Present Report	Chair of the Trust Board, Danielle Oum		
Report Author(s)	Chair of the Trust Board, Danielle Oum		
Executive Summary	The report contains information that the Chair wants to bring to the Board's attention and includes a summary of the meetings attended and activity undertaken by the chair since the last Board meeting.		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to NOTE the report for information.		

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>As above</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr>
<tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">BAF Risk No. 11 ‘That our governance remains “inadequate” as assessed under the Care Quality Commission Well-Led standard.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications detailed within the content of the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The 7 Principles of Public Life -Nolan Principles. Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Chair reports monthly to the Trust Board.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The next report will be received by the Trust Board at its meeting on the 8th March 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

CHAIR'S REPORT FEBRUARY 2018

1. INTRODUCTION

The Chair's monthly report to the Board contains information that the Chair wants to bring to the Board's attention. It includes a summary of the meetings attended and activity undertaken by the Chair since the last Board meeting.

2. CHAIR'S ACTIVITY JANUARY 2018

Director of People & Culture Interviews
I chaired the interview panel for the Director of People & Culture vacancy. Following stakeholder events, two candidates proceeded to interview but the panel found that neither were quite right for the Trust at this stage of its improvement journey.

HFMA Annual Chairs' Conference 2018
I attended the HFMA Annual Chair's Conference in London. Speakers included the new Chair of NHS Improvement regarding challenges, innovation, collaboration and transformation in the NHS.

Black Country Chair's Meeting
I met with the Black Country chairs to promote collaboration across the wider Black Country health and care system.

Engaging with Colleagues
I met with a range of colleagues across the Trust, to discuss their work including the Listening into Action Birthing and Parenting action plan, the work on Freedom to Speak Up work, the Quality Improvement Faculty and the Trust's new Equalities Coordinator.

Phyllis
I attended the Phyllis play, hosted by Birmingham and Solihull STP, which served to highlight the need to form seamless cross-organisational partnerships to work together for the best interests of the community.

Non-Executive Director Changes
John Silverwood is leaving the Trust Board after coming to the end of his term of office. John has contributed his HR expertise in chairing the People and OD Committee at a time of considerable change. I am sure that the Board will join me in thanking him for his work on behalf of WHT and wishing him well for the future.

3. RECOMMENDATION

The Trust Board is recommended to NOTE the report for information.

BOARD/COMMITTEE REPORT

Meeting	**TRUST BOARD**	**Date: 1ST FEBRUARY 2018**
Report Title	**CHIEF EXECUTIVE'S REPORT**	**Agenda Item: 7** **Enclosure No.: 5**
Lead Director to Present Report	Richard Kirby, Chief Executive	
Report Author(s)	Richard Kirby, Chief Executive	

Executive Summary	• Firstly this month, a big thank you to everyone in our hospital and community services who has worked so hard to help us cope with high levels of emergency demand over the winter period including the Christmas and New Year holiday period.
	• We continue to focus on the 4 main priorities for Q3 and Q4 that we identified at the end of Q2. These include
	  ○ Patient Care Improvement – we have produced our first stage PCIP in response to the CQC inspection and are now development the second stage focussed on "Getting to Good".
	  ○ Emergency Care Improvement – we are working with the national Emergency Care Improvement Team to reduce delays for patients.
	  ○ Financial Recovery – we face some significant risks to delivery of our forecast £20.5m deficit and are working to mitigate these.
	  ○ Culture Change – we have completed the exercise to give all of our staff a chance to help share the trust's values for the future.
	• To ensure that we progress our longer-term service strategy we are working with partners on proposals for an "alliance contract" to bring together hospital and community health services, primary care, mental health and social care.
	• We are also working with our partners in the Black Country Provider Partnership to ensure sustainable future arrangements for our acute services.
	•	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☐	☐	☐	☒

Recommendation	1. NOTE the Chief Executive's report.

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performace and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, enpowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Links to the financial and performance risks identified in the Board Assurance Framework.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">No direct resource implications.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The Trust remains in special measures following our September 2015 CQC inspection and is in Segment 4 in NHS Improvement’s oversight framework.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">No previous consideration</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">No direct next steps</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Walsall Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD
1ST FEBRUARY 2018

CHIEF EXECUTIVE'S REPORT

INTRODUCTION

As in previous recent months I will use most of this report to provide an update on the four main delivery priorities in 2017/18 that we identified following our stocktake at the end of the summer. I will also include an update on progress with the development of our longer-term service strategy including work with our local partners through Walsall Together.

The Trust Board did not meet in January, so I would like to begin this report by recording a big thank you to all of the staff across the trust who have worked hard through the winter period including the Christmas and New Year holiday to help us manage high levels of demand for emergency care and keep patients safe. We have an opportunity later on the agenda to consider the impact of the winter period in more detail but thanks are due to all those working hard to ensure we can respond effectively to the pressures of this time of year.

I would also like to thank all the staff involved in the routine Care Quality Commission inspection of our arrangements for children's safeguarding which took place during the week of 22nd January. We will share the feedback from this review as soon as we have received it.

DELIVERY PRIORITIES FOR QUARTER 4

Based on a stocktake at the end of Quarter Two, I have reported for the last few months on our four main delivery priorities for the Trust for the rest of 2017/18. I will use this section of my report to provide an overview of each one of these.

1. **Patient Care Improvement.**
   Since our last meeting we have received our Care Quality Commission inspection report confirming that our overall rating has improved to "requires improvement" and rated our community services "outstanding". We have presented the first stage of our PCIP to Quality & Safety Committee this month. This sets out the action we are taking in response to the specific recommendations from the CQC. We are working with our teams on the second stage of the plan which will identify the action we need to take to deliver a "good" rating overall.

We are also continuing to deliver our improvement plan in Maternity concentrating now on the work needed to ensure we embed an engaged and empowered culture in the team for the future.

2. Emergency Care Pathway.
Improving our emergency care pathway to reduce risk to our patients and staff through the winter is our top operational priority. Our 4 hour performance remains stable at 82% - 83%.

We will consider the impact of winter in more detail later on our agenda. We are working with the national Emergency Care Improvement Programme on the next stage of our improvement work in this area. ECIP have undertaken an initial diagnostic visit and we are agreeing with them how they can best support us over the next few months.

3. Financial Recovery.
At the end of September we reported a deficit of £20.3m - £3.9m worse than we had planned partly as a result of the impact of greater than expected winter emergency demand. We have delivered £6.6m of our £11m CIP for the year.

We face some important risks to delivery of our forecast deficit of £20.5m. We are continuing to work with Walsall CCG to reach an agreement that reduces our income risks. We shared our approach to ensuring that we deliver the action we have agreed to increase elective productivity and control expenditure in the remaining months of the year with Performance, Finance & Investment Committee this month. We will review our forecast end of year position next month when we are clearer about the scale of the impact of winter.

Listening into Action

4. A Clinically-Led, Engaged and Empowered Trust.
We have continued the work arising from focus groups held with staff in the autumn of 2017. All staff have had an opportunity to take part in helping us define our organisational values during December and January with several hundred responses received. These responses will now be reviewed to prepare a new set of values and accompanying behavioural framework in the next few months.

Work has also continued to develop our Improvement Academy to link our Listening into Action engagement approach with work to equip staff with the tools to undertake successful service improvement using, for example, PDSA cycles.

ANNUAL PLAN 2018/19

The two-year plan that we agreed a year ago provides the framework for our detailed planning for next year. We will use our January board development session to consider which elements of this plan need to be updated as we finalise our planning for 2018/19.

We will be aiming to use 2018/19 as a year to continue our improvement journey by ensuring that:

- we can deliver improvements in maternity service that enable us to exit special measures early in the year;
- we identify and deliver the actions needed to ensure all our services are rated "good" by the CQC;
- we see through the work we have begun on our culture and values;
- we agree how we need to work with partners to ensure that our services are sustainable within the resources we have available for the longer-term.

The first cut of our financial plan for 2018/19 has been shared with Performance, Finance & Investment Committee. The final plan will be brought to the Board for approval at its April meeting.

SERVICE STRATEGY

Since our last Board meeting we have taken some important steps in the development of our longer-term service strategy.

- **Walsall Together.** With our partners in primary care, social care, mental health and the CCG we have commenced the detailed work on our plans for an "alliance contract" to bring together health and social services initially for older adults to improve the support we provide to help people remain independent. The work on the business case for this alliance has continued during December and January with initial proposals now ready to be shared across the health economy. These proposals provide a basis for developing accountable care arrangements in Walsall.

- **Black Country Provider Partnership.** The proposal to create a Black Country Pathology Service serving SWBH, Wolverhampton and Dudley is included later on the agenda for our meeting. We are also continuing to develop our plans for a sustainable stroke service with Wolverhampton – work now focusses on ensuring we have effective rehabilitation pathways as part of the change. We have also launched a service sustainability exercise to provide an initial assessment of the longer-term sustainability of all of our services which will provide us with outputs over the next 3 months.

We have had a more detailed opportunity for discussion on the Walsall Together alliance approach at our recent board development session.

CONCLUSION AND RECOMMENDATIONS

This report will be my final Chief Executive's report to the Board at Walsall Healthcare before I leave for my new roles at Birmingham Community Health NHS FT and Black Country Partnership NHS FT. After nearly 7 years in Walsall, I would like to take the opportunity to record my thanks to all of the Trust's staff I have worked with during those years for their inspiration and support especially as we have delivered improvement together in the last 2-3 years. I would also like to thank all the members of the Board for your support as we have worked together.

The Board is recommended to:

1. NOTE the Chief Executive's report.

Richard Kirby
25th January 2018

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	**Date: 1st February 2018**
Report Title	Patient Care Improvement Plan	**Agenda item: 8** **Enclosure No.: 6**
Lead Director to Present Report	Barbara Beal, Director of Nursing	
Report Author(s)	Chris Rawlings, Head of Clinical Governance Kara Blackwell, Deputy Director of Nursing	
Executive Summary	• The CQC released its five inspection reports following the June 2017 comprehensive inspection on 20th December 2017. A response to the regulatory breaches identified during the inspection using the template provided by the CQC was sent on 22nd January 2018. • The CQC reports also identified a range of "must do" and "should do" actions. Following the inspection in 2015 a Patient Care Improvement Plan (PCIP) was produced to respond to the must/should do actions. The same approach has been used to produce a new PCIP following the 2017 inspection. Actions from the 2015 PCIP that have not yet been completed have been extracted and added to the first draft of the PCIP provided with this report. Some services have also reviewed the reports and included additional actions to address issues that the CQC did not list as must/should do's • Maternity Services had an existing action plan which includes the response to the Section 29a notice received following the inspection and this has been mapped to the must/should do's on the draft PCIP. This will be included in the next draft. • A large majority of must/should do's now have an action associated with them although some of the required fields remain to be completed such as estimated completion date. • As advised by the Improvement Director, now that the Trust is rated as 'requires improvement' a different approach is needed to take us forward. A simple list of reactive actions (the must and should do's) allows us to see the granular level of work required and was suitable for a Trust that was inadequate. • Placing the must/should do issues and the responses into similar themes and then linking them to the Trust's strategic objectives, the Quality Commitment and other quality improvement workstreams will help to reduce the overall number of actions, minimise duplications or conflicts, and allow us to clearly focus on a plan designed to achieve the next higher CQC rating or, indeed, remain at outstanding. • The Quality Commitment has been initially mapped to the must/should do actions and regulatory breaches to discern the overlap and recorded in the first draft of the new PCIP. While interpretation of the links will differ, around 20 out of 135 issues (15%) raised in the CQC inspection report currently map to the Trust Quality Commitment. A similar exercise will need to be undertaken at Divisional level. • A column to map to the Trust's objectives to the PCIP actions will be added in the next draft – each one should link to an objective. • A workshop is being arranged in March 2018 for service and corporate leads to determine what additional actions will be required to achieve this aim. These actions will be added to a revised PCIP with the aim of including management, monitoring and performance management through the Trust's existing management processes.	

<table>
<tr><td><u>Purpose</u></td><td>Approval
☐</td><td>Decision
☐</td><td>Discussion
☐</td><td>Note for Information
☒</td></tr>
<tr><td><u>Recommendation</u></td><td colspan="4">The Trust Board is asked to note the first draft of the PCIP.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td colspan="2">Provide Safe High Quality Care Across all of Our Services</td><td colspan="2">Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td colspan="2">Care for Patients at Home Whenever we can</td><td colspan="2">Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td colspan="2">Work Closely with Partners in Walsall and Surrounding Areas</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Value our Colleagues so they recommend us as a place to work</td><td colspan="2">Embed continual service improvement as the way we do things linked to our improvement plan</td></tr>
<tr><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">Embed the quality, performance experience improvements that we have begun in 2016/17</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="4">The report supports the following Key Lines of Enquiry:
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="4"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="4">The resource implications to meet the must and should do actions are identified in the PCIP report attached but further work will be required to complete the costing for individual actions.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">The CQC inspection is conducted under and assessed using the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Part 3
The breaches identified in the report have to be addressed in the timescales indicated. Failure to do so could result in further regulatory action.</td></tr>
<tr><td><u>Report History</u></td><td colspan="4">The report was received by the Trust Quality Executive and Quality & Safety Committee in January 2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="4">Develop the PCIP into a form that can be accessed and used by action owners to record their progress.
Set up confirm and challenge meetings to incorporate services progress with PCIP actions.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="4">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RBK
Our reference	INS2-3696437391
Location ID	N/A
Trust name	Walsall Healthcare NHS Trust, Manor Hospital, Moat Road, Walsall West Midlands, WS2 9PS

(For regulations requiring actions: Require one page per regulation)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Part 3 Regulation 18 Staffing 18(2)(a) - Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. 18(1) Sufficient numbers of suitably qualified, competent, skilled, and experienced persons must be deployed in order to meet the requirements of this part.
	How the regulation was not being met:
	There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

An action plan has been developed with these two objectives:

1 Provide accurate and meaningful assurance that the Safe Staffing Establishments are in place
2 That these are consistently applied at ward level that reflect the acuity of the patients ward by ward/department and keep them safe, and assure the quality of care

Individual actions are listed below:

1. Internal Review of Safer Staffing Establishment and Acuity using Safer Staffing Care Tool.

2. Invite NHSI to review to provide additional scrutiny and oversight, increased assurance from ward to board and to external regulators.
3. Include and implement Internal Audit reports into safer staffing and temporary staffing
4. Review of Quality and Patient Safety ward/department, care group, division and Trust wide.
5. Review and refresh of Recruitment and Retention Strategy, Policies, systems and processes with support of NHSI
6. Review of systems and processes for e-rostering, consistently apply new Standard Operating Procedure
7. Establish consistent use of the live nurse staffing dashboard in bed meetings
8. Continue to pursue overseas recruitment
9. To continue to develop and embed new roles within the nursing workforce, including ongoing development of the Trainee Nursing Associates

Who is responsible for the action?	Executive: Director of Nursing Operational: Divisional Directors of Nursing

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

1. Embedding the new ways of working described in the actions above and ensuring that there is Divisional ownership and performance monitoring.

Measures:

2. Unify submission
3. Workforce metrics: Vacancy rates / new starters / leavers / unfilled shifts / agency utilisations / substantive versus temporary workforce
4. Increased senior nursing presence on the wards

Who is responsible?	Director of Nursing

What resources (if any) are needed to implement the change(s) and are these resources available?

No additional resources are required to fill the vacancies

Date actions will be completed:	31st May 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?

We are minimising the risks to patient safety and the quality of care through a set of controls and actions which include: proactive roster management; daily assessment of nurse staffing across the Trust by Divisional Directors of Nursing and Deputy Director of Nursing; senior nursing presence on the wards – Divisional Directors of Nursing and Matrons are undertaking clinical shifts.

Completed by: (please print name(s) in full)	Barbara Beal
Position(s):	Director of Nursing
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment
	How the regulation was not being met:
	12 (2) (a) Venous Thromboembolism assessments were not carried out for all patients at risk. 12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005. This includes best interest decision making; lawful restraint; and, where required, application for authorisation and for Deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards or the Court of Protection. 12.(2) The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients. 12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely? Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target. 12(1), 12(2)(e), 12(2)(h). Blind cords were not secured in all of the rooms at the child development centre. **The five items within this regulation breach have been separated out onto the following pages:**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment
	How the regulation was not being met:
	12 (2) (a) Venous Thromboembolism assessments were not carried out for all patients at risk.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The aim is to ensure as a minimum 95% of patients admitted to the trust, referencing NICE guideline CG92, are assessed for the risk of VTE on admission. December 2017 performance reached 93%.

- An existing action plan has been revised to achieve this aim and includes the following individual actions:
    1. Provide daily performance reports to all Divisional Directors (DD), Clinical Directors (CD), Divisional Directors of Nursing (DDON) and Maternity Leads
    2. Provide a ward/clinical area weekly summary report to all DDs, CDs, Consultants, DDON, Senior Ward Sisters
    3. Provide Vitalpac training on induction for all medical staff
    4. Provide training for ACPs and lead nurses in AMU and Swift Ward and other adhoc training as requested
    5. Include VTE performance in the divisional quarterly reviews as part of the Divisional Accountability Framework
    6. Implement a local process for assessing VTE risks for patients attending fracture clinic requiring plaster casts
    7. Daily review of the performance report and escalation to responsible consultants and CDs regarding outstanding VTE
    8. Education and engagement with junior doctors at educational forums
    9. Standing agenda item for Medical Advisory Committee
    10. Senior Ward Sisters to monitor compliance during morning board rounds and review during afternoon handover. None compliance to be escalated to the Medical Director

Who is responsible for the action?	Executive Lead: Medical Director Operational Lead: Divisional Directors

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

1. The actions described above include elements to provide a sustainable improvement in performance: staff training, monitoring performance, performance review, action when performance is below that required.

Measures:

1. A monthly performance of 95%
2. Monthly nil return of hospital acquired thrombosis

Who is responsible?	Medical Director

What resources (if any) are needed to implement the change(s) and are these resources available?

No additional resources beyond those already committed are required

Date actions will be completed:	March 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?

By not undertaking a risk assessment for VTE patients are potentially at risk of developing an avoidable embolism. However, the Trust has demonstrated a significant improvement in performance since the inspection.

- VTE assessment performance has improved from July 2017 (79%) through to December 2017 (93%).
- Every VTE event is also subjected to a review as part of the incident reporting and investigation process.
- There have been no avoidable VTEs identified where the lack of a VTE assessment was a factor.

Completed by: (please print name(s) in full)	Mr Amir Khan
Position(s):	Medical Director
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment
	How the regulation was not being met:
	12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005. This includes best interest decision making; lawful restraint; and, where required, application for authorisation and for Deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards or the Court of Protection.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

An action plan has been developed with the following objective: Consistently apply, implement and evaluate the Mental Capacity Act 2005 requirements and DOLs.

The individual actions are listed below.

1. Monitor mandatory training compliance
2. Link with lead in the Local Authority and with the MCA project to provide training
3. Continue to complete quarterly audit with feedback to individual clinicians
4. Continue to monitor compliance with MCA when completing DNACPR decisions
5. Provide bespoke training sessions as required

Who is responsible for the action?	Executive Lead: Director of Nursing Operational Leads: Divisional Directors and Divisional Directors of Nursing

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

- Delivery of on-going training , visible improvement in audit results

Measures:

- Number of staff compliant with MCA mandatory training (MCA Training Figures)
- Quarterly audits of compliance with the Trust policy

Who is responsible?	Director of Nursing

What resources (if any) are needed to implement the change(s) and are these resources available?

1. Staff time to be released for Mandatory training.
2. Safeguarding adult Lead Nurse and Safeguarding Adult Named Nurse to complete Quarterly audits

Date actions will be completed:	March 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?	

• Patients may be subjected to avoidable harm or omissions in care or treatment which may impact on their human rights or clinical outcomes
• Since the inspection in June 2017, training compliance has improved:
  ○ June 2017 - DOLS 77% : MCA 76%
  ○ December 2017 - DOLS 89% : MCA 95%	

Completed by: (please print name(s) in full)	Barbara Beal Amir Khan
Position(s):	Director of Nursing Medical Director
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment
	How the regulation was not being met:
	12.(2) The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
The following actions will be taken: • Revise Trust Isolation Policy to describe the appropriate management of patients within ITU requiring isolation - this includes additional space made available to isolate patients • New build replacement for ITU and HDU which will have 8 single accommodation facilities – due for completion in October 2018	
Who is responsible for the action?	Executive Directors: Medical Director & Director of Strategy
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Delivery of the new build ITU project and full implementation of the new operating procedure.	
Who is responsible?	Executive Directors: Medical Director & Director of Strategy
What resources (if any) are needed to implement the change(s) and are these resources available?	
Resources are described in the business case for the new build	
Date actions will be completed:	Revised SOP – February 2018 New build – October 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Implementation of the revised SOP will mitigate the significant risk to patients requiring isolation prior to a sustainable solution with the opening of the new build ITU unit which will be fit for purpose.

Completed by: (please print name(s) in full)	Amir Khan Daren Fradgley
Position(s):	Medical Director Director of Strategy
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment Regulations 12(1), 12(2)(e), 12(2)(h). Blind cords were not secured in all of the rooms at the child development centre.
	How the regulation was not being met:
	Blind cords were not secured in all of the rooms at the child development centre.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The actions taken to secure blind cords at the child development centre are:

1. Anti-ligature risk assessment for blinds at CDC to be reviewed and revised.
2. Following a review by estates a permanent solution has been actioned as follows:
    a. The blind cords in the CDC Nursery, Waiting Room, Staff Room, Disabled toilet and Consulting rooms 1 & 2 have been adapted to comply with anti-ligature policy. The shortened cords will only need to be gently adjusted to ensure blinds are opened without having to tie and re-tie cords constantly and avoids the risk of cords being left down when children are present. As several of the fastenings at the bottom of the blinds were broken these have also been removed, avoiding any risk of loose pieces of plastic being left around or children getting tangled up.
    b. The blinds in the main hall will be adjusted over the next few weeks to ensure staff can easily reach the fastenings and those cords will also be shortened to avoid any further risk. Until that work is completed the blinds will be permanently tied up.
3. Audit of compliance to be undertaken and reported to the care group quality team meeting.

Who is responsible for the action?	Executive Lead: Director of Strategy Operational Lead: Divisional Director of Nursing Children, Young People and Neonates (Acute and Community)

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

An audit of compliance will be undertaken to ensure that the interim measures are effective and sustained.

Who is responsible?	Divisional Director of Nursing Children, Young People and Neonates (Acute and Community)

What resources (if any) are needed to implement the change(s) and are these resources available?

Estates Department support – now completed	
Date actions will be completed:	January 2018
How will people who use the service(s) be affected by you not meeting this regulation until this date?	
Children were at risk of strangulation. A permanent solution is now in place which removes this risk	
Completed by:(please print name(s) in full)	Caroline Whyte
Position(s):	Divisional Director of Nursing Children, Young People and Neonates (Acute and Community)
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment
	How the regulation was not being met:
	12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely? Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The action plan developed has the following objective: To meet the Trust target of 90% compliance for Mandatory training by 30th June 2018.

Individual actions are listed below:

1. Review of the mandatory training programme to ensure that the relevant subjects are included and the method of delivery in both reasonable and achievable
2. Provide and agree a clear plan for each Division for the staff required to attend mandatory training which takes into account known periods of increased activity
3. Staff to be released to attend classroom face to face sessions.
4. Staff be given protected learning time to complete e-learning.
5. Staff that require Level 3 safeguarding have been booked directly onto classroom sessions, provided staff are released to attend these sessions the required compliance will be met.
6. Appraisals will require mandatory training to have been completed.

Who is responsible for the action?	Director of Organisational Development and HR

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

- A revised and achievable training programme with performance monitoring and management

Measures:

- Mandatory training attendance

Who is responsible?	Director of Organisational Development and HR

What resources (if any) are needed to implement the change(s) and are these resources available?

1. Extra classroom dates for Safeguarding Adults/Children Level 3, & Fire training. Portable devices would be beneficial to allow staff better access to e-learning.

Date actions will be completed:	30th June 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The potential for harm or omissions of care due to staff not being competent with core skills or not recognising circumstances that require action and escalation.

Completed by: (please print name(s) in full)	Louise Ludgrove
Position(s):	Director of Organisational Development and HR
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 13: Safeguarding 1) Service users must be protected from abuse and improper treatment in accordance with this regulation 2) Systems and processes must be established and operated effectively to prevent abuse of service users
	How the regulation was not being met:
	Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014). The lack of training caused the potential risk of service users not always being protected from abuse and improper treatment.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

An action plan has been developed with the following objective:

- Ensure full compliance with Safeguarding training across the Trust for all staff

Actions:

1 Monitor mandatory training compliance and report via Safeguarding committee and Trust Quality executive
2 Provide bespoke sessions for groups of staff
3 Provide differing methods of training delivery such as face to face and e-learning.
4 Support from Walsall CCG to provide additional training sessions
5 Review and refresh safeguarding arrangements within the Trust

Who is responsible for the action?	Director of Nursing

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

1. The provision of appropriate resources to provide training and timely release of staff

Measures:

1. Assessment / audit to show that staff are fully conversant with Safeguarding Adult and Children practices and procedures.
2. The number of staff trained at each level

Who is responsible?	Director of Nursing

What resources (if any) are needed to implement the change(s) and are these resources available?

1. Staff time to enable release for Mandatory training.
2. Safeguarding adult Lead Nurse and Safeguarding Adult Named Nurse to deliver training

Date actions will be completed:	March 31st 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Potential harm to patients due to staff not recognising and reporting safeguarding concerns

Completed by: (please print name(s) in full)	Barbara Beal
Position(s):	Director of Nursing
Date:	22nd January 2018

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17: Good Governance 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
	How the regulation was not being met:
	Staff were not consistently completing patient records. There were trust documentation that was not completed and staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

An action plan has been developed which includes three workstreams:

- To ensure there are secure, accurate and complete contemporaneous patient records to include signature, date, time, name, title and all notes.
- To address the physical condition of the notes
- To ensure a clear strategy for EPR (Electronic Patient Records)

The individual actions related to the breaches identified are listed below:

- Ensure staff are aware of their professional responsibilities for accurate and timely record keeping and the secure storage of patient notes when not in use by March 31st 2018
    a. Delivery of educational sessions relating to professional standards for documentation and secure storage
    b. Quarterly audit of health records.
    c. Results of audits to be shared with all stakeholders.
    d. Divisional teams to develop action plans to address outputs from audits
    e. Audit results to be discussed as an objective via appraisal with individual clinicians
    f. All consultants to have an audit of 10 sets of notes per annum and findings and actions agreed via the appraisal process
- Develop a workstream / plan to address the physical condition of the paper by 31st March 2018
- Confirm Trust strategy for EPR by June 2018

Who is responsible for the action?	Medical Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Sustainability:

1. Implementation of the EPR

2. Continuing audit of the patient notes and remedial actions Measures: 1. Audit of medical and nursing records 2. Monitoring the physical condition of paper notes	
Who is responsible?	Medical Director
What resources (if any) are needed to implement the change(s) and are these resources available?	
The resources required will be identified following the development of the strategy to address the physical condition of the patient records and the EPR strategy,	
Date actions will be completed:	• To ensure there are secure, accurate and complete contemporaneous patient records to include signature, date, time, name, title and all notes – 31st March 2018 • Develop a workstream / plan to address the physical condition of the paper by 31st March 2018 • Confirm Trust strategy for EPR by 30th June 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Incomplete and unsigned patient records lead to the potential for ineffective communication between clinicians for the patient's care plan, potential harm and increased length of stay. Unsecure records carry the potential for a breach of confidentiality. The actions described above are designed to reduce these risks.

Completed by: (please print name(s) in full)	Amir Khan
Position(s):	Medical Director
Date:	22nd January 2018

	Regulation	*As described in the report*			*Please complete this when reviewing the issue*		*As described by the CQC*	*Translate the CQC issue into a meaningful, SMART, objective*	*Describe the steps that need to be taken to achieve the desired outcome*	*Who is responsible for this completing step?*		*Describe the resources required to complete this action*	*Who else needs to be involved in this step – either to achieve it or will be affected by it?*	*What are the challenges, barriers or risks to completing this action step?* Risk on, if available	*Explain how you will know that the action has been completed and is successful in achieving its purpose*	*Where is this action overseen and the evidence tested*	*A realistic date for completion*	*Red = Action will not be completed / effective Amber = behind target Green = On target*		*Hyperlink to evidence store* *Do not embed documents*	*Include any relevant information on progress, new challenges, resources required etc.*
No.	**Regulatory breach**	**Must do / Should do**	**Quality Commitment ref.**	**New / Old PCIP**	**CQC Quality Domain**	**Core Service**	**Issue**	**Objective**	**Action**	**Accountability**	**Operational Lead**	**Resources required**	**Stakeholders**	**Constraints / Risks**	**Measures**	**Oversight / Assurance group**	**Due date**	**Status**	**Date completed**	**Evidence of completion**	**Comments**
	Section 29a	Section 29a		New		Maternity and Gynaecology	Monitoring, recording and escalation of concerns for Cardiotocography (CTG) requires significant improvement to ensure timely assessments, fresh eyes review and appropriate actions are taken.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
1	Section 29a	Section 29a		New		Maternity and Gynaecology	There are insufficient midwives with HDU training to ensure that women in HDU are cared for by staff with the appropriate skills.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
	Section 29a	Section 29a		New		Maternity and Gynaecology	Safeguarding training is insufficient to protect women and babies on the unit who may be at risk.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
	Section 29a	Section 29a		New		Maternity and Gynaecology	There are insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
	18 - staffing	Regulation	S11	New		Corporate	18(2)(a) - 18(1) There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe.			Director of Nursing	DDNs										
	12 - Safe care and Treatment	Regulation	S9	New		Corporate	12 (2) (a) Venous Thromboembolism assessments were not carried out for all patients at risk.			Medical Director	MD Business Manager										
	12 - Safe care and Treatment	Regulation	E21?	New		Corporate	12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005. This includes best interest decision making; lawful restraint; and, where required, application for authorisation and for Deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards or the Court of Protection.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
	12 - Safe care and Treatment	Regulation		New		Critical Care	12.(2) The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.			Medical Director	DDN Surgery										
	12 - Safe care and Treatment	Regulation	S14	New		Corporate	12(2)(c) Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target.			Director of HR	Divisional ToTs										
	12 - Safe care and Treatment	Regulation		New		Community CYP	12(1), 12(2)(e), 12(2)(h) Blind cords were not secured in all of the rooms at the child development centre.			Director of Strategy	DDN Children and Young People										
	13 - Safeguarding	Regulation	C9?	New		Corporate	Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014). The lack of training caused the potential risk of service users not always being protected from abuse and improper treatment.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
	17 - Good Governance	Regulation		New		Corporate	17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Staff were not consistently completing patient records. There were trust documentation that was not completed and staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.			Medical Director	Divisional ToTs										
	17 - Good Governance	Regulation		New		Community Services for Children and Young People	10(1), 10(2)(a). - Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records.			Trust Secretary	DDN Children and Young People										
		Must		New	Safe	Maternity and Gynaecology	Risks are explained when consenting women for procedures.			DMD WCSS	CD Obs & Gynae										
		Must	S15	New	Safe	Maternity and Gynaecology	The service uses an acuity tool to evidence safe staffing.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Must	E10 / S18	New	Safe	Maternity and Gynaecology	Action plans are monitored and managed for serious incidents.			DMD WCSS	Divisional ToT WCSS										
		Must	S18	New	Safe	Maternity and Gynaecology	Lessons are shared effectively to enable staffing learning from serious incidents, incidents and complaints.			DMD WCSS	Divisional ToT WCSS										
		Must		New	Effective	Maternity and Gynaecology	Staff follow best practice national guidance.			DMD WCSS	Divisional ToT WCSS										

		Must		New		Urgent and Emergency Services	Take action to improve ED staff's compliance with mandatory training.			DMD WCSS	Care Group ToT - A&E										
		Must		New	n/a	Urgent and Emergency Services	ED completes the action plan compiled following the CQC inspection carried out in September 2015.			DMD WCSS	Care Group ToT - A&E										
		Must		New	Safe	Critical Care	Plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.			DMD Surgery	Care Group ToT - Critical Care										
		Must		New	Safe	Critical Care	All staff working within the outreach team are competent to do so.			DMD Surgery	Care Group ToT - Critical Care										
		Must		New	Effective	Children and young people	All local guidelines are updated and regularly reviewed for staff to follow.			DMD WCSS	Divisional ToT WCSS										
		Must		New	Safe	Outpatients and Diagnostic Imaging	Staff undertake required mandatory and safeguarding training as required for their role.			Director of HR	Divisional ToT WCSS										
		Must		New	Safe	Outpatients and Diagnostic Imaging	Staff undertake required mandatory and safeguarding training as required for their role.			Director of HR	Divisional ToT Surgery										
		Must		New	Safe	Outpatients and Diagnostic Imaging	All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.			DMD Surgery	Divisional ToT WCSS										
		Must		New	Safe	Outpatients and Diagnostic Imaging	All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.			DMD Surgery	Divisional ToT Surgery										
		Must		New	Safe	Outpatients and Diagnostic Imaging	Patients medical records are kept secure at all times			DMD WCSS	Divisional ToT WCSS										
		Must		New	Safe	Outpatients and Diagnostic Imaging	Patients medical records are kept secure at all times			DMD WCSS	Divisional ToT Surgery										
		Must		New	Safe	End of life care	Attendance for mandatory training is improved.			Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Must		New	Safe	End of life care	Undertake required safeguarding training as required for their individual role.			Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Must		New	Safe	End of life care	All staff are trained and competent when administering medications via syringe driver.			Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Must		New	Safe	Medical care	Mandatory training is up-to-date including safeguarding training at the required level.			DMD MLTC	Divisional ToT MLTC										
		Must		New	Safe	Medical care	There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe.			DMD MLTC	DDN MLTC										
		Must		New	Safe	Surgery	All professional staff working with children have safeguarding level 3 training.			DMD Surgery	Divisional ToT Surgery										
		Must		New	Safe	Surgery	All staff are up-to-date with safeguarding adults.			DMD Surgery	Divisional ToT Surgery										
		Must		New	Safe	Surgery	The safeguarding adults and safeguarding children policies are up-to-date and include relevant references to external guidance.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Must		New	Safe	Surgery	Patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.			DMD Surgery	Divisional ToT Surgery										Also recorded as a breach in regulations
		Must		New	Safe	Surgery	All shifts have the correct skill mix for wards to run safely.			DMD Surgery	DDN Surgery										Also recorded as a breach in regulations
		Must		New	Safe	Surgery	All staff are up-to-date with mandatory training.			DMD Surgery	Divisional ToT Surgery										Also recorded as a breach in regulations
		Must		New	Safe	Community Services for Children and Young People	Ensure blind cords are secured in all areas where children and young people may attend.			DMD WCSS	DDN Children and Young People										Also recorded as a breach in regulations
		Must		New	Safe	Community Services for Children and Young People	Ensure patient records remain confidential and stored securely.			DMD WCSS	Divisional ToT WCSS										
		Must	S5	New	Safe	Community Services for Children and Young People	Continue to follow standard operating procedures with medicines in special schools.			DMD WCSS	DDN Children and Young People										
		Should		New	Effective	Maternity and Gynaecology	There is a consultant obstetrician as the designated guideline development lead.			DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	Staff read and sign newly launched guidelines in a timely manner.			DMD WCSS	Care Group ToT Womens										
		Should		New	Responsive	Maternity and Gynaecology	Staff opinion is sought when developing the service.			DMD WCSS	Care Group ToT Womens										
		Should		New	Responsive	Maternity and Gynaecology	There are displays to inform the public how to complain.			DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	There are chaperone signs in outpatient areas.			DMD WCSS	Care Group ToT Womens										
		Should		New	?	Maternity and Gynaecology	Available appointments for women to access the clinic for vaginal birth after caesarean.			DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women do not have long waits to be discharge from the fetal assessment unit.			DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women are informed and involved in the planning of their care.			DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women are supported during their stay.			DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Pain relief is given as prescribed or when requested.			DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Documentation is completed and audited.			DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Handovers follow a Situation Background Assessment Review (SBAR).			DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	The service had an alternative plan in place based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP).			DMD WCSS	Care Group ToT Womens										

		Should		New	Safe	Maternity and Gynaecology	Student midwives are not practising unsupervised.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health											
		Should		New	Effective	Maternity and Gynaecology	There is a robust data collection system.			DMD WCSS	Care Group ToT Womens											
		Should		New	Effective	Maternity and Gynaecology	The stillbirth rate is reviewed and an action plan developed.			DMD WCSS	Care Group ToT Womens											
		Should		New	Effective	Maternity and Gynaecology	The dashboard data is reviewed and action plans are monitored.			DMD WCSS	Care Group ToT Womens											
		Should		New		Maternity and Gynaecology	Ensure the breast milk fridge is locked.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health											
		Should		New		Maternity and Gynaecology	Women are offered breast feeding support.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health											
		Should		New		Maternity and Gynaecology	Scans are uploaded to the electronic database.			DMD WCSS	Care Group ToT Womens											
		Should		New		Maternity and Gynaecology	All cardiotocography machines have the correct time.			DMD WCSS	Care Group ToT Womens											
		Should		New		Maternity and Gynaecology	Staff know their role in a major incident.			Chief Operating Officer	Care Group ToT Womens											
		Should		New		Maternity and Gynaecology	Staff complete major incident training in line with the trust target.			Chief Operating Officer	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	Prescription charts are fully completed.			DMD WCSS	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	Ensure the women's antenatal handheld records are fully completed.			DMD WCSS	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	All the areas of the electronic computer system are completed.			DMD WCSS	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	Medical records are stored safely.			DMD WCSS	Care Group ToT Womens											
		Should		New	Caring	Maternity and Gynaecology	Invasive treatments to babies are performed in a private environment respecting privacy and dignity of the baby.			DMD WCSS	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	The environmental audits improve.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health											
		Should		New	Safe	Maternity and Gynaecology	All areas are appropriately clean.			DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health											
		Should	S8	New	Safe	Maternity and Gynaecology	Audits of surgical infections are performed.			DMD WCSS	Care Group ToT Womens											
		Should		New	Effective	Maternity and Gynaecology	An audit programme is developed and presented to the service.			DMD WCSS	Care Group ToT Womens											
		Should	E10	New	Safe	Maternity and Gynaecology	Low harm incidents are reviewed in a timely manner.			DMD WCSS	Care Group ToT Womens											
		Should		New	Safe	Maternity and Gynaecology	Gynaecology staff complete the adult resuscitation training.			DMD WCSS	Care Group ToT Womens											
		Should		New		Urgent and Emergency Services	The nominated ED triage nurse is clearly identifiable to ambulance staff.			DMD MLTC	Matron A&E											
		Should		New		Urgent and Emergency Services	Risk assess and re-evaluate its use of a cubicle as an ED review room.			DMD MLTC	Matron A&E											
		Should		New		Urgent and Emergency Services	Reassess its policy for the use of review rooms in ED and ensure all staff are aware of and adhere to the process.			DMD MLTC	Matron A&E											
		Should		New		Urgent and Emergency Services	Take action to ensure no confidential conversations between doctors, patients or their representatives take place in the ED review rooms, if there is a chance they could be overheard by other patients or visitors.			DMD MLTC	Care Group ToT Emergency & Acute											
		Should		New		Urgent and Emergency Services	Raise awareness of its chaplaincy service amongst its ED staff and ensure patients and relatives who may benefit from it are made aware of it.			DMD MLTC	Care Group ToT Emergency & Acute											
		Should	C8?	New		Urgent and Emergency Services	ED is able to offer written information to patients in languages other than English.			DMD MLTC	Matron A&E											
		Should		New		Urgent and Emergency Services	Review its decision-making process around using RAT cubicles in ED to accommodate patients in time of increased demand, rather than ring-fencing the cubicles to allow the RAT team to contribute to ED patient flow.			Chief Operating Officer	Care Group Manager Emergency & Acute											
		Should		New		Urgent and Emergency Services	ED continues to improve its staff appraisal completion rates.			DMD MLTC	Care Group ToT Emergency & Acute											
		Should		New		Critical care	Review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.			Chief Operating Officer												
		Should		New		Critical care	Provide follow up clinics to patients after discharge from the critical care unit; in line with Core Standards for Intensive Care.			DMD Surgery	Matron Critical Care											
		Should		New		Critical care	Consider how to effectively identify and manage all infectious patients in the critical care wards given the lack of appropriate isolation facilities.			DIPC	Matron Critical Care											
		Should		New		Critical care	That essential equipment is procured and used with relevant patients; and staff are fully trained and competent to use this equipment. Such as capnographs.			DMD Surgery	CD Theatres, Anaesthetics & Critical Care											
		Should		New	Well Led	Critical care	All risks to the service are included on the risk register.			DMD Surgery	Care Group ToT Theatres, Anaesthetics & Critical Care											
		Should		New		Critical care	Deprivation of Liberty Safeguards are applied in all cases where these are required; for example restricting patients movements by use of bed rails.			DMD Surgery	Matron Critical Care											
		Should		New		Outpatients and Diagnostic Imaging	There is a robust system in place for monitoring clinic running times to ensure they are running to time on a consistent basis, and take action where this is not the case.			Chief Operating Officer	DOps Surgery											

		Should		New	Well Led	Outpatients and Diagnostic Imaging	Review how staff review, document and update risks and progress against action plans.			DMD Surgery	Divisional ToT Surgery										
		Should		New	Well Led	Outpatients and Diagnostic Imaging	Review how staff review, document and update risks and progress against action plans.			DMD WCSS	Divisional ToT WCSS										
		Should	C17	New		Outpatients and Diagnostic Imaging	Staff are confident and competent to support a patient, or relative, with dementia.			DMD Surgery											
		Should		New		Outpatients and Diagnostic Imaging	All outpatient clinics are suitable for the purpose for which they are being used.			DMD Surgery	Divisional ToT Surgery										
		Should		New		End of life care	All staff must ensure they are up-to-date and aware how to complete EoLC documentation.			Medical Director	Divisional ToTs										
		Should		New		End of life care	Look for ways to improve privacy on the wards/ department when breaking bad news or consoling bereaved families.			Director of Nursing											
		Should		New		End of life care	Ensure staff including porters are clear on who is responsible for cleaning trolleys when transferring patient from one department to another.			DIPC	Divisional Director Estates and Facilities										
		Should		New		End of life care	Look for ways to support the porters with equipment such as trolleys that are not always suitable to use but for which there are no other options.			Director of Strategy	Divisional Director Estates and Facilities										
		Should		New		Medical care	Medication trolleys are adequate for the amount of medications stored.			Director of Pharmacy											
		Should		New		Medical care	Computers are password protected to protect against unauthorised access and that these are not left unlocked.			Director of Finance											
		Should		New	Safe	Medical care	Patients have access to call bells at all times and that all call bells can be heard by staff and used to signify an emergency.			DMD MLTC											
		Should	S7	New	Safe	Medical care	Review the nursing documentation to ensure it is fit for purpose and that risks, such as falls are regularly reassessed and recorded.			DMD MLTC											
		Should	S1	New	Safe	Medical care	Staff on wards have sufficient knowledge to care safely for neutropenic patients, including knowledge of neutropenic sepsis.			DMD MLTC	Divisional ToT MLTC										
		Should	C14	New		Medical care	Patients' nutritional needs are assessed and reviewed in accordance with current guidance.			DMD MLTC	DDN MLTC										
		Should		New	Safe	Medical care	All staff are up-to-date with their appraisals.			DMD MLTC	Divisional ToT MLTC										
		Should		New	Safe	Medical care	There are sufficient staff trained in administering medication via a PICC line.			DMD MLTC	Divisional ToT MLTC										
		Should		New	Safe	Medical care	Medical records are kept secure and that information contained within is kept safe.			DMD MLTC	Divisional ToT MLTC										
		Should		New	Safe	Medical care	The fire exit on ward 29 is alarmed to alert staff if a patient leaves the ward.			Director of Strategy	Divisional Director Estates and Facilities										
		Should		New		Surgery	The cleaning rota responsibilities are completed and documented on all wards.			DMD Surgery	Divisional ToT Surgery										
		Should		New		Surgery	Razors and COSHH items are stored appropriately, securely and in places where people who use services are not able to access.			DMD Surgery											
		Should		New		Surgery	Ensure that it is easy to see what contents should be available in the paediatric difficult intubation trolley in the surgical recovery area.			DMD Surgery											
		Should		New		Surgery	Intravenous fluids and other fluid items, such as nutritional drinks, are stored in a locked place and are not accessible to the public on ward 10.			DMD Surgery											
		Should		New		Surgery	Fridge and room temperature checks' monthly audits are carried out and recorded consistently across all wards.			DMD Surgery											
		Should		New		Surgery	Controlled drug checks' monthly audits are carried out and recorded consistently across all wards.			DMD Surgery											
		Should		New		Surgery	Consider streamlining their processes for patient records. There are a number of different formats and systems for one patient record, which can cause confusion and has a potential risk of staff not having all relevant information when treating patients.			DMD Surgery											
		Should		New		Surgery	Continue with improvements in performance of patient outcomes.			DMD Surgery											
		Should		New		Surgery	Continue with improvements in performance of referral to treatment times and patient flow through the hospital.			Chief Operating Officer											
		Should	S3	New		Surgery	Continue with improvements in managing deteriorating patients.			Medical Director											
		Should		New		Surgery	Continue with improvement plans for IT software to ensure full compliance with the Accessible Information Standards.			Director of Strategy											
		Should		New		Surgery	Continue to do all it can to resolve the issues with recruitment to improve staff morale.			DMD Surgery											
		Should		New		Surgery	The hospital should consider reviewing the developmental opportunities available for junior physiotherapists.			DMD WCSS											
		Should		New		Children and Young People's Services	Review the system for recording safeguarding training and assure themselves that clinical staff in children's services complete safeguarding children training to level 3.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Should		New		Children and Young People's Services	Review their safeguarding children policy and ensure it reflects national guidance.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Should	C14	New		Children and Young People's Services	Introduce a systematic approach to assessing and monitoring children's nutritional and hydration risks.			DMD WCSS	DDN Children and Young People										

		Should		New		Children and Young People's Services	Review the environment within the fracture clinic and make improvements to meet the needs of children using the service.			DMD Surgery											
		Should	C11?	New		Children and Young People's Services	Put into place systems and processes to identify those with a learning disability and ensure adjustments are made to cater for their special needs.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Should	E20?	New		Children and Young People's Services	Improve the timeliness of provision of medicines for children to take home.			DMD WCSS											
		Should		New	Safe	Community Adults	The trust should ensure that all staff follow safeguarding policies and procedures.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Should		New	Safe	Community Adults	The trust should ensure that there are suitable arrangements in place to ensure that all staff receive required safeguarding training.			Director of Nursing	Senior Nurse – Quality and Safeguarding										
		Should		New	Safe	Community Adults	The trust should ensure risk assessments are appropriately completed and reviewed.			Director of Nursing											This refers to clinical risk assessments
		Should		New		Community Services for Children and Young People	The service should provide leaflets or posters to give information to families who may wish to raise complaints.			Director of Nursing											
		Should		New		Community Services for Children and Young People	The service should ensure all policies are reviewed and up-to-date.			DMD WCSS	DDN Children and Young People										
		Should		New		Community Services for Children and Young People	All staff members to keep within professional boundaries.			DMD WCSS	DDN Children and Young People										

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		Should		New		Maternity and Gynaecology	Staff know their role in a major incident.	qadar		Chief Operating Officer	Care Group ToT Womens										
		Should		New		Maternity and Gynaecology	Staff complete major incident training in line with the trust target.	qadar		Chief Operating Officer	Care Group ToT Womens										
		Should		New		Urgent and Emergency Services	Review its decision-making process around using RAT cubicles in ED to accommodate patients in time of increased demand, rather than ring-fencing the cubicles to allow the RAT team to contribute to ED patient flow.	dodd		Chief Operating Officer	Care Group Manager Emergency & Acute										
		Should		New		Critical care	Review systems to improve flow throughout the hospital to reduce the number of delayed discharges in critical care.	winyard		Chief Operating Officer											
		Should		New		Outpatients and Diagnostic Imaging	There is a robust system in place for monitoring clinic running times to ensure they are running to time on a consistent basis, and take action where this is not the case.	winyard		Chief Operating Officer	DOps Surgery										
		Should		New		Surgery	Continue with improvements in performance of referral to treatment times and patient flow through the hospital.	winyard		Chief Operating Officer											

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		Should		New		Critical care	Consider how to effectively identify and manage all infectious patients in the critical care wards given the lack of appropriate isolation facilities.			DIPC	Matron Critical Care										
		Should		New		End of life care	Ensure staff including porters are clear on who is responsible for cleaning trolleys when transferring patient from one department to another.	Ensure porters know who and how to clean trolleys between patients	1. Porters leaflet sent to Alison Potts 2. Alison Potts will ensure circulated to all Porters 3.Documented completion in Estates ICC report	DIPC	Divisional Director Estates and Facilities		Porters	None	All Porters will of received the leaflet with this information	Infection Control Committee	Feb-18				

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	12 - Safe care and Treatment	Regulation	S14	New		Corporate	12(2)(c) Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target.	To meet the Trust target of 90% compliance for Mandatory training by 31st March 2018.	Staff to be released to attend classroom face to face sessions. Staff be given protected learning time to complete e-learning. Staff that require Level 3 safeguarding have been booked directly onto classroom sessions, provided staff are released to attend these sessions the required compliance will be met. Appraisals will require mandatory training to have been completed.	Medical Director/Director of Nursing	Divisional ToTs	Extra classrrom dates for Safeguarding Adults/Children Level 3, & Fire training. Portable devices would be beneficial to allow staff better access to e-learning.	DD, Line Managers staff themselves to take responsibility.	Level of pressure for the Trust requiring staff to remain in work areas. Under staffing in deprtments due to sickness and leave. No access to computers on ward areas to complete e-learning. Some PC's are experiencing technical issues accessing e-learning.	Mandatory Compliance will increase	Trust Workforce Executive. POD	31st March 2018					There has been a recent upgrade nationally of ESR (Over the christmas period). This has created a few additional problems for some areas accessing e-learning. To support this whislt issues are being resolved access to paper copies of e-learning modules are still available on the intranet or from Learning and Development. The L&D team will continue to target poor performing areas
		Must		New	Safe	Outpatients and Diagnostic Imaging	Staff undertake required mandatory and safeguarding training as required for their role.	To meet the Trust target of 90% compliance for Mandatory training by 31st March 2018.	Staff to be released to attend classroom face to face sessions. Staff be given protected learning time to complete e-learning. Staff that require Level 3 safeguarding have been booked directly onto classroom sessions, provided staff are released to attend these sessions the required compliance will be met. Appraisals will require mandatory training to have been completed.	Medical Director/Director of Nursing	Divisional ToT WCSS	Extra classrrom dates for Safeguarding Adults/Children Level 3, & Fire training. Portable devices would be beneficial to allow staff better access to e-learning.	DD, Line Managers staff themselves to take responsibility.	Level of pressure for the Trust requiring staff to remain in work areas. Under staffing in deprtments due to sickness and leave. No access to computers on ward areas to complete e-learning. Some PC's are experiencing technical issues accessing e-learning.	Mandatory Compliance will increase	Trust Workforce Executive. POD	31st March 2018					There has been a recent upgrade nationally of ESR (Over the christmas period). This has created a few additional problems for some areas accessing e-learning. To support this whislt issues are being resolved access to paper copies of e-learning modules are still available on the intranet or from Learning and Development. The L&D team will continue to target poor performing areas
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	18 - staffing	Regulation	S11	New		Corporate	18(2)(a) - 18(1) There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe.	1 Provide accurate and meaningful assurance that the Safe Staffing Establishments are in place 2 That these are consistently applied at ward level that reflect the acuity of the patients ward by ward/department and keep them safe, and assure the quality of care	1. Internal Review of Safer Staffing Establishment and Acuity using Safer Staffing Care Tool. 2. Invite NHSI to review to provide additinal scrutiny and oversight, increased assurance from ward to board and to external regulators. 3. Include and implement Internal Audit reports into safer staffing and temporary staffing 4. Review of Quality and Patient Safety ward/department, care group, division and Trust wide. 5. Review and refresh of Recruitment and Retention Strategy, Policies, systems and processes with support of NHSI 6. Review of systems and processes for e rostering, consistently apply new SOP 7. Establish consistent use of the live nurse staffing dashboard in bed meetings 8. Continue to pursue overseas recruitment	Director of Nursing	DDNs									
	12 - Safe care and Treatment	Regulation	E21?	New		Corporate	12 (2)(a) Not all staff were compliant or completed timely assessments for patients- in accordance with the Mental Capacity Act 2005. This includes best interest decision making; lawful restraint; and, where required, application for authorisation and for Deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards or the Court of Protection.	Consistently apply, implement and evaluate the Mental Capacity Act 2005 requirements and DOLs	1. Monitor mandatory training compliance 2. Link with lead in the Local Authority and with the MCA project to provide training 3. Continue to complete quarterly audit with feedback to individual clinicians 4. Continue to monitor compliance with MCA when completing DNACPR decisions 5. Provide bespoke training sessions as required	Director of Nursing	Senior Nurse – Quality and Safeguarding	staff to be released for Mandatory training. Safeguarding adult Lead Nurse and Safeguarding Adult Named Nurse to complete Quarterly audits	all staff	Risk of lack of resources to ensure attendance at training	Compliance with the MCA will be evident through audits and care given to patients.	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety					
	13 - Safeguarding	Regulation	C9?	New		Corporate	Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014). The lack of training caused the potential risk of service users not always being protected from abuse and improper treatment.	Ensure full compliance with Safeguarding compliance across the Trust for all staff	1. Monitor mandatory training compliance and report via Safeguarding committee and Trust Quality executive 2. Provide bespoke sessions for groups of staff 3. Provide differing methods of training delivery such as face to face and e-learning.	Director of Nursing	Senior Nurse – Quality and Safeguarding	staff to be released for Mandatory training. Safeguarding adult Lead Nurse and Safeguarding Adult Named Nurse to deliver training	all staff	Risk of lack of resources to ensure attendance at training	Staff fully conversant with Safeguarding Adult and Children practices and procedures.	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety					
		Must		New	Safe	Surgery	The safeguarding adults and safeguarding children policies are up-to-date and include relevant references to external guidance.	The Safeguarding Policies are up to date and include references to external guidance	1. Safeguarding children, Safeguarding Adult, MCA and DOLs being reviewed and updated	Director of Nursing	Senior Nurse – Quality and Safeguarding	Safeguarding Adult Lead Nurse and Safeguarding Lead Nurse to complete	all staff	Staff will have no up to date guidance of what is and what to do when Safeguarding concerns occur	Up to date policies identifying safeguarding concerns and procedures	Safeguarding Steering Group, Trust Quality Executive, Quality & Safety					
		Should		New		Children and Young People's Services	Review the system for recording safeguarding training and assure themselves that clinical staff in children's services complete safeguarding children training to level 3.	ESR system is up to date with training needs of staff and staff have completed correct level of Safeguatrding Training.	1. review of ESR to map staff to level of safeguarding training 2. Review of training sessions to ensure adequate training slots for the number of staff to be trained. 3. Reports generated and sent to Heads of Nursing and Safeguarding professionals to monitor compliance with Safeguarding Training	Director of Nursing	Senior Nurse – Quality and Safeguarding	Staff to be released for Mandatory training. Safeguarding Children Team to deliver training.	Clinical Staff - children services	Risk of lack of resources to ensure attendance at training	Clinical Staff in Children Services trained to Level 3 in Safeguarding Children	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety					
		Should		New		Children and Young People's Services	Review their safeguarding children policy and ensure it reflects national guidance.	The Safeguarding Policies are up-to date and include references to external guidance	1. Safeguarding children being reviewed and updated	Director of Nursing	Senior Nurse – Quality and Safeguarding	Safeguarding children Lead Nurse to complete	all staff	Staff will have no up to date guidance of what is and what to do when Safeguarding concerns occur.	Up to date policies identifying safeguarding concerns and procedures	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety					
		Should	C11?	New		Children and Young People's Services	Put into place systems and processes to identify those with a learning disability and ensure adjustments are made to cater for their special needs.	Flagging System to be implemented to notify staff that the patient has a learning disability	1. working with information governance to identify consent procedures for the flagging of all patients with a Learning disability 2. Working / waiting for National Guidance which is expected 2018 regarding data protection and Flagging of patients with a Learning Disability 3.Patients who have capacity will be asked for consent to be flagged. 5. Parents and or NOK for those patients who lack mental capacity will be asked regarding their views on their relative to be flagged.	Director of Nursing	Senior Nurse – Quality and Safeguarding	Flagging system	all staff	information sharing gidance / law does not at this moment in time allow the sharing of information from GP's / CCG those patients with a Learning Disability hence consent is being sought as the patient attends a service hence may take some time to achieve	Flagging system in place	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety					

		Should		New	Safe	Community Adults	The trust should ensure that all staff follow safeguarding policies and procedures.	all staff follow safeguarding policies and procedures	1. work with the Local Safeguarding Boards to complete audits 2. undertake internal safeguarding audits 3. monitor incidents to ensure processes are followed	Director of Nursing	Senior Nurse – Quality and Safeguarding	Staff to be released for Mandatory training.	all ataff	audit will show staff following policy and procedures	staff compliant with safeguarding policy and procedures	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety						
		Should		New	Safe	Community Adults	The trust should ensure that there are suitable arrangements in place to ensure that all staff receive required safeguarding training.	ESR system is up to date with training needs of staff and staff have completed correct level of Safeguatrding Training.	1. review of ESR to map staff to level of safeguarding training 2. Review of training sessions to ensure adequate training slots for the number of staff to be trained. 3. Reports generated and sent to Heads of Nursing and Safeguarding professionals to monitor compliance with Safeguarding Training	Director of Nursing	Senior Nurse – Quality and Safeguarding	Staff to be released for Mandatory training.	all staff	Risk of lack of resources to ensure attendance at training	Staff fully conversant with Safeguarding Adult and Children practices and procedures.	Safeguarding Steering Group, Trust Quality Executive, Quality and Safety						
		Should		New	Safe	Community Adults	The trust should ensure risk assessments are appropriately completed and reviewed.	Established on going monitoring and review of use of patient assessments.	1. Pain and MUST assessments to be added to the quarterly documentation audit to monitor use. 2. To add some assessments as mandatory fields within Mobile technology for community staff to ensure completion.	Director of Nursing	Care Group Manager / Professional Lead - Adult Community.	Time for staff to complete audit and attend training.	All Staff	Time for total mobile to go live across all community teams.	Audit compliance. Total Mobile data and audit.	Care Group Quality meeting, Divisional Quality board, Trust Quality Executive.	Mar-18					This refers to clinical risk assessments
		Should		New		Community Services for Children and Young People	The service should provide leaflets or posters to give information to families who may wish to raise complaints.		The development of a specific leaflet	Director of Nursing	Head of Patient Relations		DDN Children and Young People				??				
		Must		New	Safe	End of life care	Attendance for mandatory training is improved.	Attendance for mandatory training is improved for Palliative End of Life Services	1.. Closer frequent monitoring of achievement against KPI 2. Establish more frequent reporting for all Palliative & End of Life Services.	Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Must		New	Safe	End of life care	Undertake required safeguarding training as required for their individual role.	Undertake required safeguarding training as required for their individual role for staff within Specialist Palliative & End of Life Care Services	1.. Closer frequent monitoring of achievement against KPI 2. Establish more frequent reporting for all Palliative & End of Life Services.	Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Must		New	Safe	End of life care	All staff are trained and competent when administering medications via syringe driver.	Attendance for mandatory training is improved for Palliative End of Life Services	1. Re-establish Syringe Pump Implementation Group to monitor bi-monthly incidents and training compliance 2. Agree Level of training compliance for the organisation. 3.Review the current training programme and agree acceptable training approach which facliatates staff to attend and resukts in increased competence. 4.Agree with EBME on mode of recording training to prevent duplication and aid completeness	Director of Nursing	Care Group Manager/Professional Lead for Palliative Care										
		Should		New		End of life care	Look for ways to improve privacy on the wards/ department when breaking bad news or consoling bereaved families.	Look for ways to improve privacy on the wards/ department when breaking bad news or consoling bereaved families.	1. Review of current space and potential existing areas within the acute site which are currently available or could be utilised 2. Invite Jane Longden to End of Life Strategic Delivery to present possibilities and location	Director of Nursing										

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		Should		New		Medical care	Medication trolleys are adequate for the amount of medications stored.	The medication trolleys in all clinical areas will be (i) physically adquate for the purposes of storing stock medicines, and (ii) the stock medicines stored withn the drug trolleys are done so in a neat, tidy and appropriate manner	Pharmacy will conduct a series of monthly drug trolley audits to identify where (i) the current drug trolleys are inadequate and require repair or replacement, anf (ii) that remedial actions are put in place to correct any storage issues with medicines within the trolleys.	The Director of Pharmacy will be responsible for conducting the audits and resulting action plans. The respective matrons will be responsible for the completion of the action plans.	Gary Fletcher	None	Neads of Nursing & Matrons	There are no barriers to completing the audits. There may be a risk in the completion of audit actions.	When the audits demonstarte that drug trolleys are all fit for purpose and being used appropriately.		1st July 2018				

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	12 - Safe care and Treatment	Must		New		Community CYP	12(1), 12(2)(e), 12(2)(h) Blind cords were not secured in all of the rooms at the child development centre.	Ensure that all blind cords at the CDC are secured in all areas where Children and Young People attend.	1. Anti-ligature risk assessment for blinds at CDC to be reviewed and updated. 2. Enquire with community estates to identify a permanent solution for securing the blinds. 3. As an interim arrangement CDC member of staffs to be identified for daily checking of all blinds prior to CDC opening each morning. 4. Audit of compliance to be reported into care group quality team meeting.	DD WCCSS	CGM community children's	To be identified if permanent solution can be sought	NA	NA	Blinds are either permanently secured or robust process for checking in place with associated audit trail.	Community Children's Quality Team	Mar-18	Action commenced Jan 18			Also recorded under Community CYP
		Should		New		End of life care	Look for ways to support the porters with equipment such as trolleys that are not always suitable to use but for which there are no other options.		Highlight faulty equipment Clean and label equipment and remove from use Report to Skanska and record job no When equipment has been repaired put back into use	Director of Strategy	Divisional Director Estates and Facilities		Imaging staff A&E staff Portering staff SKANSKA		Porters being able to transfer patients and equipment safely without harming themselves, patients or damaging the fabric of the hospital - Ensure porters are aware of process for reporting faulty equipment and escalation processes		31/03/2018	Action commenced Jan 18			
		Should		New	Safe	Medical care	The fire exit on ward 29 is alarmed to alert staff if a patient leaves the ward.	The fire exit on ward 29 is alarmed to alert staff if a patient leaves the ward.	A small works requisition has been raised	Director of Strategy	Divisional Director Estates and Facilities	Funding for the work		Previously rejected small works requisition	Alarm fitted		28/02/2018	Action commenced Jan 18			
		Should		New		Surgery	Continue with improvement plans for IT software to ensure full compliance with the Accessible Information Standards.	Continue with improvement plans for IT software to ensure full compliance with the Accessible Information Standards.	Plan on a Page provided	Director of Strategy	Head of Patient Relations ; Lead for Patient Experience		Assistant Director of IT Business Delivery RTT & Redesign Manager Director of Surgery Head of Information		Recommendations implemented, a report submitted to IOG referencing a RFC used to implement the change - Report to the IG Steering Group		30/04/2018	Action commenced Jan 18			
		Should		New		Medical care	Computers are password protected to protect against unauthorised access and that these are not left unlocked.		Conduct review and produce list of the desktops that remain unlocked due to the use of a generic login and identify the logins used Discuss the use of generic logins with a selection of the locations to understand the business requirement Write a paper advising IG steering group on the issue and seeking approval of next steps Comms campaign to advise on the requirement for all desktops to be password protected.	Director of Strategy	IT Service Delivery Manager			Ward staff do not accept the constraint of a password locked device			30/04/2018	Action commenced Jan 18			

	Regulation	*As described in the report*			*Please complete this when reviewing the issue*		*As described by the CQC*	*Translate the CQC issue into a meaningful, SMART, objective*	*Describe the steps that need to be taken to achieve the desired outcome*	*Who is responsible for this completing step?*		*Describe the resources required to complete this action*	*Who else needs to be involved in this step – either to achieve it or will be affected by it?*	*What are the challenges, barriers or risks to completing this action step?* *Risk no. if available*	*Explain how you will know that the action has been completed and is successful in achieving its purpose*	*Where is this action overseen and the evidence tested*	*A realistic date for completion*	*Red = Action will not be completed / effective* *Amber = behind target* *Green = On target*		*Hyperlink to evidence store* *Do not embed documents*	*Include any relevant information on progress, new challenges, resources required etc.*
No.	**Regulatory breach**	**Must do / Should do**	**Quality Commitment ref.**	**New / Old PCIP**	**CQC Quality Domain**	**Core Service**	**Issue**	**Objective**	**Action**	**Accountability**	**Operational Lead**	**Resources required**	**Stakeholders**	**Constraints / Risks**	**Measures**	**Oversight / Assurance group**	**Due date**	**Status**	**Date completed**	**Evidence of completion**	**Comments**
		Should		New	Safe	Urgent and Emergency Services	The nominated ED triage nurse is clearly identifiable to ambulance staff.	100% compliance of utilising new ID provided	New High Visibility ID purchased and in use by Ambulance Handover Nurse	DD MLTC	Matron A&E	New High Visibility ID	Ambulance Handover Nurse	None	Daily checks by ED Nurse In Charge	New Handover Standards document in ED	Mar-18			Daily Complaince Check	The new High Visibility ID is currently in place checked daily with the Nurse In Charge. The Ambulance Standard document drafted for use in ED
		Should		New	Safe Effective	Urgent and Emergency Services	Risk assess and re-evaluate its use of a cubicle as an ED review room.	Monitor compliance of use as cubicle and no more than 2 patients in the room at 1 time	Measure included in the ED Trigger Tool and monitored hourly Escalation protocols to be in place in MLTC to support de-escation in ED	DD MLTC	Matron A&E	Escalation Protocol IT ED Trigger Tool	ED Progress Chaser - Update ED Trigger Tool NIC - Manage rreview Room utilisation	Risk 250 - Ability to de-escalate and prevent doubling up in cubicles	ESM Escalation Levels ED Trigger Escalation Levels	Patient Safety Meeting	May-18			Daily ED Log for compliance of doubling up	There is a requirement from a Whole Hospital Approach to ensure de-escalation is in place and ED Escalation Levels remain at Amber or below
		Should		New	Safe Effective	Urgent and Emergency Services	Reassess its policy for the use of review rooms in ED and ensure all staff are aware of and adhere to the process.	Carry out shared learning session for ALL staff in the use and compliance of the review room 100% compliance required	Review the current criteria for review rooms Carry out teaching sessions and sign off of awareness amongst staff	DD MLTC	Matron A&E	Teaching Time for all RNs and CSWs in ED	Matron ED Registered Nurses ED CSWs	Ability to provide teacing time during winter pressures	Completion sign off	Band 6 Meeting CSW Meeting Band 7 Meeting Patient Safety Meeting	May-18				Meeting structure in place for Band 6 and CSWs - arranging for band 7s and will hold LIA to discuss with each
		Should		New	Safe Effective	Urgent and Emergency Services	Take action to ensure no confidential conversations between doctors, patients or their representatives take place in the ED review rooms, if there is a chance they could be overheard by other patients or visitors.	Carry out Patient Experience session with ED team to support privacy and dignity Measure FFT responses relating to Privacy and Dignity 0% negative responses related to Provacy and Dignity in Review Room	Carry out teaching session with Medical Team on Patient Experience and specifically Privacy and Dignity in Review Room Montior FFT Responses relating to Privacy and Dignity Produce and sign-off with medical Team Patient Charter to provide patients details on their rights and expectations during time in ED	DD MLTC	Care Group ToT Emergency & Acute	Teaching Time for Medical team	Clinical Director ED medical team	Ability to provide teacing time during winter pressures	Completion of teaching Session with Patient Experience Team Sign off of Patient Charter	Medics Meeting ED Team Meeting	Apr-18			Teaching session compeleted led by Patient Experience Team with ED medics	Teaching session carried out with ED Medics in Nov 17 to cover all aspects of Patient Experience as well as National Survey Responses. Action plan developed on medic responses and Patient Charter agreed and signed off - all in place and visible in ED Cubicles
		Should		New	Responsive Effective	Urgent and Emergency Services	Raise awareness of its chaplaincy service amongst its ED staff and ensure patients and relatives who may benefit from it are made aware of it.	Monitor use of providing Chaplaincy Information during patient RIPs 100%	Develop comms with Multi-faith services to inform patients of services and support available Provide stamp for ED Team to use on RIP patient documentation to monitor compliance of information provision	DD MLTC	Care Group ToT Emergency & Acute	Chaplaincy Support for teaching sessions with team Comms to develop sewrvice leaflet for patients Stamps to be obtained and in use for mortality to be using in patient documentation	ED Team Acute Team Comms Chaplaincy Services		Stress Tests of complaince of information provisong (stamp)	ED Teaching session ED Team Meeting Patient Safety Meeting	Jun-18			Audits of stamp on Patient Documentation for information provision	Comms already commenced with Chaplaincy Services
		Should	C8?	New	Responsive Effective	Urgent and Emergency Services	ED is able to offer written information to patients in languages other than English.	Provide 100% of Patient Information Leaflets in other languages	Obtain all Patient Information leaflets in other languages	DD MLTC	Matron A&E	Funding to provide additional leaflets Comms team to develop the leaflets in other languages	Comms	Restrictions to provide leaflets in MOST COMMON other languages used only	Completion and provision of leaflet in Main ED	ED Team Meeting	Apr-18			Availability in ED	All Leaflets produced in English currently Developing other languages with Comms
		Should		New	Responsive Effective	Urgent and Emergency Services	ED continues to improve its staff appraisal completion rates.	Compliance of minimum 90% IPDR completion rate	Trajectory of IPDR completion to be obtained Diarise all IPDRs for the year to manage completion rates	DD MLTC	Care Group ToT Emergency & Acute	management Time to continue to complete	care Group ToT	Management Time for completion Risk 598	IPDR completion rates	Care Group Meeting Quarterley Review	May-18			Divisional Compliance	
		Must		New		Urgent and Emergency Services	Take action to improve ED staff's compliance with mandatory training.			DMD WCSS	Care Group ToT - A&E										
		Must		New	n/a	Urgent and Emergency Services	ED completes the action plan compiled following the CQC inspection carried out in September 2015.			DMD WCSS	Care Group ToT - A&E										
		Must		New	Safe	Medical care	Mandatory training is up-to-date including safeguarding training at the required level.	Mandatory training is relevant to role and areas achieve 90% compliance	1. Review by corporate as to content and relevance 2. Review corporately as to what can be delivered online 3. Trajectory defined by all care groups 4. Management of trajectory OR LINK TO 12 (2)c for corporate actions??	DD MLTC	Divisional ToT MLTC	Time allowed within roles to complete quarterly review. ESR up to date and timely with training inputted within 24 hours.	Corporate nursing	Ability to release staff due to risk number MLTC 164	Figures from ESR demonstrate compliance						
		Must		New	Safe	Medical care	There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe.	corporate link to regulatory breach 18		DoN	DDN MLTC										
		Should		New	Safe	Medical care	Patients have access to call bells at all times and that all call bells can be heard by staff and used to signify an emergency.	Patients have access to a call bell or a hand bell at all times	1. Audit of call bell location 2. Written risk of all areas which use hand bell submitted to RMC.	DD MLTC	Senior Matron - MLTC										
		Should	S7	New	Safe	Medical care	Review the nursing documentation to ensure it is fit for purpose and that risks, such as falls are regularly reassessed and recorded.	Link to 17 (2) ©		DD MLTC	Senior Matron - MLTC										
		Should	S1	New	Safe	Medical care	Staff on wards have sufficient knowledge to care safely for neutropenic patients, including knowledge of neutropenic sepsis.		**No action:** the nurse rotate on shifts so the nurses in hours are the nurses out of hours. The trust is too small for a cancer ward.	DD MLTC	Divisional ToT MLTC										
		Should	C14	New		Medical care	Patients' nutritional needs are assessed and reviewed in accordance with current guidance.	Patients nutritional needs are assessed timely and reviewed in accordance with Trust guidance	1. Audit used reviewed 2. New audit launched and linked to ward review process	DD MLTC	DDN MLTC	Protected audit time	Senior sisters	Capacity pressures at certain times of the year	Patients initial assessment completed. Reassessment completed.	SNMAG	31/03/2019				
		Should		New	Safe	Medical care	All staff are up-to-date with their appraisals.	Appraisal rate of 90% achieved by Q2 2018	1. Trajectory set by care groups. 2. Monitored by quarterly reviews.	DD MLTC	Divisional ToT MLTC	Protected management time for staff. Training for those who require it to complete appraisal.	HR - Proactive monitoring	Capacity pressures at certain times of the year	ESR data	OD Committee	31/9/18				
		Should		New	Safe	Medical care	There are sufficient staff trained in administering medication via a PICC line.	Two areas to be identified as PICC areas.	1. Two areas to be chosen (AMU/7). 2. Training to be put in place by chemotherapy team. 3. Competence document to be produced and completed.	DD MLTC	Divisional ToT MLTC	PDU development of competence document. Chemo team to deliver training.	PDU to develop competence. Consultant Nurse Oncology	Development of tool. Monitoring of completion.	Compliance rates.	MLTC Senior Sisters	31/03/2019				
		Should		New	Safe	Medical care	Medical records are kept secure and that information contained within is kept safe.	Healthcare records are stored as per trust policy	1. Re issue policy to ward clerks 2. Audit of compliance	DD MLTC	CGM MLTC	New notes storage trolleys	Medical Records	Medics compliance	Audit compliance	Healthcare Records Committee	31/10/2018				
		Additional			Safe	Medical care	Medication trolleys were not always adequate for the medications stored	AMU trolleys are insufficient for the amount of medication required	1. Source larger trolleys 2. Purchase larger trolleys for AMU	DD MLTC	DDN MLTC	New drug trolley x 4	Nursing staff amu	Ability to purchase trolleys	Visible trolleys	DQT	31/4/18				

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		Must		New	Safe	Critical Care	Plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.	TACC 90% compliant with all aspects on mandatory training and safeguarding by 30th June 2018	1. TACC TOT in conjuction with critical care PDN's to identify staff that are not up to date with mandatory training via ESR 2. Training dates to be scoped with MLCC 3.PDN's to scope alternative methods of training within the unit 4. Lead nurses/Rota coordinator to allocate time to staff members to attend course or complete E learning.	DD surgery	Care Group ToT - Critical Care	1. Appropriate courses 2. Sufficient back fill	1. PDN's 2. MLCC 3.Clinical staff	1. Availability of slots on courses 2. Financial impact of backfilling staff	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	30th June 2018				11/1/18 PDN's have begun to identify staff that require training and allocating dates.
		Must		New	Safe	Critical Care	All staff working within the outreach team are competent to do so.	All staff who participate in the provision of outreach services can provide evidence to prove competent to do so.	1. TACC TOT in conjuction with PDN's to liaise with other trusts to scope a competency framework 2. Present outreach staff to be assessed via framework 3. Resources to be identified to ensure outreach team are competent to carry out role 4. Business case to be completed by TACC TOT to support need for 24/7 team	DD surgery	Matron, TACC	1.Time 2. Finances 3. Support from external organisations	1.DDON 2. Lead intensivist 3.Critical care nursing team	1. Finance implications 2. Staff resources	Documented completion of competencies on personal file/ESR/Revalidation folder	1. DQB 2. Care group quarterly review	1st January 2018				4/1/18 Scoping meeting has taken place with City and Sandwell Critical Care and outreach lead. Some immediate actions identified
		Must		New	Safe	Outpatients and Diagnostic Imaging	All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.	OPD matron and Sister to provide a plan to ensure all OPD nursing staff reach 90% compliance with all elements of mandatory training and safeguarding by 30th June 2018	1.OPD sister to identify staff that require training via ESR 2.Training dates to be scoped with MLCC 3.OPD sister to allocate dates/time for staff to attend relevent training sessions and complete E learning modules. 4. Outreach to be included in team meetings	DD surgery	Matron, OPD.	1. Appropriate courses 2. Sufficient back fill if required	1. MLCC 2.Matron, OPD 3. OPD nursing staff	1. Availability of slots on courses 2. Financial impact of backfilling staff	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	30th June 2018				OPD sister has already identified that figures sent to CQC were not up to date.ESR information has now been validated.
		Must		New	Safe	Surgery	All professional staff working with children have safeguarding level 3 training.	All staff identified as requiring level 3 safeguarding have completed it by July 31st 2018	1. Staff requiring level 3 training to be identified via ESR 2.Dates of level 3 training to be scoped 3.Staff to be written to by care group TOT's allocating a date to attend	DD surgery	Care group managers, Division of Surgery	1. Appropriate courses 2. Sufficient back fill if required	1. Care group TOT's 2. MLCC 3.Availability of lectureres	1. Availability of slots on courses 2. Financial impact of backfilling staff	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	31st July 2018				10/1/18 Care group TOT are in possesion of latest KPI's and have been asked to complete plan on a page
		Must		New	Safe	Surgery	All staff are up-to-date with safeguarding adults.	All staff identified as requiring adult safeguarding have completed it by July 31st 2018	1. Staff requiring training to be identified via ESR 2.Dates of level 3 training to be scoped 3.Staff to be written to by care group TOT's allocating a date to attend	DD surgery	Divisional ToT Surgery	1. Appropriate courses 2. Sufficient back fill if required	1. Care group TOT's 2. MLCC 3.Availability of lectureres if level 3 training is indicated	1. Availability of slots on courses 2. Financial impact of backfilling staff	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	31st July 2018				
		Must		New	Safe	Surgery	Patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.	All patient records will be completed as per governing body Record keeping standards and section 4.2 in the organisations Patients Records Policy	1. All Division of surgery care group TOT's to complete a monthly audit based on record keeping standards 2. Compliance and actions to be presented at care group quality team meetings	DD surgery	CD's	1. Allocated time	All care group TOT's	None	Monthly audits	1.DQB 2. Care group quarterly review	31st July 2018				
		Must		New	Safe	Surgery	All shifts have the correct skill mix for wards to run safely.	Wards to have correct skill mix as per funded establishment	1. Introduce a daily (Mon - Fri) senior nurse safety huddle to confirm staffing levels on wards and SAU. 2.Adherance to The Management of Escalation of Nurse Temporary Staffing Shifts SOP 3.Continue with recruitment of staff offering flexible shift patterns to attract newcomers 4. Job offers to student nurses without interview subject to successful qualification 5. Continue to monitor via risk register	DD surgery	DDN Surgery	1.Temporary staffing availability	1. Resourcing team 2.Recruitment team	1. Finance implications 2. Staff resources	1. Monthly safer staffing paper	1. DQB 2. Monthly staffing returns	Dec 31st 2018				Date to commence 22nd Jan 2018
		Must		New	Safe	Surgery	All staff are up-to-date with mandatory training.	90% compliant by 31st July 2018	1.Care group TOT to identify staff that require training via ESR 2.Training dates to be scoped with MLCC 3.Care group TOT to monitor uptake of training and report to DQB on a monthly basis	DD surgery	Care group managers in Division of Surgery	1. Appropriate courses 2. Sufficient back fill if required	1. Care group TOT's 2. MLCC	1. Availability of slots on courses 2. Financial impact of backfilling staff	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	31st July 2018				
		Should		New		Critical care	Provide follow up clinics to patients after discharge from the critical care unit; in line with Core Standards for Intensive Care.	Follow up clinics in place	1. Business case to be developed 2. BC to be agree by Div TOT 3. Exec agreement	DD surgery	Care Group Manager/CD TACC	1. Staff resources 2. OPD access	1. Access team 2. OPD	1. Financial implications 2. Resourcing	1.Care group quarterly review	1.Care group quarterly review 2.DQB	Jan 1st 2019				
		Should		New		Critical care	That essential equipment is procured and used with relevant patients; and staff are fully trained and competent to use this equipment. Such as capnographs.	Capnography equipment in place and all staff trained in its use	1. Equipment procured 2. Staff trained to use new equipment 3. Equipment training records updated 4. New staff to unit undergo equipment training and record s maintained.	DD surgery	TACC TOT							ACTION COMPLETED	TBC	1.Equipment in place 2. Training records available on TACC drive	
		Should		New	Well Led	Critical care	All risks to the service are included on the risk register.	All risks identified in TACC are assessed and on the care group register	1. Risks identified 2. Discussed at TACC meeting 3. Risk raised on register 4. New risks escalated at DQB 5. Risk/mitigations reviewed as stated	DD surgery	Care Group ToT Theatres, Anaesthetics & Critical Care	1. training	1. TACC staff 2. Patient safety	None	1. Peer review by critical care network	1.Care group quarterly review 2.DQB 3, Care group confirm and challenge	Nov 30th 2018				
		Should		New		Critical care	Deprivation of Liberty Safeguards are applied in all cases where these are required; for example restricting patients movements by use of bed rails.	DoL's is not applicable when using cot sides in a critical care setting.		DD surgery	Matron Critical Care									Please refer to ICS/FICM Guidence on MCA/DoIs February 2017
		Should		New	Well Led	Outpatients and Diagnostic Imaging	Review how staff review, document and update risks and progress against action plans.	All risks and mitigating actions identified to be reviewed by due dates	1. Identify if training required regarding risk management 2. Liaise with patient safety to organise training on risk register with regarde to generating a risk, mitigating actions and reviews 3. OPD TOT to review risk register at quality meetings	DD surgery	OPD TOT	Training	1. OPD staff 2. Patient Safety	None	1. Care group quarterly review	1.Care group quarterly review 2.DQB 3, Care group confirm and challenge	July 31st 2018				
		Should	C17	New		Outpatients and Diagnostic Imaging	Staff are confident and competent to support a patient, or relative, with dementia.	OPD Nursing staff to be 95% compliant with regard to dementia training	1. Staff to attend dementia training	DD surgery	Matron, OPD.	1. Appropriate course	1. Nursing staff OPD	None	Monthly ESR KPI figures	1.DQB 2. Care group quarterly review	Jan 31st 2018	ACTION COMPLETED. Dec 207 KPI document shows 95% compliant	Dec-17	Dec KPI document	
		Should		New		Outpatients and Diagnostic Imaging	All outpatient clinics are suitable for the purpose for which they are being used.	Fracture clinic waiting area and corridors will be compliant with the Health and Social Care Act 2008, regulation 15:Premises and equipment	1. OPD TOT to assess waiting area and corridor area in fracture clinic for accessability for patients in wheelchairs or those that require the use of a walking aid. 2. Areas to be decluttered 3. Risk assessment to be completed and added to risk register	DD surgery	Matron OPD	1. Storage space	1. Patients and visitors	Staff compliance	1. Review by div TOT 2. Risk register confirm and challenge	1. Care group quarterly review 2. DQB	July 31st 2017				
		Should		New		Surgery	The cleaning rota responsibilities are completed and documented on all wards.	Cleaning rota will be completed on a daily basis	1. Review of cleaning rota content, roles and responsibilities 2. Discussion at all ward meetings regarding the completion of the cleaning rota 3.Daily checks to check for compliance by nurse in charge	DD surgery	All matrons in division of surgery	None	1. Infection prevention control team	Staff compliance	Monthly enviromntal audits	1. Care group quality teams 2. DQB 3. Infection control committee	June 30th 2018				
		Should		New		Surgery	Razors and COSHH items are stored appropriately, securely and in places where people who use services are not able to access.	All sharps and COSHHE items are stored in a locked cupboard	1. Each ward/dept to identify a cupboard to keep sharps and COSHHE items safley stored 2. Job logged to fit lock 3.Communication to staff regarding change in process	DD surgery	All matrons in division of surgery	locked storage areas	1. Skanska	Staff compliance	Matron rounds	1. Care group quality teams 2. DQB	Jul-18				
		Should		New		Surgery	Ensure that it is easy to see what contents should be available in the paediatric difficult intubation trolley in the surgical recovery area.	Contents list available on trolley	1. Lead practitioner, theatres, to develop list in conjuction with clinical lead for theatres 2. Laminated list to be placed on trolley 3. Daily checks of trolley to be undertaken using list	DD surgery	Lead theatre practitioner	Laminator	Anaesthetists	None	List in place	1. DQB	Complete		Oct-17	Photograph	List was always in place
		Should		New		Surgery	Intravenous fluids and other fluid items, such as nutritional drinks, are stored in a locked place and are not accessible to the public on ward 10.	All IV fluids and nutritional drinks are locked away	1. Scope all areas and departments to check lockable areas available to store IV fluids and nutritional drinks 2.Log jobs for locks to be fitted to storage areas if required 3. Communication to all staff regarding the need to store IV fluids and nutritional drinks in a locked area 4. Include audit of above on matrons round	DD surgery	All matrons in division of surgery	locked storage areas	Nursing teams	Staff compliance	Ward/dept review	1. Care group quality teams 2. DQB	July 31st 2018				
		Should		New		Surgery	Fridge, CD checks and room temperature checks' monthly audits are carried out and recorded consistently across all wards.	Monthly audit sheets for CD checks, Crash trolley checks, Fridge temp checks and room checks are completed monthly.	1. Senior sisters of all wards and depts to complete audit 2. Completed audit to be scanned and sent to matron 3. Audit results and actions to be part of ward review	DD surgery	All matrons in division of surgery	locked storage areas	Nursing teams	Staff compliance	Ward/dept review	1. Care group quality teams 2. DQB	July 31st 2018				Two should do's have been combined - includes fridge, CD checks
		Should		New		Surgery	Consider streamlining their processes for patient records. There are a number of different formats and systems for one patient record, which can cause confusion and has a potential risk of staff not having all relevant information when treating patients.	All patients have a single record in the correct format	1.Electronic solution is currently being scoped for full roll out. 2. Quality control and merging project is currently being monitored through the patient records committee 3.Medical records availability in outpatients remains high. Monitoring to be rolled out to the other areas such as elective inpatients	DD surgery	Medical records manager and DO Surgery	Electonic solution requires full business case development	All departments	Continued improvement work in records to ensure core processes are improved.	Monthly audits	Patient records committee	Sep-18				
		Should		New		Surgery	Continue with improvements in performance of patient outcomes, specifically PROM's.	PROM's participation returns to increase to 80% of eligible participants	1.Elective joint pathway to be developed which clarifies when patient prompts regarding the completion of PROM's form will be 2. Results and actions to be discussed and monitored at MSK SMG	DD surgery	MSK TOT	Electronic solution	Preassessment and opd	Patient compliance	Monthly Participation rate Bulletin from PROMs manager at Quality Health	1. Care group quality teams 2. DQB 3. MSK quarterly review	Jan 31st 2019				Pathway developed
		Should		New		Children and Young People's Services	Review the environment within the fracture clinic and make improvements to meet the needs of children using the service.	Separate area for children and young people to be created within fracture clinic	1. Estates to scope out feasibility of creating a paediatric area. 2. Options to be presented for consideration. 3. Option agreed and funding sought via trust funds. 4. Paediatric area to be created	DD surgery	DDon Children and young people	Dedicated area to be created	Fracture clinic staff	Funding to complete works	MSK update	1. DQB	Dec 31st 2018				Skanska have submitted plan. Waiting for confirmation of funding and start date.
		Added		New		Critical Care	Consider how to effectively identify and manage all infectious patients in critical care	All patients requiring isolation for infection control reasons will be located in a suitable environment	1. Policy review regarding the use of West Wing theatre recovery as an isolation area by IPCT 2. Verification of policy at infection control committee. 3. Disemination of policy in TACC 4. Monitoring of compliance to policy	DD surgery	TACC TOT	None	Critical Care Staff	Agreement regarding policy by Infection Control Committee	IPCT audits	1. DQB 2. Infection control committee	July 31st 2018				
		Added		New		Surgery	All agency nurses are checked appropriately	Agency checklist completed for all new agency nurses to area	1. Comunication to all wards regarding the requirement to complete an agency checklist 2. Agency nurse checklist to be completed by nurse in charge after handoverif new to area and one hasn't been completed previously 3. Senior sister to monitor compliance	DD surgery	All matrons in division of surgery	None	All staff	Staff compliance	Ward reviews	1.Ward Review 2. DQB	July 1st 2018				
		Added		New		Surgery	Review the fracture hip pathway to support the improvement of data collection and patient outcomes.	Revised fracture neck of femur pathway to incorporate outcomes as identified in best practice tarif.	1. Agreement at MSK care group quality team meeting of pathway 2.Development of document 3. Discussion of NHFD results made an agenda item at care group quality team meetings 4. Escalation of concerns to DQB	DD Surgery	MSK TOT	None	1.Trauma co ordinator 2. Ward 9 staff 3. TACC 4. Orthogeriatrician	Staff compliance	1. Interrogation of NHFD	1. DQB 2. MSK quarterly review	Dec 1st 2018				
		Added		New		Surgery	Ensure that deteriorating patients are managed appropriately	All deteriorating patients are recognised, escalated and reviewed in a timely manner	1.Identify what training is required to support the safe management of deteriorating patients 2. Support staff to attend training 3. Disseminate Ten Messages for the safe management of the deteriorating patient 4.Montly audits	DD surgery	All care groups	Training	1. All staff 2. MLCC	1. Availability of support	1. Monthly audit results	1. Care group quality teams 2. DQB	July 31st 2018				Band 7 senior nurse identifiedto commence supporting staff as of 18th January 2018 for 6 weeks.
		Added		New		Critical Care	CCU had mixed sex breaches due to delayed discharges. Bed occupancy was consistently high.	All patients identified for stepdown are done so as per agreed pathway	1. Present pathway to be reviewed, particulary escalation process. 2.Process to be agreed at TACC, DQB and Execs 3. Concise RCA's to be carried out if pats not stepped down in time frame agreed in pathway 4. Monthly report to DQB	DD Surgery	TACC TOT	Bed availability	1. Capacity team	1. Compliance to agreed pathway	1. TACC audit and RCA report	1. DQB	July 31st 2018				

	Regulation	*As described in the report*			*Please complete this when reviewing the issue*		*As described by the CQC*	*Translate the CQC issue into a meaningful, SMART, objective*	*Describe the steps that need to be taken to achieve the desired outcome*	*Who is responsible for this completing step?*		*Describe the resources required to complete this action*	*Who else needs to be involved in this step – either to achieve it or will be affected by it?*	*What are the challenges, barriers or risks to completing this action step?* *Risk no. if available*	*Explain how you will know that the action has been completed and is successful in achieving its purpose*	*Where is this action overseen and the evidence tested*	*A realistic date for completion*	*Red = Action will not be completed / effective* *Amber = behind target* *Green = On target*		*Hyperlink to evidence store* *Do not embed documents*	*Include any relevant information on progress, new challenges, resources required etc.*
No.	**Regulatory breach**	**Must do / Should do**	**Quality Commitment ref.**	**New / Old PCIP**	**CQC Quality Domain**	**Core Service**	**Issue**	**Objective**	**Action**	**Accountability**	**Operational Lead**	**Resources required**	**Stakeholders**	**Constraints / Risks**	**Measures**	**Oversight / Assurance group**	**Due date**	**Status**	**Date completed**	**Evidence of completion**	**Comments**
	Section 29a	Section 29a		New	Safe	Maternity and Gynaecology	Monitoring, recording and escalation of concerns for Cardiotocography (CTG) requires significant improvement to ensure timely assessments, fresh eyes	**Compliance with best practice for CTG Documentation**	**See Maternity Improvement Plan V7 V4.3 Action Numbers: Safe Domain: S7, S8, S9, S10, S11, S12, S13, S14, S15, S16, S17, S18, S19 & S20**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
1	Section 29a	Section 29a		New	Effective	Maternity and Gynaecology	There are insufficient midwives with HDU training to ensure that women in HDU are cared for by staff with the appropriate skills.	**HDU Training and Competence .**	**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E5, E6, E7 & E8**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
	Section 29a	Section 29a		New		Maternity and Gynaecology	Safeguarding training is insufficient to protect women and babies on the unit who may be at risk.	**Ensure all staff will receive safeguarding training and remain up to date.**	**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E11 & E12**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
	Section 29a	Section 29a		New		Maternity and Gynaecology	There are insufficient numbers of suitably qualified staff in the delivery suite and on the maternity wards	**Safe Midwifery Staffing levels**	**See Maternity Improvement Plan V7 V4.3 Action Numbers: Safe Domain: S1, S2, S3, S4, S5 & S6**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Must		New	Safe	Maternity and Gynaecology	Risks are explained when consenting women for procedures.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	CD Obs & Gynae										
		Must	S15	New	Safe	Maternity and Gynaecology	The service uses an acuity tool to evidence safe staffing.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Safe Domain: S1**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Must	E10 / S18	New	Safe	Maternity and Gynaecology	Action plans are monitored and managed for serious incidents.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Divisional ToT WCSS										
		Must	S18	New	Safe	Maternity and Gynaecology	Lessons are shared effectively to enable staffing learning from serious incidents, incidents and complaints.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Divisional ToT WCSS										
		Must		New	Effective	Maternity and Gynaecology	Staff follow best practice national guidance.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E14 & E15**	DMD WCSS	Divisional ToT WCSS										
		Should		New	Effective	Maternity and Gynaecology	There is a consultant obstetrician as the designated guideline development lead.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	Staff read and sign newly launched guidelines in a timely manner.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Responsive	Maternity and Gynaecology	Staff opinion is sought when developing the service.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Well Led Domain: W3, W4 & W6**	DMD WCSS	Care Group ToT Womens										
		Should		New	Responsive	Maternity and Gynaecology	There are displays to inform the public how to complain.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	There are chaperone signs in outpatient areas.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	?	Maternity and Gynaecology	Available appointments for women to access the clinic for vaginal birth after caesarean.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women do not have long waits to be discharge from the fetal assessment unit.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women are informed and involved in the planning of their care.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Safe Domain S22** Team need to review this action and see if more needs to be added	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Women are supported during their stay.		???? Team need to review	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Pain relief is given as prescribed or when requested.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E2 & E3**	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Documentation is completed and audited.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E4**	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Handovers follow a Situation Background Assessment Review (SBAR).		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	The service had an alternative plan in place based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP).		? Not sure what this is related to	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Student midwives are not practising unsupervised.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Caring Domain, C3**	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Should		New	Effective	Maternity and Gynaecology	There is a robust data collection system.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E4**	DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	The stillbirth rate is reviewed and an action plan developed.		**See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain, E13** Team need to review this action and see if more needs to be added	DMD WCSS	Care Group ToT Womens										

		Should		New	Effective	Maternity and Gynaecology	The dashboard data is reviewed and action plans are monitored.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New		Maternity and Gynaecology	Ensure the breast milk fridge is locked.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Should		New		Maternity and Gynaecology	Women are offered breast feeding support.		See Maternity Improvement Plan V7 V4.3 Action Numbers: Responsive R8	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Should		New		Maternity and Gynaecology	Scans are uploaded to the electronic database.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New		Maternity and Gynaecology	All cardiotocography machines have the correct time.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Prescription charts are fully completed.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Ensure the women's antenatal handheld records are fully completed.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	All the areas of the electronic computer system are completed.		See Maternity Improvement Plan V7 V4.3 Action Numbers: Effective Domain: E4	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Medical records are stored safely.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Caring	Maternity and Gynaecology	Invasive treatments to babies are performed in a private environment respecting privacy and dignity of the baby.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	The environmental audits improve.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Should		New	Safe	Maternity and Gynaecology	All areas are appropriately clean.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Divisional Director of Midwifery, Gynaecology and Sexual Health										
		Should	S8	New	Safe	Maternity and Gynaecology	Audits of surgical infections are performed.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Effective	Maternity and Gynaecology	An audit programme is developed and presented to the service.		See Maternity Improvement Plan V7 V4.3 Action Numbers: Caring Domain, C4	DMD WCSS	Care Group ToT Womens										
		Should	E10	New	Safe	Maternity and Gynaecology	Low harm incidents are reviewed in a timely manner.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
		Should		New	Safe	Maternity and Gynaecology	Gynaecology staff complete the adult resuscitation training.		Not on Maternity Improvement Plan - This will be added on as Number ???	DMD WCSS	Care Group ToT Womens										
1		Must		New	Effective	Children and Young People's Services	All local guidelines are updated and regularly reviewed for staff to follow.	All out of date guidelines to be reviewed and updated. Process to be developed for on-going monitoring and updating.	1. All out of date guidelines to be identified. 2. Guideline to be allocated to relevant clinician. 3. Database of guidelines to be developed with dates for renewal and responsible clinician for updating. 4. Guideline reviewed and updated. 5. All updated guidelines to go through ratification via paediatric governance and DQT.	DD WCCSS	Care Group ToT (acute)WCSS	NA	NA	NA	All guidelines updated and tracked via new process.	Paediatric governance meeting.	Mar-18	Actions 1-3 complete Actions 4-5 in progress			
2		Should	C14	New		Children and Young People's Services	Introduce a systematic approach to assessing and monitoring children's nutritional and hydration risks.	STAMP nutritional risk assessment will be embedded into the paediatric department and all children admitted to the paediatric ward will be risk assessed as per the tools guidance.	1. Tool to developed and approved via paediatric governance. 2. Competency framework to be developed. 3. Staff to receive training in use of the tool. 4. Staff to be assessed and signed off as competent. 5. Compliance of use of tool to be measured via ward metrics and reported into paediatric governance.	DD WCCSS	DDoN Children and Young People	NA	NA	NA	STAMP tool is used consistently with the department.	Paediatric governance meeting.	Apr-18	Actions 1-3 complete Actions 4-5 in progress			15/01/18 - JT to confirm competency assessment of remaining staff. FM / CY to add onto metrics and measure complicance from Jan 2018.
3		Should	E20?	New		Children and Young People's Services	Improve the timeliness of provision of medicines for children to take home.	Children and young people will receive their take home medications in a timely manner.	1. Baseline audit from time of decision to discharge to take home medication 2. Review of medication available in dispensing medi-save to be reviewed. 3. Range of medication in med-save to be increased. 4. Post intervention audit to be completed and reported into paediatric governance.	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	Improvement in availability of discharge medications.	Paediatric governance meeting.	Apr-18	Action commenced Jan 18			15/01/18 - CY has contacted LP. To undertake baseline audit.
4		Additional		New		Children and Young People's Services	Lack of suitable chairs on the NNU for kangaroo care.	A sufficient number of chairs will be available.	1. Ward manager to review number of chairs required. 2. Ward manager to discuss with procurement for a suitable chair. 3. Chairs to be ordered.	DD WCCSS	Ward manager NNU	NNU trust funds	Finance	NA	Sufficient number of chairs available in NNU.	Paediatric governance meeting.	Mar-18	Actions 1-2 complete Action 3 in progress			15/01/18 - Quote obtained, CW to speak to finance about NNU trust fund to ensure adequates funds - complete. LP completed non-stock order.
5		Additional		New		Children and Young People's Services	The Children's OPD assessment room contained scissors and was not locked when not in use.	Assessment room to remain locked and secured when not in use.	1. Job to be logged with Skanska to fit high handle to the door. 2. Job to be logged with Skanska to fit digital lock on door. 3. Works to be agreed with finance. 4. Works to be completed.	DD WCCSS	Matron paediatrics and neonates	Funding for small works, TBC	Skanska	NA	High handle and digital lock in place on door.	NA	Mar-18	Actions 1-2 complete Action 3 partially complete			15/01/18 - Jobs logged with Skanska for both handle and digilock. CW to chase further with Skanska. Update, high handles x 2 expected in next week. Workd for digital lock awaiting approval.
6		Additional		New		Children and Young People's Services	Medicines for children and young people were not always administered on time.	Medicines to be administered in a timely fashion unless in exceptional circumstances.	1. Medication chart to be reviewed and updated to provide a time period for administration. 2. Communication with staff in relation to work load and escalating to the senior sister or matron if there is a delay in administration. 3. To discuss in ward meetings and grand round.	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	1. New medication chart in place. 2. Evidence of communication with ward staff.	NA	Apr-18	Action 1 complete, new medication chart on trial.			15/01/18 - To collect evidence of discussion in ward meetings / governance.
7		Additional		New		Children and Young People's Services	Care plans reviewed were standardised and not tailored to individual needs.	All standardised care plans to be updated inline with available evidence.	1. All care plans to be reviewed and updated. 2. New suite of care plans to be available on department. 3. To be monitored through senior nurses meeting.	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	New suite of care plans to be available on department.	Paediatric governance meeting.	Apr-18	Action commenced Jan 18			15/01/18 - CW and CY to go through care plans and revise. CY to develop spreadsheet with list of all care plans and status on.

8		Additional		New		Children and Young People's Services	Data supplied showed that only one member of nursing staff and two medical staff required level 3 safeguarding training. This is not inline with national guidance.	All relevant staff will be assigned safeguarding level 3 competency on ESR and department compliance will be ≥90%.	1. Review of ESR data to ensure that staff have the correct competencies. 2. Line managers to ensure that all staff are booked on appropriate level 3 training.	DD WCCSS	DDoN Children and Young People	NA	ESR team	NA	ESR data will be correct and training KPIs will show compliance ≥90%.	Paediatric governance meeting.	Mar-18	1. Completed 2. In progress			15/01/18 - SH to check the compliance of medical staff and speak to medical staff as necessary.
9		Additional		New		Children and Young People's Services	Overall compliance for medical staff mandatory training.	Medical staff mandatory training will be at trust target of ≥ 90%.	1. Deputy care group manager to keep database of all training completed by medical staff and liaise with individual consultants regarding compliance. 2. Database to be reviewed monthly at paediatric governance.	DD WCCSS	CD for paediatrics and NNU	NA	ESR team	NA	ESR data will be correct and training KPIs will show compliance ≥90%.	Paediatric governance meeting.		Action commenced Jan 18			15/08/18 - SN to keep database up to date and work with ESR team to ensure ESR is an accurate reflection.
10		Additional		New		Children and Young People's Services	There was no prompt for sepsis on the initial assessment document in PAU.	Initial assessment document to contain a prompt for sepsis and to consider using the sepsis 6 bundle.	1. Document to be updated.	DD WCCSS	DDoN Children and Young People	NA	NA	NA	Updated document will contain sepsis 6 bundle prompt.	Paediatric governance meeting.	Mar-18	Action commenced Jan 18			15/01/18 - Document updated, to go to governance meeting in January 2018.
11		Additional		New		Children and Young People's Services	A small proportion of parents on the NNU said they missed the ward round and did not receive an update on their babies progress.	A process will be developed to ensure robust communication between medical staff and parents.	1. Appropriate use of communication sheet and used consistently. To do spot check audit monthly and put on metrics. 2. Update communication leaflet to advise parents that if they are unable to attend ward round, they can request an update from medical staff.	DD WCCSS	CD for paediatrics and NNU	NA	NA	NA	Monthly spot check audit of use of communication sheet to be reported on metrics. Completion of updated communication leaflet	Paediatric governance meeting.	Mar-18	Action started Jan 18			15/01/18 - CY and CW to go through communication leaflet.
12		Additional		New		Children and Young People's Services	Environment in the fracture clinic was unsuitable for children and did not provide a separate waiting area.	Separate area for children and young people to be created within fracture clinic.	1. Estates to scope out feasibility of creating a paediatric area. 2. Options to be presented for consideration. 3. Option agreed and funding sought via trust funds. 4. Paediatric area to be created.	DD Surgery	DDoN Children and Young People	NA	Skanska	NA	Dedicated paediatric area created.	Surgery DQT	Apr-18	1 - 3 complete. 4 - waiting for confirmation for start of works.			15/01/18 - CW to confirm start date with Skanska
13		Additional		New		Children and Young People's Services	Systems and processes were not in place to identify those with a learning disability and ensure adjustments were made to cater for their needs.	To ensure a process is in place to identify children and young people with a learning disability.	1. Small task and finish group to be organised to map out options. 2. Once options identified, process to be put in place.	DD WCCSS	DDoN Children and Young People	NA	School nursing, health visiting, CCN team	NA	Robust process in place to identify children and young people with a learning disability.	Paediatric governance meeting.	Jun-18	Action commenced Jan 18			15/01/18 - CW to pull together a task and finish group.
14		Additional		New		Children and Young People's Services	There was no concession for food for resident parents and the food in the hospital was expensive.	To scope out options with estates and private outlet providers in the hospital for feasibility.	1. DDoN to meet with facilities manager and head of performance (estates) to scope options. 2. If feasible, process to be developed and put in place.	DD WCCSS	DDoN Children and Young People	NA	Estates and facilities	NA	Concession agreed if feasible.	Paediatric governance meeting.	Apr-18	Action commenced Jan 18			15/01/18 - CW to meet with providers to see if a concession can be arranged.
15		Additional		New		Children and Young People's Services	Staff did not monitor or record the waiting times in children's outpatients.	Waiting times to be recorded on the board in children's outpatients.	1. Process to be developed for advertising the waiting times in children's outpatients. 2. Data to be collected to inform paediatric governance.	DD WCCSS	DDoN Children and Young People	NA	NA	NA	Waiting times are recorded and reported into paediatric governance.	Paediatric governance meeting.	Mar-18	Action commenced Jan 18			15/01/18 - CW to speak to HM regarding monitoring of this and appropriate communication. SH to speak to information team about getting data.
16		Additional		New		Children and Young People's Services	PALS leaflets were not available in a format for children and young people to understand.	Age appropriate PALS leaflets to be developed and available.	1. PALS leaflets from other organisations to be obtained. 2. Leaflets to be developed and printed.	DD WCCSS	DDoN Children and Young People	NA	PALS team	NA	Age appropriate PALS leaflets will be available.	Paediatric governance meeting.	Apr-18	Action commenced Jan 18			15/01/18 - Appropriate leaflet identified from previous work. CW to circulate for comments.
17		Additional		New		Children and Young People's Services	Patient experience tops and pants was not formally reviewed.	Feedback from pants and top board will feed into wider patient experience agenda for paediatrics.	1. Template developed for monthly collation of data. 2. To be discussed at paediatric governance and patient experience group.	DD WCCSS	Matron paediatrics and neonates & DDoN Children and Young People	NA	Governance team	NA	Monitoring of feedback by paediatric governance	Paediatric governance meeting, patient experience group	Feb-18	Action commenced Jan 18			15/01/18 - CY has developed feedback template and circulated.
6	17 - Good Governance	Regulation		New		Community Services for Children and Young People	10(1), 10(2)(a). - Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records.	All records held by the community children's team will remain secured as outlined in the SOP.	1. Review of current record management SOP to ensure it is fit for purpose. 2. Communication of SOP with all community children's teams.	Trust Secretary	DDoN Children and Young People	NA	NA	NA	SOP is reviewed and all community children's team are aware and following.	Community Children's Quality Team	Mar-18	Action commenced Jan 18			Also included in the Trust Secretary section Progress as above **NOT INCLUDED IN THE CQC ACTION RESPONSE TEMPLATE**
1		Regulation		New	Safe	Community Services for Children and Young People	Ensure blind cords are secured in all areas where children and young people may attend.	Ensure that all blind cords at the CDC are secured in all areas where Children and Young People attend.	1. Anti-ligature risk assessment for blinds at CDC to be reviewed and updated. 2. Enquire with community estates to identify a permanent solution for securing the blinds.	DD WCCSS	CGM community children's	To be identified if permanent solution can be sought	NA	NA	Blinds are either permanently secured or robust process for checking in place with associated audit trail.	Community Children's Quality Team	Mar-18	Action commenced Jan 18			Also recorded as a breach in regulations
2		Must		New	Safe	Community Services for Children and Young People	Ensure patient records remain confidential and stored securely.	All records held by the community children's team will remain secured as outlined in the SOP.	1. Review of current record management SOP to ensure it is fit for purpose. 2. Communication of SOP with all community children's teams.	DD WCCSS	DDoN Children and Young People	NA	NA	NA	SOP is reviewed and all community children's team are aware and following.	Community Children's Quality Team	Mar-18	Action commenced Jan 18			09/01/18 - CW has discussed with KM. Review of SOP and safe haven policy.
3		Must	S5	New	Safe	Community Services for Children and Young People	Continue to follow standard operating procedures with medicines in special schools.	All assistant practitioners in the special schools will follow the standard operating procedure (SOP) for the administration of medicines.	1. All assistant practitioners will sign to acknowledge that they have read and understand the SOP. 2. Competencies for the administration of medicines to be assessed on an annual	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	Completed database of competencies.	CCN metrics reported monthly into senior paediatric nurses meeting.	Jan-18	Complete	03/01/2018		09/01/18 - JF to provide database for evidence. Action to close and be monitored via CCN metrics.
4		Should		New		Community Services for Children and Young People	The service should ensure all policies are reviewed and up-to-date.	All out of date guidelines to be reviewed and updated. Process to be developed for on-going monitoring and updating.	1. All out of date guidelines to be identified. 2. Guideline to be allocated to relevant member of team 3. Database of guidelines to be developed	DD WCCSS	DDoN Children and Young People	NA	NA	NA	All guidelines updated and tracked via new process.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			15/01/18 - Deputy CGM in process of contacting professional leads and collating database.
5		Should		New		Community Services for Children and Young People	All staff members to keep within professional boundaries.	All staff members to keep within professional boundaries.	1. Issue raised in the relevant team. 2. Communication provided for team in relation to maintaining professional boundaries. 3. To be discussed in relevant team meetings.	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	All staff members to keep within professional boundaries.	NA	Jan-18	Complete			15/01/18 - copy of information provided in relation to professional boundaries evidence of discussion at ward meeting to be provided as evidence.
7		Additional		New		Community Services for Children and Young People	School nursing waiting times were up to 5 months for routine patients.	Waiting times for routine referral to School Nursing to be bought into line with RTT times	1. Review of current referral criteria and process 2. Review of intervention pathways	DD WCCSS	Professional lead school nursing	NA	NA	NA	Evidence of referral numbers and waiting times	Community Children's Quality Team	Aug-17	Action completed August 2017			

8		Additional		New		Community Services for Children and Young People	The service sickness rate was 7%, which was above the trust of 3.39%.	All sickness and absence will be managed in line with the Trusts Attendance Policy	1. Professional leads to receive a weekly report with sickness and absence rates. 2. Communication with relevant team leads regarding stages of sickness and absence and current plans. 3. Sickness and absence rates and compliance with the policy to be monitored via service review process and service quarterly reviews.	DD WCCSS	Care Group ToT (comm) WCCSS	NA	ESR	NA	Evidence of attendance management and sickness / absence reports.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			
9		Additional		New		Community Services for Children and Young People	Mandatory training was below Trust target of 90%.	Mandatory training for all community children's services to be ≥ 90%	1. Professional leads to receive a weekly report with mandatory training rates. 2. Communication with relevant team leads regarding performance and compliance. 3. Mandatory training rates to be monitored via service review process and service quarterly reviews.	DD WCCSS	Care Group ToT (comm) WCCSS	NA	ESR	NA	Evidence of mandatory training reports showing compliance.	Community Children's Quality Team	Jun-18	Action commenced Jan 18			
10		Additional		New		Community Services for Children and Young People	Concerns in regards to the security of FP10s in the CCN team.	FP10s will remain secure as per Trust guidance.	1. FP10 policy to be communicated with all staff who prescribe independently.	DD WCCSS	DDoN Children and Young People	NA	Pharmacy	NA		Community Children's Quality Team & Paediatric governance meeting		Action commenced Jan 18			15/01/18 - CW contacted LP, awaiting ratification of FP 10 SOP and update of non-medical prescribing policy.
11		Additional		New		Community Services for Children and Young People	A lockable fridge had not been provided at one of the special schools.	This is the responsibility of the local authority. The fridge has now been purchased by the school.	NA	NA	NA	NA	NA	NA	NA	NA	NA	Complete			
12		Additional		New		Community Services for Children and Young People	Record keeping audit within the school nursing and SLT services highlighted areas for improvement.	Record keeping audits will show improved compliance with record keeping standards.	1. All community children's areas to undertake a baseline record keeping audit in February 2018. 2. Deficits in practice to be identified and action plan developed. 3. Re-audit in 6 months post implementation of action plan.	DD WCCSS	Care Group ToT (comm) WCCSS	NA	NA	NA	Improved compliance with record keeping standards.	Community Children's Quality Team & Paediatric governance meeting	Aug-18	Action commenced Jan 18			
13		Additional		New		Community Services for Children and Young People	Cleanliness audit at the CDC showed a compliance of 83%.	Audit of cleanliness at CDC will show improved compliance of ≥ 90%.	1. Cleanliness audit to be undertaken and any deficits identified and action planned.	DD WCCSS	CGM community children's	NA	NA	NA	Improved compliance with cleanliness standards.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			
15		Additional		New		Community Services for Children and Young People	Nursery nurses in health visiting team had to use personal phones for lone working.	All nursery nurses to be provided with Trust mobile phones.	1. Mobile phones to be procured and distributed.	DD WCCSS	Professional lead health visiting	NA	NA	NA	All nursery nurses have trust mobile phone.	Community Children's Quality Team	Jan-18	Complete			
16		Additional		New		Community Services for Children and Young People	Staff were aware of trusts major incident policy but had not received any specific training.	Staff to be aware of their role in relation to a major incident	1. Business continuity plans to be reviewed for community children's services. 2. Review of major incident plan in relation to community children's services. 3. Staff to be provided with information in relation to their role.	DD WCCSS	Care Group ToT (comm) WCCSS	NA	NA	NA	Staff have received relevant written information.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			
17		Additional		New		Community Services for Children and Young People	87% of staff had received an appraisal, below the trust target of 90%.	Appraisal rates for all community children's services to be ≥ 90%	1. Professional leads to receive a weekly report with IPDR rates. 2. Communication with relevant team leads regarding performance and compliance. 3. IPDR rates to be monitored via service review process and service quarterly reviews.	DD WCCSS	Care Group ToT (comm) WCCSS	NA	ESR	NA	Evidence of IPDR reports showing compliance.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			
18		Additional		New		Community Services for Children and Young People	SOPs for CCNs are in a folder out of date and not signed	All SOPs to be available for review and evidence of sign off by staff.	1. Signature sheet for confirmation of sign off by staff to be available in SOP file. 2. All SOPs to be the most up to date copy.	DD WCCSS	Matron paediatrics and neonates	NA	NA	NA	Evidence of signature sheet.	CCN metrics reported monthly into senior paediatric nurses meeting.	Jan-18	Complete			15/01/18 - JF / CY to provide copy of signature sheet for evidence.
19		Additional		New		Community Services for Children and Young People	PALS leaflets not available in community settings	PALS leaflets to be available	1. Appointment letters to be reviewed to ensure they make reference to PALS. 2. PALS leaflets to be available in all community settings / clinics. 3. Community staff will have PALS leaflets when on home visits. 4. PALS leaflet for young people to be	DD WCCSS	DDoN Children and Care Group ToT (comm) WCCSS	NA	PALS	NA	PALS leaflets available in community settings and home visits.	Community Children's Quality Team	Apr-18	Action commenced Jan 18			
20		Additional		New		Community Services for Children and Young People	No strategy was available for community children's services (Adult district nursing strategy had been provided by trust in error)	Reviewed strategy to be produced in line with the Trusts quality commitment.	1. Strategy to be reviewed. 2. Strategy to be updated in line with quality commitment. 3. Strategy to be shared with staff.	DD WCCSS	DDoN Children and Care Group ToT (comm) WCCSS	NA	NA	NA	Strategy ratified via Community Children's Quality Team and WCCSS DQT.	Community Children's Quality Team and WCCSS DQT	Apr-18	Action commenced Jan 18			
		Must		New	Safe	Outpatients and Diagnostic Imaging	Patients medical records are kept secure at all times			DMD WCSS	Divisional ToT WCSS										
		Should		New	Well Led	Outpatients and Diagnostic Imaging	Review how staff review, document and update risks and progress against action plans.	To ensure that the Diagnostic imaging risk register if up to date at all times, detail risk , mitigation and actions, and reflective of current position.	Regular risk review is in place within the Division and imaging services. This involves divisional and care group confirm and challenge meetings. These will be planned for the next 12 months with meeting minutes formulated for assurance of DQT and TQE.	DMD WCSS	Divisional ToT WCSS	Time to undertake confirm and challenge. Governance support	Imaging Team and Governance	Compliance and engagement of staff but motogated through clear communications and involvement	Confirm and challenge notes and action log.	Imaging Services Quality Team and Divisional Quality Team	1st September 2018	Green			Plan on a Page also provided
		Should		New		Surgery	The hospital should consider reviewing the developmental opportunities available for junior physiotherapists.			DMD WCSS											

	Regulation	*As described in the report*			*Please complete this when reviewing the issue*		*As described by the CQC*	*Translate the CQC issue into a meaningful, SMART, objective*	*Describe the steps that need to be taken to achieve the desired outcome*	*Who is responsible for this completing step?*		*Describe the resources required to complete this action*	*Who else needs to be involved in this step – either to achieve it or will be affected by it?*	*What are the challenges, barriers or risks to completing this action step?* *Risk no. if available*	*Explain how you will know that the action has been completed and is successful in achieving its purpose*	*Where is this action overseen and the evidence tested*	*A realistic date for completion*	*Red = Action will not be completed / effective* *Amber = behind target* *Green = On target*		*Hyperlink to evidence store* *Do not embed documents*	*Include any relevant information on progress, new challenges, resources required etc.*
No.	**Regulatory breach**	**Must do / Should do**	**Quality Commitment ref.**	**New / Old PCIP**	**CQC Quality Domain**	**Core Service**	**Issue**	**Objective**	**Action**	**Accountability**	**Operational Lead**	**Resources required**	**Stakeholders**	**Constraints / Risks**	**Measures**	**Oversight / Assurance group**	**Due date**	**Status**	**Date completed**	**Evidence of completion**	**Comments**
	12 - Safe care and Treatment	Regulation	S9	New		Corporate	12 (2) (a) Venous Thromboembolism assessments were not carried out for all patients at risk.		Plan on a Page provided	Medical Director	MD Business Manager										
	12 - Safe care and Treatment	Regulation		New		Critical Care	12.(2) The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.	Consider how to effectively identify and manage all infectious patients in the critical care wards given the lack of appropriate isolation facilities.	• Revise standard operating procedure for the management of infectious patients within ITU requiring isolation which includes additional space made available to isolate patients • New build replacement for ITU and HDU which will have 8 single accommodation facilities – due for completion in October 2018	Medical Director	DDN Surgery	Resources are described in the business case for the new build			Audit of compliance with the SOP Delivery of the new build ITU project and full implementation of the new operating procedure.						
	17 - Good Governance	Regulation		New		Corporate	17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Staff were not consistently completing patient records. There were trust documentation that was not completed and staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.	To maintain securely an accurate and complete contemporaneous record to include signature, date, time, name, title and all notes are legible.	Plan on a Page provided	Medical Director	Divisional ToTs										
		Should		New		End of life care	All staff must ensure they are up-to-date and aware how to complete EoLC documentation.			Medical Director	Divisional ToTs										
		Should	S3	New		Surgery	Continue with improvements in managing deteriorating patients.	Improvments to continue with the care of the deteriorating patient which will be evidenced in the recording of timely observations and where necessary timely escalation and review by clinician	1. All clinical staff will continue to have deteriorating patient and sepsis as part of both clinical update and Resuscitation training. 2. Monthly data capture from Vital Pac regarding all observations carried out timely 3. Review of data from Vital Pac regarding patients with a NEWS of 5 for a deep dive into timelness of next observations carried out and recorded.random audit 4. Monthly ward deep dive audit to monitor patients NEWS of 5 and above for timely escalation and review by clinician 5. Feedback to Wards and individual clinicians good points and learning from audits. 6. Review of incident forms with the category of deteriorating patient for lessons learnt. 7. Mortality reviews, particularly sepsis mortality to identify good points, learning points etc. 8. learning from Sepsis CQUIN audits shared across the organisation and if necessary incident reported to ensure review and learning identified	Medical Director	CD - Emergency and Acute Care / Senior Nurse Quality and Safeguarding	Time for auditing and report production	all clinical staff	1. Capacity of staff to ensure timely obs and review 2. IT system failure, however this is mitigated by paper based recording but may see an error in the data capture	1. Reduction in clinical incidents regarding deteriorating patient. 2. improvement in audits.	Resus Committee, Trust Quality Executive, Quality and Safety					

	Regulation	*As described in the report*			*Please complete this when reviewing the issue*		*As described by the CQC*	*Translate the CQC issue into a meaningful, SMART, objective*	*Describe the steps that need to be taken to achieve the desired outcome*	*Who is responsible for this completing step?*		*Describe the resources required to complete this action*	*Who else needs to be involved in this step – either to achieve it or will be affected by it?*	*What are the challenges, barriers or risks to completing this action step?* *Risk no. if available*	*Explain how you will know that the action has been completed and is successful in achieving its purpose*	*Where is this action overseen and the evidence tested*	*A realistic date for completion*	*Red = Action will not be completed / effective* *Amber = behind target* *Green = On target*		*Hyperlink to evidence store* *Do not embed documents*	*Include any relevant information on progress, new challenges, resources required etc.*
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	17 - Good Governance	Regulation		New		Community Services for Children and Young People	10(1), 10(2)(a). - Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records.	see CYP		Trust Secretary	DDN Children and Young People										

Plan ID	Your Ref	Plan Name
1647	Corp21	Appropriate Medication Storage
348	EST3a	Availability Of Medical Equipment
869	WCSS9	Consider Use Of Specialist Midwives
954	Surg 1	Data Quality Of PTL & PAS
1657	Corp2022	Drug Fridge Temperatures & Security
1839	CG2	Duty Of Candour Training
2188		End Of Life Care Pathway
1069	Corp3	Ensure Adequate Qualified Staffing Levels
1984	MLTC23	Ensure Saline Flushes Appropriatly Prescribed
1899	MLTC11	EoL Identify & Achieve Preferred Place of Care
1874	MLTC6	EoL Pts Have Anticipatory Meds Supplied
2763	MLTC9 A	EoL Use Of Advance Planning
2758	MLTC9 B	EoL Use Of Amber Care Bundle
1854	CG4/7	Feedback For Reported Incidents
336	EST2	Fire Exits Safety
1834	CG1	Governance Of Incident Reporting
1142	WCCSS20	Implement Maternity Safety Thermometer
939	WCCS13	Improve Breastfeeding Support To New Mothers
979	Surg 12	Improve Pt Flow To Reduce CCU Delay Discharges
924	WCCSS11	Induction Of labour & C Section Rates Reduction
969	Surg 8	Morbid & Mortality Reviews For All Crit Care Pts
2186		Risk Management
354	EST1	Safe Storage & Access To Medical Equipment
874	WCCSS10	Support & Improve Active Birth
1066	Corp1	Timeliness Of MCA DOLS DNACPR
999	WCCSS17	Trust Guidelines To Inc NICE & Best Practice
1125	Corp 16	Review Major Incident Training
1879	WCCSS36	Review RCA and M&M Processes In Children's
1386	MLTC24	Robust Fluid Balance Recording & Monitoring

Open projects extracted from PM3

Workflow Status	Plan Type	Plan Owner	Planned Start	Overall
Active	Project	Jane Hayman	16/08/2016	Green
Active	Project	Jane Sillitoe	08/08/2016	Green
Active	Project	Katie Wardle	25/01/2016	Amber
Active	Project	Chris Harris	25/01/2016	Amber
Active	Project	Jane Hayman	16/08/2016	Green
Active	Project	Christopher Rawlings	16/08/2016	Green
Active	Project	Jane Sillitoe	04/10/2016	Green
Active	Project	Gaynor Farmer	24/08/2016	Red
Active	Project	Katie Wardle	16/08/2016	Green
Active	Project	Joyce Bradley	16/08/2016	Amber
Active	Project	Joyce Bradley	16/08/2016	Green
Active	Project	Joyce Bradley	16/08/2016	Amber
Active	Project	Joyce Bradley	16/08/2016	Amber
Active	Project	Christopher Rawlings	16/08/2016	Amber
Active	Project	Jane Sillitoe	05/08/2016	Green
Active	Project	Christopher Rawlings	16/08/2016	Green
Active	Project	Katie Wardle	16/08/2016	Green
Active	Project	Jane Sillitoe	25/01/2016	Amber
Active	Project	Katie Wardle	25/01/2016	Amber
Active	Project	Jane Sillitoe	25/01/2016	Red
Active	Project	Jane Hayman	25/01/2016	Green
Active	Project	Jane Sillitoe	04/10/2016	Green
Active	Project	Jane Sillitoe	08/08/2016	Green
Active	Project	Katie Wardle	25/01/2016	Green
Active	Project	Zena Young	24/08/2016	Amber
Active	Project	Om Sharma	17/02/2016	Amber
Live	Project	Chris Harris	16/08/2016	Blue
Live	Project	Jane Sillitoe	16/08/2016	Blue
Live	Project	Julie Romano	15/08/2016	Blue

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 1st February 2018**
Report Title	Quality Commitment			**Enclosure No.: 6**
Lead Director to Present Report	Barbara Beal, Director of Nursing			
Report Author(s)	Chris Rawlings – Head of Clinical Diane Rhoden – Senior Corporate Nurse – Quality and Safeguarding			
Executive Summary	A progress report for the Quality Commitment is provided. This has been limited due to a several factors including the late and incomplete presentation of Divisional level Quality Commitments and lack of resource for programme management. • Divisional reports being reviewed to ensure cross-over with overall Trust Quality Commitment. • Proposed workshops with each division late January / early February 2018 to complete the Division's version and map the Trust / Divisional elements. • Similar support will be offered to the corporate leads for their improvement priorities • Where a pre-existing plan does not exist around a quality improvement, a 'Plan on a Page' template will be used to describe the aim of the improvement priority, how it will be implemented and how it will be measured. Recovery action will be taken including offering additional support to the Divisions and subject leads to complete the Quality Commitments and improve the plans to deliver the objective.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Trust Board is recommended to: NOTE – Report for Information.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Not Relevant</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Potential requirement for a programme manager for quality improvement initiatives</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Report received by the Trust Quality Executive and Quality & Safety Committee in December 2017.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Actions as described in the report</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

1. Introduction

The Trust's Quality Commitment was created to bring together improvement aims, covering the three quality domains of safe, effective and caring, from many sources, into one place to bring focus to the Trust's improvement work.

The Quality Commitment was revised for the 2017/18 year and a 'RAG' rated report was produced in September 2017. This was received well by the Board and Divisions. Three of the improvement priorities were also selected for inclusion in the Quality Account.

The Divisions agreed to produce personalised versions for their own areas of responsibility, agreed at their Divisional Quality Team / Board meetings for the October 2017 TQE meeting. The sources of assurance were agreed to be kept locally but described in a document similar to that which was provided with the Trust-wide Quality Commitment with evidence also being kept locally. The aim was to not over-engineer the process and create an unhelpful administrative burden. This exercise would show how the Trust's priorities were being implemented in the Divisions and also allow space for the Division's own quality improvement priorities to be included.

Other factors also need to be taken into account for the future development of the Quality Commitment:

- The CQC Inspection report and the resulting PCIP;
- the business planning cycle;
- other supporting or conflicting quality workstreams.

2. Q3 Position statement – December 2017

The Divisions provided Divisional Quality Commitments in varying stages of completion at the November TQE meeting. Two had improvement priorities which had been RAG rated. Assurance sources for all of them were in development. The reports are being reviewed by the corporate team to determine the cross-over with the Trust's Quality Commitment. Several of the corporately led improvements also require information to be provided in order to update them.

The September Quality Commitment report provided a RAG rated version for the Trust based on information available to the Director of Nursing, some of which was subjective.

As the Quality Commitment is still being revised to capture the current status, providing an inaccurate report with estimated status at this time would not be helpful. Section 3 of this report describes how this will be remedied.

3. Next Steps

Remedial action will be taken to bring the existing Quality Commitment report up to date.

- Further support will be offered to the Divisions to complete their Division's version and map the Trust / Divisional elements.
- Similar support will be offered to the corporate leads for their improvement priorities
- Where a pre-existing plan does not exist, a 'Plan on a Page' template will be used to describe the aim of the improvement priority, how it will be implemented and how it will be measured.

The Patient Care Improvement Plan (PCIP) has been produced in response to the CQC Inspection report.

- The draft PCIP has been provided for the January reporting round, followed by workshops to determine what services need to do to move from their new CQC rating to the next level, or to remain at 'outstanding'.
- The Deputy Director of Nursing is leading on the PCIP with support from other corporate teams
- Workshops will be arranged for February with an LIA approach being considered

Other activity has taken place which will inform the reporting of progress with the improvement priorities:

- Nurses mapping exercise – safe care during winter
- Business planning cycle – budget setting is currently under way

A review of the Trust's quality reporting process and timeline would be welcomed. Reporting within a 4 week period leads to congestion and late reports with little time to take action before the next report is due.

The Quality Commitment and other quality workstreams contain many individual projects and schemes which are independently managed without high level oversight or resource to monitor progress and produce reports. A programme manager to organise, manage and report on the range of quality improvement workstreams, including the Quality Commitment, should be considered in order to provide oversight, challenge, a clear reporting structure and a consistent approach across the board.

4. Conclusion

The Quality Commitment report is being plan. There is a piece of work to be completed to ensure that each of the elements of the Trust Quality Commitment are included within one or more of the Divisional Quality commitments so that the elements can be tracked and RAG rated. Due to winter pressures, the proposal is for workshops to be arranged late January / early February with each division to assist completion and ensure plans for assurance.

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 1st February 2018**
Report Title	Safer Staffing Report			**Agenda item: 9** **Enclosure No.: 7**
Lead Director to Present Report	Barbara Beal – Director of Nursing (interim)			
Report Author(s)	Barbara Beal- Director of Nursing (interim) Kara Blackwell – Deputy Director of Nursing			
Executive Summary	This report aims to set out the nursing safer staffing, quality, patient safety, and operational accountability and assurance status in relation to the nurse staffing skill mix/ratios on the medical and surgical inpatient wards and outline the level of risk/issues, mitigation and management of these risks and issues. The report outlines the review of the SNCT data, current skill mix and staffing ratios on the ward and comparison with ward budgeted establishments. The staffing data is also referenced against the national guidance in this report which shows some variation by ward/speciality but that for a majority of wards Registered Nurse to Patient ratios in the day, based on the currently agreed skill mix/WTE establishments rather than actual filled shifts exceeds the recommended 1:8 ratio outlined by NICE (2014) in relation to safe staffing with a majority of wards having a 1:6 or 1:7 ratio with the exception of the MFFD ward. WHT staffing data is also benchmarked against peer/Model Hospital data which provides a comparison of the Trust staffing in relation to peers and CQC good. This demonstrates that the Trust is in Quarter 1 (lowest 25%) for Care Hours per Patient Day (CHPPD); these results are impacted on by the current vacancies for registered nurses in the Trust. The report outlines the plans for a full review of the ward nursing ward workforce, realignment of nursing skill mix based on the evidence based approach and in collaboration with our ward managers and senior nurses, as well as finance. This review will triangulate all the workforce data, quality and safety KPIs (i.e. falls, complaints, pressure ulcers, sickness) working patterns, systems and processes around the management of rosters and staffing, as well as addressing nursing leadership and accountability within the clinical areas. The risks/issues and action plan to mitigate and address these are included in the report.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Trust Board is asked to note the report for information.			

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<tr><td><u>Report History</u></td><td colspan="2">Presented to the Executive Team meeting, Trust Quality Executive and Quality & Safety Committee in January.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">To progress the actions set out in the report.</td></tr>
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Safe Staffing Walsall Healthcare NHS Trust

1. Introduction

This report aims to set out the nursing safer staffing, quality, patient safety, and operational accountability and assurance status in relation to the nurse staffing skill mix/ratios on the medical and surgical inpatient wards and determine the level of risk, mitigation and management of those risks. This paper does not include the extra capacity wards and additional beds opened as part of the winter plan.

It is recognised, as reflected in the recent Care Quality Commission Report (CQC), that significant progress has been made in improving the quality and standards of care across the Trust. However whilst mindful of the Trusts financial position and recovery plan, it remains imperative that we strengthen our assurance on patient safety, quality, and continue our journey of improvement and embed these changes across the organisation to ensure sustained changes in quality and efficiency across the organisation. The delivery of safe, effective, high quality care necessitates that we have the right workforce, with the right skills to care for our patients and the regular review of our nursing skill mix and funded establishment is a key element of this. Therefore, in this report the Executive Director of Nursing has set out to the Trust Quality Executive and Trust Quality and Safety Committee the level of assurance on nurse safe staffing, quality and patient safety.

Whilst it is acknowledged that safe staffing is a complex area and has to take account of many factors it is incumbent on us all to match safe staffing to patients' needs. This report presents the current analysis of the nurse staffing within the medical and surgical wards, the identified risks and mitigating actions being taken to address this.

It is anticipated that the translation of the actions into 'business as usual' and the continued improvement in cultural shift, behaviours, professional responsibility and accountability and performance, as well as those in the rest of the organisation will in turn provide an increasing source of assurance to the Executive and Trust Board.

However this will require strong leadership, behaviours, accountability and responsibility to anchor the work we are undertaking if this is to succeed and assure the quality and safety of our patients and indeed our workforce going forward.

It is incumbent on us all to continue to mitigate and manage identified risks/issues, implement, embed and sustain the required actions/changes to assure patient safety. The actions being taken to manage the risks/issues set out in this report are intended to mitigate against this but cannot stand in isolation from the actions required from the rest of the organisation. This is linked to the Trust Board Assurance Framework and Corporate Risk Register, and is being aligned to the refresh of the Trust Quality Commitment and CQC Improvement Plan from Ward to Board to ensure that the 'right staff are in the right place, with the right skills in the right way at the right time'.

2. Nurse Staffing Review

Boards should carry out a strategic staffing review at least annually, aligned to the operational planning process or more frequently, if changes to services are planned (National Quality Board 2016). The key elements of this planning approach are:

- Using a systematic, evidence-based approach to determine the number and skill mix of staff required
- Exercising professional judgement in relation to ward staffing needs
- Benchmarking with peers (Care Hours per Patient Day via Model Hospital)
- Taking account of national guidelines, bearing in mind they are based on professional consensus

At WHT the Director of Nursing has presented the Safer Nursing Care Tool Report bi-annually to the Executive Committee.

2.1 The Safer Nursing Care Tool

At Walsall Healthcare NHS Trust, a bi-annual nurse staffing review is undertaken using the Safer Nursing Care Tool (SNCT, Shelford Group 2012). Undertaking the SNCT helps inform the review of the staffing establishments alongside professional judgement and benchmarking. Clear criteria for undertaking the review are outlined which include quality assurance of the acuity data collected. Despite this, there is always some variation in the data reflecting the seasonal aspects of acuity, the general variation in patient acuity and an element of reviewer interpretation of the acuity levels within the tool. Reconfiguration of wards can also make comparison of current and previous SNCT results problematic for some areas. The SNCT results from the reviews undertaken in January 2017 and September 2017 are outlined below which includes the adult medical and surgical wards, with the exception of Ward 7, as this is co-located with the cardiac intervention unit, AMU (Ward5/6) and 20B/C. The SNCT recommended WTE is based on a skill mix ratio of RN:CSW of 65:35, recommended by the RCN (2012) as ideal for ensuring good quality care.

Clinical Area	SNCT – SEPT 2017 Recommended WTE		Budgeted WTE- SEPT 2017		SNCT – JAN 2017 Recommended WTE		Budgeted WTE- JAN 2017	
	SNCT RN Sept 2017	**SNCT HSW Sept 2017**	**Funded RN Sept 2017** (excludes Band 7 Ward Manager)	**Funded HSW Sept 2017**	**SNCT Jan 2017**	**SNCT HSW Jan 2017**	**Funded RN Jan 2017** (excluding Band 7 Ward Manager)	**Funded HSW Jan 2017**
Swift	22.50	12.12	14.08	19.68	20.37	10.97	18.18	15.58
Ward 01	18.90	10.18	20.78	17.18	17.88	9.63	20.98	18.18
Ward 03	33.49	18.03	20.78	17.18	21.51	11.58	21.78	18.18
Ward 04	31.14	16.77	20.78	17.18	24.22	13.04	20.78	18.18
Ward 09	18.16	9.78	18.18	17.18	16.96	9.13	19.18	18.18
Ward 10*	11.91	6.42	12.99	9.39	21.20	11.42	19.18	15.58
Ward 11	21.36	11.50	18.18	14.58	18.41	9.91	19.18	15.58
Ward 15	24.12	12.99	18.18	14.58	20.32	10.94	19.18	15.58
Ward 16	20.13	10.84	18.18	14.71	17.72	9.54	18.68	14.59
Ward 17	25.67	13.82	18.18	11.99	18.98	10.22	19.18	12.99
Ward 20a	10.83	5.83	12.99	6.79	10.09	5.43	13.99	7.79
Ward 29	23.28	12.54	18.18	15.58	20.06	10.8	19.17	15.58
Total WTE	**261.49**	**140.82**	**211.48**	**176.02**	**227.72**	**122.61**	**229.46**	**185.99**
	402.31		**387.75**		**350.33**		**415.45**	

*Data for Ward 10 for September 2017 not comparable with January 2017 as Ward was previously a 24 bedded ward when audit undertaken in January and subsequently reduced to 15 beds when SAU was relocated.

2.2 Current skill mix/staffing ratios by Ward (Medicine and Surgery).

The table below outlines the current staffing ratios and skill mix for days and nights on the wards. These have been taken from the e-roster and confirmed by the Divisional Directors of Nursing.

Clinical Area	**Funded Beds**	**Days**		**Nights**		**Ratio RN:HCA**			**Care Staff : Patient(PT) Ratio DAY**		**Care Staff: Patient (PT Ratio NIGHT**		**Required WTE** (excluding Ward manager)	
		RN	**HCA**	**RN**	**HCA**	**Days**	**Nights**	**Overall**	**RN:PT**	**All Staff: PT**	**RN:PT**	**All Staff: PT**	**RN**	**HCA**
Swift (MFFD)	34	3	5	2	3	37.5 : 62.5	40 : 60	38.5 : 61.5	1 :11	1: 4.25	1:17	1 :6.8	12.99	20.78
Ward 01 (Stroke)	28	5	4	3	3	55.5 : 44.5	50 : 50	50 : 50	1 :5.6	1: 3.1	1: 9.3	1: 4.6	20.78	18.18
Ward 03 (Rehab Elderly)	34	4	5	3	3	44.4 : 55.6	50 : 50	46.7 : 53.3	1: 8.5	1: 3.7	1: 11.3	1: 5.6	18.18	20.78
Ward 04 (Acute Med, Elderly)	34	4	5	3	3	44.4 : 55.6	50 : 50	46.7 : 53.3	1: 8.5	1: 3.7	1: 11.3	1: 5.6	18.18	20.78
Ward 09 (T&O)	26	4	4	3	3	50 : 50	50 : 50	50 : 50	1: 6.5	1: 3.25	1: 8.6	1: 4.3	18.18	18.18
Ward 10 (exc SAU)	15	3	2	2	2	60 : 40	50:50	55.5 : 44.4	1: 5	1: 3	1: 7.5	1: 3.75	12.99	10.39
Ward 11 (Gen Surg)	25	4	4	3	2	50 : 50	60 : 40	53.8 : 46.2	1: 6.25	1: 3.25	1: 8.3	1: 5	18.18	15.58
Ward 15 (Gen Med)	28	4	4	3	2	50 : 50	60 : 40	53.8 : 46.2	1: 7	1: 3.5	1: 9.3	1: 5.6	18.18	15.58
Ward 16 (Gastro)	25	4	4	3	2	50 : 50	60 : 40	53.8 : 46.2	1: 6.25	1: 3.25	1: 8.3	1: 5	18.18	15.58
Ward 17 (Resp)	25	4	3	3	3	57 : 43	50 : 50	53.8 : 46.2	1: 6.25	1: 3.57	1: 8.3	1: 4.16	18.18	15.58
Ward 20a (Elective Ortho)	16	3	2	2	1	60 : 40	66.6 : 33.3	62.5 : 37.5	1: 5.3	1: 3.3	1: 8	1: 5.33	12.99	7.79
Ward 29 (Med Short Stay)	26	4	3	3	3	57 : 43	50 : 50	53.8 : 46.2	1: 6.5	1: 3.7	1: 8.6	1: 4.3	18.18	15.58
TOTAL													**205.19**	**194.78**

2.3 Comparison of Budgeted WTE and Required WTE based on current Skill mix/shifts patterns

Based on the current skill mix and shift patterns the comparison of budgeted WTE to required WTE for both RNs and HSW is outlined and shows that the current budgeted WTE exceeds that required for the current skill mix/shifts by 6.29WTE, but for HSW there is a 18.76 WTE deficit compared to budget (These ward budgets have not been reviewed/ reset since 2015 when the Trust made significant investments in the nursing workforce).

	Budgeted WTE RN	RN WTE (based on shifts)	Budgeted HSW	HSW (shifts)
Swift	14.08	12.99	19.68	20.78
Ward 01	20.78	20.78	17.18	18.18
Ward 03	20.78	18.18	17.18	20.78
Ward 04	20.78	18.18	17.18	20.78
Ward 09	18.18	18.18	17.18	18.18
Ward 10	12.99	12.99	9.39	10.39
Ward 11	18.18	18.18	14.58	15.58
Ward 15	18.18	18.18	14.58	15.58
Ward 16	18.18	18.18	14.71	15.58
Ward 17	18.18	18.18	11.99	15.58
Ward 20a	12.99	12.99	6.79	7.79
Ward 29	18.18	18.18	15.58	15.58
Total	**211.48**	**205.19** (+6.29)	**176.02**	**194.78** (-18.76)

2.4 Benchmarking with Peers

2.4.1 Comparison with a Peer Organisation

The table below outlines the skill mix and staffing ratios by ward speciality in peer organisation within the West Midlands

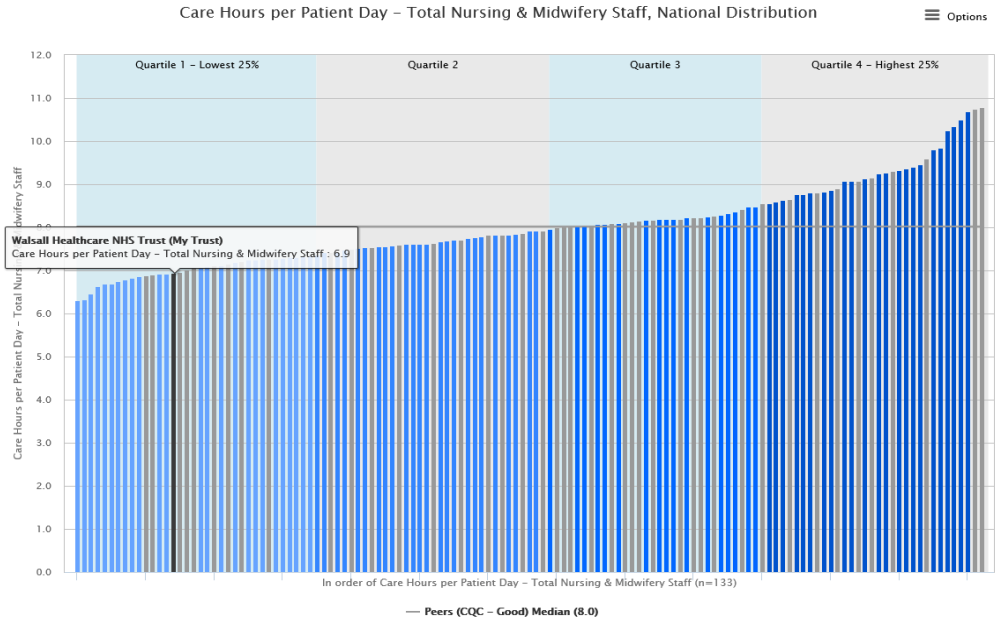
Clinical Area	Ratio RN:HCA			Care Staff : Patient(PT) Ratio DAY		Care Staff: Patient (PT Ratio NIGHT	
	Days	Nights	Overall	RN:PT	All Staff: PT	RN:PT	All Staff: PT
Respiratory (including NIV)	62.5: 37.5	62.5: 37.5	62.5: 37.5	1: 5.6	1: 3.4	1: 6.8	1: 4.25
Respiratory WHT	57: 43	50:50	53.8: 46.2	1: 6.25	1: 3.57	1: 8.3	1: 4.16
Stroke	66.6 : 33.3	66.6: 3.3	66.6: 33.3	1: 4.16	1: 2.77	1: 4.16	1: 2.77
Stroke WHT	55.5: 44.5	50:50	50: 50	1 :5.6	1: 3.1	1: 9.3	1: 4.6
Gastro	66.6 : 33.3	60: 40	63.6: 36.4	1:6	1:4	1:8	1: 4.8
Gastro WHT	50:50	60:40	53.8: 46.2	1: 6.25	1: 3.25	1: 8.3	1: 5
Elderly Gen Med	55.5: 44.5	44.5: 55.5	50:50	1:6.8	1: 3.7	1: 8.5	1: 3.7
Elderly Gen Med WHT	44.4: 55.6	50:50	46.7: 53.3	1: 8.5	1: 3.7	1: 11.3	1: 5.6
General Surgery	57:43	60:40	58.3: 41.7	1:6	1: 3.43	1:8	1:4.8
General Surgery WHT	50:50	60:40	53.8: 46.2	1: 6.25	1: 3.25	1: 8.3	1: 5
T&O	55.5: 44.5	50:50	60:40	1:6.6	1: 3.66	1:11	1: 5.5
T&O WHT	50:50	50:50	50:50	1: 6.5	1: 3.25	1: 8.6	1: 4.3

Comparison of the speciality wards at WHT with the peer organisation do not show much variation, although there are some specialities which require further analysis alongside the SNCT data, and other measures of safe staffing and national guidelines.

2.4.2 Model Hospital - Safe Staffing Comparison

The model hospital dashboard makes it possible to compare peers using Care Hours per Patient Day (CHPPD). CHPPD give a picture of the total workforce but it is also split between registered nurses and health support workers. While the summary CHPPD measure includes all care staff, the registered nurse hours must also be considered in any benchmarking alongside quality care metrics in order to assess the impact on patient outcomes. The data below outlines the CHPPD for Walsall Healthcare NHS Trust in comparison to the National Median, and the median for CQC Good Organisations. This data is presented in relation to overall CHPPD (Registered and HSW), CHPPD for Registered Nurses and CHPPD for Health Support Workers. The CHPPD for Walsall healthcare NHS Trust are also compared with Peer organisations and across the West Midlands to aid comparison across the local health economy.

Care Hours per Patient Day (CHPPD) Nursing & Midwifery (including Registered and HSW)

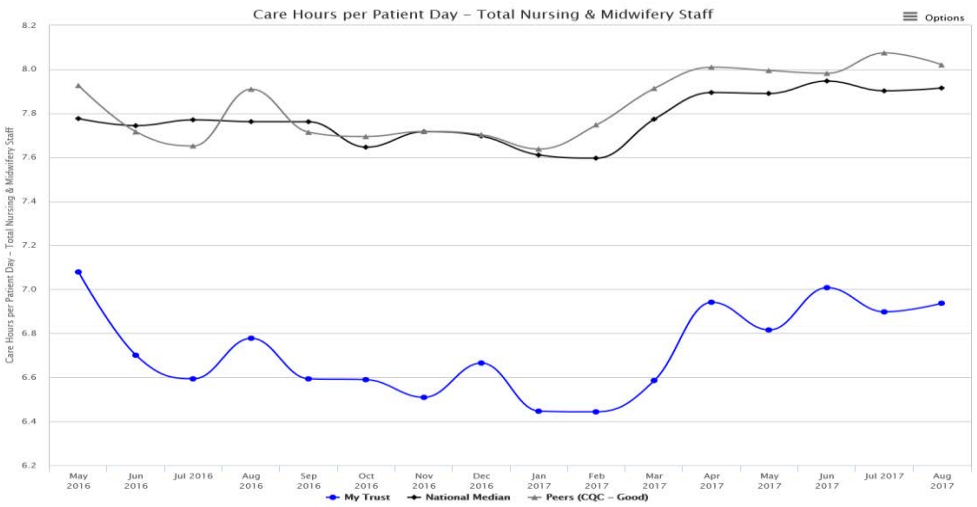


The Model Hospital Safe Staffing data available (May-Aug 17) shows that in relation to CHPPD for Nursing and Midwifery (Registered and HSW) the Trust is:

- In the lowest Quartile for CHPPD for Nursing and Midwifery staff (including HSW) with a median of 6.9
- CHPPD for Nursing and Midwifery staff in National Peer Organisations (CQC Good) median is 8.0

CHPPD Nursing & Midwifery comparison with Peer organisations:

- Morecombe Bay (Peer Organisation & CQC Good) : Median 7.6

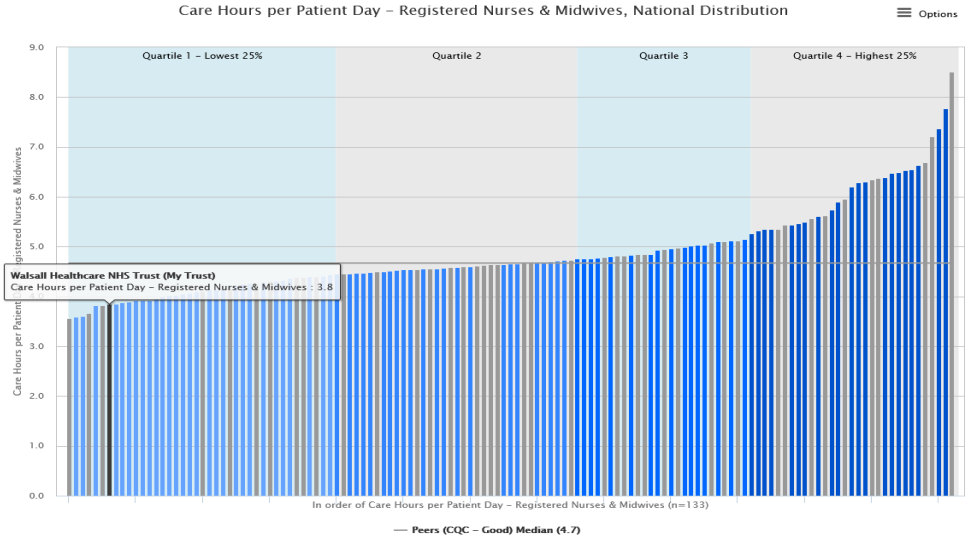


CHPPD Nursing and Midwifery comparison with Acute Trusts across the West Midlands:

- Burton NHS Trust: Median 7.8
- George Elliott NHS Trust: Median 8.0
- Dudley Group: Median 8.8
- SWBH: Median 7.6
- Royal Wolverhampton NHS Trust: Median 7.3

The Trend for Nursing & Midwifery (RN & HSW) CHPPD for the last 16 months (May 16-Aug 17) shows that WHT CHPPD has improved over the last 6 months to its highest since May 16 however, it consistently trials well below both the National and Peer CQC (Good) organisations

Safe Staffing Model Hospital Care Hours per Patient Day (CHPPD) Registered Nurses

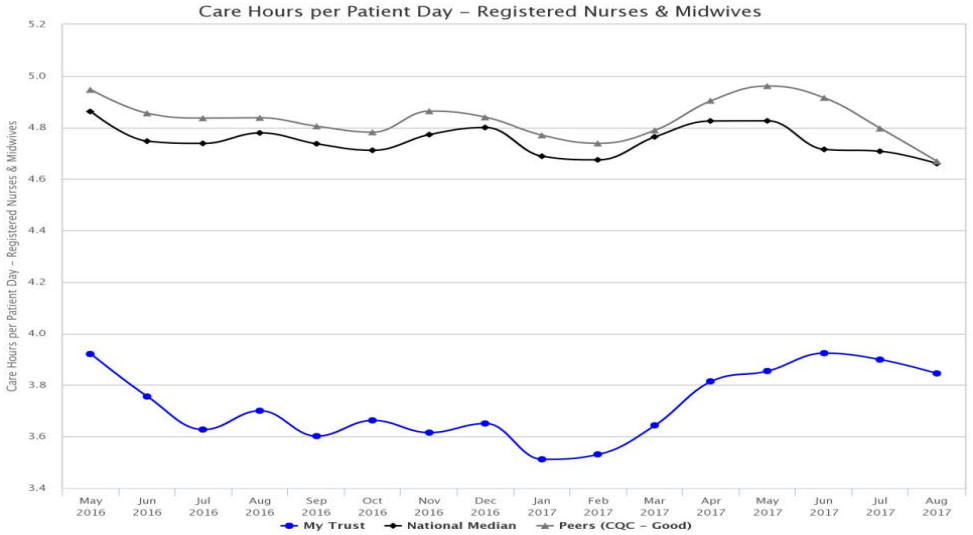


CHPPD for Registered Nurses shows that the Trust is:

- In the lowest Quartile for CHPPD for RNs with a median of 3.8
- CHPPD for RNs Peer Organisations comparison shows a median of 4.7
- CHPPD for RNs shows a National Median of 4.7

CHPPD for RNs comparison with Peer organisations shows:

- Morecombe Bay (Peer Organisation and CQC Good): Median 4.3

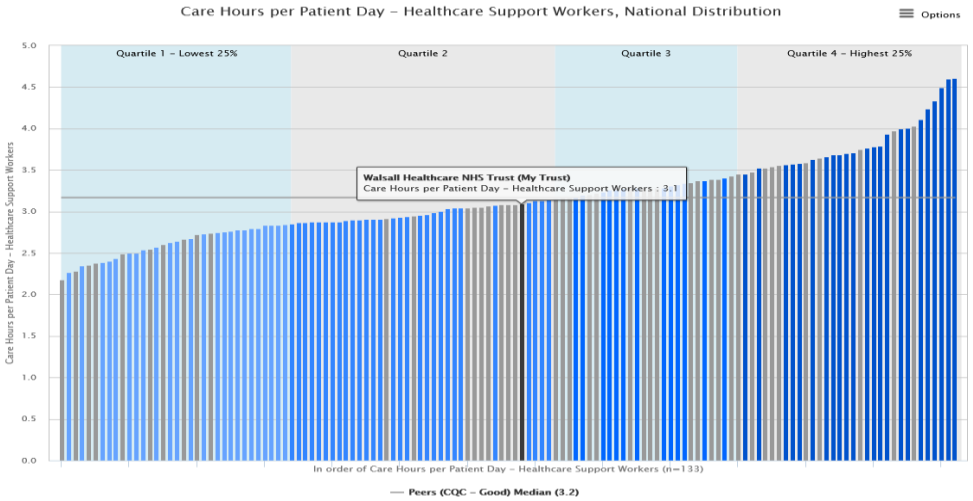


CHPPD for RNs comparison with the Acute Trusts across the West Midlands:

- Burton NHS Trust: Median 5.0
- George Elliott NHS Trust: Median 4.9
- Dudley Group: Median 4.8
- SWBH: Median 4.8
- Royal Wolverhampton NHS Trust: Median 4.5

The trend in CHPPD for RNs in WHT shows this has steadily improved from its lowest point in January 2017 but it has consistently trialled well below both the National and Peer CQC (Good) organisations

Safe Staffing Model Hospital Care Hours per Patient Day Health Support Workers (HSW)

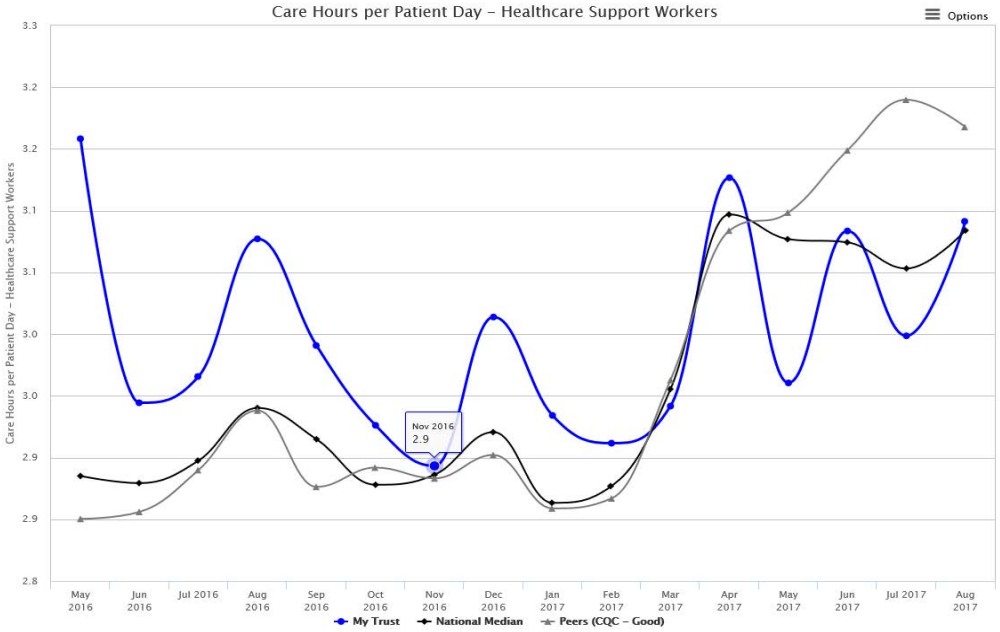


CHPPD for Health Support Workers (HSW) shows that Trust is:

- In the Upper Quartile 2 for CHPPD for HSW with a median of 3.1
- Comparison of CHPPD for HSW in Peer Organisations shows a median of 3.2
- CHPPD for HSW Nationally shows a median 3.1

CHPPD for HSW comparison with Peer organisations shows:

- Morecombe Bay (Peer Organisation and CQC Good): Median 3.3



CHPPD for HSW comparison with the Acute Trusts across the West Midlands:

- Burton NHS Trust: Median 3.3
- George Elliott NHS Trust: Median 3.1
- Dudley Group: Median 4.0
- SWBH: Median 2.8
- Royal Wolverhampton NHS Trust: Median 2.8

The CHPPD trend over the last 16 months for HSWs shows that the HSW CHPPD was significantly higher than both the Peer Organisations and National median until March 2017. HSW care hours significantly increased, both nationally and in CQC Peer Good organisation over the last 6 months meaning the Trust trend for CHPPD for HSW has been equivalent to/below the National Median and below the CQC Good since May 2017.

2.5 Comparison with National Guidelines

2.5.1 The Supervisory Ward Nurse Manager

The inquiry report into Mid-Staffordshire NHS Trust (Francis 2012) made specific recommendations in relation to the ward nurse managers outlining that:
"Ward managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as role model and mentor, developing clinical competencies and leadership skills within the team"
Ward managers at WHT are supervisory and not included in the direct care nursing establishments for the ward, however, there is variation in work patterns and role deliver which require standardisation and clarification across the clinical areas to ensure the role delivers the needs of patients, staff and the service as a whole.

2.5.2 National Guidelines, Skill Mix/Staffing Ratios

The RCN published guidance on staffing which presented the positive association between registered nurse levels and patient outcomes; with more registered nurses meaning better patient care, increased patient safety and improved patient experience (RCN 2010, 2012). The correlation between the ratio of registered nurses to patients in relation to quality of care was further supported by the Safe Staffing Guidance (NICE 2014) which outlined the ratio of one nurse to more than 8 patients as evidence of the point at which there is an increased risk of harm during day shifts. Comparison of the Trust RN : Patient ratio shows that for most areas on days the staffing ratios exceed the 1:8 ratio. There is some variation on nights and by speciality.

3.0 Safe Staffing- Internal Audit Assurance Report

A recent internal assurance audit was undertaken in October 2017 with regards to safe staffing. A copy of the final report is awaited and any recommendations from this audit will be added to the action plan below.

4.0 Conclusion, Recommendations and Action Plan

- Following the initial review of the SNCT data, current skill mix and staffing ratios on the ward, comparison with ward budgeted, benchmark comparison with peer organisation/Model Hospital data demonstrate that there now needs to be a full review of the ward nursing ward workforce, realignment of nursing skill mix based on the evidence based approach
- This review needs to triangulate all the workforce data, quality and safety KPIs (i.e. falls, complaints, pressure ulcers, sickness) working patterns, systems and processes around the management of rosters and staffing, as well as strengthening nursing leadership and accountability within the clinical areas.
- Whilst there is no one definitive single ratio of staff to patient that can be applied across all acute adult wards, "the biggest safeguard we have got to ensure great quality of care is the registered nurse" (May 2016), a robust

recruitment and retention plan around registered nurses also need to be implemented

- To complete and implement the findings of the clinical nurse specialist review to ensure that they are included in the clinical expert resource to the in-patient ward areas in medicine and surgery
- To ensure that the development and management of the nursing resource across in patient wards is safely and consistently applied
- To implement the 'Real Time Roster Pro dashboard, Standard operation procedure and hold wards, care groups and divisions to account
- To ensure that the Nursing and Midwifery Workforce Plan and rotas reflect the emergent new roles going forward including Trainee Nursing Associates, Apprentice nurses, and ANP where appropriate

These actions are outlined in the risk and mitigation action plan included below.

Risk, Mitigations and Actions:

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
Safer Nursing Care Tool Staffing Review, current roster skill mix profile and alignment to ward budgets and to determine potential impact on quality and safety, as well as finances	Moderate assurance on the findings, analysis and questions about the reliability of the data.	Initially Reported requirement to review the September 17 SS Establishment Review to Executive 24th December 17 by DON, and reported to NHSI, CQC regulatory meetings and Trust Quality Executive and SNMAG December 17. Paper presented to Executive 9th January 2018	8th January 2018	DON	Green
		Repeat Safer Staffing Establishment Review and wider triangulation of sources to be undertaken and completed February 18 Review undertaken by DON and Deputy DON of the SNCT data, alongside benchmark data, peer data and professional judgement alongside triangulation of quality data, CNS and wider workforce review	1st March 18 1st March 18	DON/DDON DON/DDON	
		Following above review, agreement with senior nurses/ward sisters of skill mix, and recommended establishments	14th March 18	DON/Senior Nurses	
		Agreement of budgets and budget realignment with Finance Leads and sign off of budgets	30th April 18	DON/DOF	
		Divisional Senior Nursing Workforce Working Arrangements under review to ensure consistent senior nurse presence in clinical areas	31st March 18	DON/DDON	

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
		Review of Staffing Policies	31st March 2018	DON/HR Director	
		Implementation of recommendations from Internal Audit Review of Safer Staffing 2017	31st March 18	DON/DDON	
		1. Policy and procedural guidance to be developed approved and circulated to relevant staff in respect of Safe Staffing Risk Management; to include an escalation policy to ensure that staffing establishments are met on a shift-to-shift basis and to include process for evaluating the impact of staffing on quality.	4th January 2018	DON/Senior Nurse Workforce	
		2. Reinforcement of Roster Policy rules to include rosters to be completed and signed off by Matron in accordance with Roster Policy and timescales. This will be monitored via the establishment of monthly staffing/roster management clinics	31st January 2018 (Policy developed and circulated, managers now need to be held to account)	DON/Divisional DONs/Senior Nurse Workforce	
		3. Quality Crosses notice boards to be reviewed by matrons for consistency, accuracy and completeness across wards	31st January 2018	DON/Divisional DON	

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
		4. Links between rostering, staffing levels, vacancies and quality are reported at Board level on a monthly. These are under-review to strengthen further and include all staffing quality matrix.	1st March 18	DON	
Nursing Workforce- Requirements to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe (identified in recent CQC report 2017 as a regulatory breach)	The Trust is currently facing persistent significant gaps in its Nursing Workforce due to high numbers of RN vacancies and operational vacancies due to sickness, maternity leave	Nursing Workforce work-stream established Oct 2017 supported by KPMG and Trust PMO in place	October 2017	DON	
		Nursing Workforce Review and Terms of Reference agreed by Executive and TQE, QEC December 17 to be progressed through the work-stream. Key priority for SNMAG and Divisions	31st March 2018	DON/Senior Nurses	
		Implementation on commencement of training offer letter to student nurses with necessary safeguards	31st December 2017	DON/HR Director	
		Reviewing Nursing Education and Training Needs Analysis, Commissioning intentions with HEE including New Roles, competencies including increased placements for Nursing Associates and work being progressed for Midwifery Support Workers	31st March 2018	Associate Director Nursing/HR Transformation lead	
		Robust strategy for recruitment and retention	31st March	DON/HR	

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
		of registered nursing staff required DON highlighted concerns to CQC, NHSI, and secured support from NHSI for Recruitment and Retention	2018	Director	
Leadership, Values, Behaviours and Culture	Strengthen leadership behaviours and culture of nursing staff/groups and the associated link with quality and patient outcomes	Under review and being addressed in line with the Trust Executive staff survey findings action plan Nursing and Midwifery Code of Conduct update sessions/workshops to be planned through SNMAG to set the standard of leadership and behaviours in line with values Development and implementation of a Nursing Accountability Framework	31th March 18 31st March 18	DON	
		Review of effectiveness of SNMAG , membership, TOR and core business/work programme	27th February 2018	DON/DDON	
		Review of interface, and team working between corporate nursing and divisions and vice versa – ongoing	31st March 2018	DON/DDON	
		Proposed Review of the level of leadership and development support required for -Band 7 ward managers, band 6 nurses and band 5 nurses through LiA	31st March 2018	DON/DDON	

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
		Take action where evidenced to address inappropriate professional standards and behaviour in line with Trust Policies and NMC	Ongoing	DON/Divisional DON/	
Bank and Agency Controls and Expenditure	Moderate assurance on Trust, Divisional and Care Group Bank and Agency Controls	Agreement with HR and FD to undertake a root and branch review of the Trusts internal controls and assurance on Bank and Agency. Ensuring consistency of operational, performance and financial data, analysis, cost and reporting	1st March 2018	DON/DOF/HRD	
		Implemented revised Standard Operating Procedure for Bank and Agency Controls including effectiveness and responsiveness of the Nurse Bank	31st January 18	DON/Senior Nurse Workforce, Divisional DON	
		Implemented Revised Standard Operating Procedure for Roster Controls and Processes, to include rosters developed and signed off by matron 6 weeks in advance, appropriate skill mixes, annual leave allocation, shifts out to bank 6 weeks in advance and Tier 1 agency 2 weeks in advance. To be monitored through implementation of roster management clinics and SNMAG	31st January 18	DON/Senior Nurse Workforce, Divisional DON	
		Re-launch of e-rostering staffing hub to enable real time management of staff utilisation	1st March 18		

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
		As offered by NHSI support to strengthen the Trust procurement and management of agency controls	31st March 18	DON/Senior Nurse Workforce	
		Undertaken and analysis of Trust Nurse Bank against NHSI proposed shared bank arrangements	31st January 18	DON/Senior Nurse Workforce	
Strengthen review and learning from Patient Safety incident	Established SI Review Group with Divisional Representation	Strengthen divisional attendance with clear TOR, implement and embed actions and learning and feedback loop to those who have reported risks.	27th February 18	Head of Clinical Governance	
		To monitor nursing SI etc more effectively through the professional section of the SNMAG, to be standard agenda item and to include effectiveness of actions implemented	31st March 18	DON	
		Standardised agenda item on Care group/Divisions Quarterly Reviews to include effectiveness of actions implemented and lessons learnt.	31st March 18	DON	
		Introduce Human Factors Behaviour training to band 6 nurses and above (first phase maternity and Paeds)	April 18		

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
Operational Capacity and demand on Performance and its subsequent Impact and Risks on Quality and Patient Safety	Inconsistent standards across Care Groups, Divisions and Trust for Flow whilst safeguarding and assuring the quality and safety of patients, and care – 'SAFER, RED TO GREEN' , 'Get up, get dressed, get moving'. Increase in Escalation levels and opening and closing of additional bed capacity to cope with demand, constant movement and transfer of patients and associated risks, boarding of patients, appropriate utilisation of discharge lounge, Mental Health Act, DoLS, IPC, Dementia, end of life care, deteriorating patient, VTE etc (significant impact of safer staffing, workforce issues, gaps, bank and agency, staff bank effectiveness, R & R etc highlighted earlier)	Review by ECIP/NHSI of how we are keeping patients safe during winter, positive and constructive feedback December 17. Input of Emergency Care Improvement Programme Team input commences 5th and 8th January 17 (Critical to support the required changes in systems, processes, efficiency and controls	31st January 2018	COO/DON	
		Risk review findings and actions of opening of extra capacity wards (Ward 12) and introduction of a standardised risk assessment tool	27th February 18	DON/Divisional DON	
		Four times daily review of nurse staffing through Divisional Nurses, Matrons and Deputy Director of Nursing utilising e-roster hub Establishment of a standardised approach to safety huddles	March 18	DON/Divisional DONs	
		Deputy DON aligned to support operational safety and performance as a % of her role from November 17	31stNovember 2017	DDON	
		Escalation and review of issues at daily bed meetings and through Internal incident reporting systems and processes and SNMAG from November 17 ongoing	31st January 2018	DON/COO	

Risk/Issue	Current State January 18	Action Being taken to Mitigate and Manage Risk	Timeframe for Completion	Person Responsible	RAG Rated
Quality, Patient Safety Standards and Assurance	Quality and safety data is currently collected but not fully triangulated with staffing data	Dashboards to be revised and Divisional Nursing reporting templates for quality, safety and staffing to be developed and implemented at ward through to Divisional level via development of Nursing exception reports	27th February 2018	DON/DDON	
		Revision of Ward Review process to ensure corporate input as part of this process via DON/nominated rep attendance and following through with appropriate action plans Review of Peer audit proforma to include fresh eyes approach and in my shoes/15 steps approach to quality and patient experience	27th February 2018	DON	

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date:** 1 February 2018
Report Title	Report and Action Plan following Independent Review of the Care Received by Patient SH			**Agenda Item: 10** **Enclosure No.: 8**
Lead Director to Present Report	Barbara Beal, Interim Director of Nursing			
Report Author(s)	Kara Blackwell, Deputy Director of Nursing Garry Perry, Head of Patient Relations			
Executive Summary	An independent review of the care and treatment received by patient SH during their hospital from 28th July to 16th September 2013 was commissioned by the Trust in 2017. The terms of reference for the Independent Review included: • The medical and nursing care provided to patient SH • The management by the Trust of the complaint raised by the family on behalf of patient SH • The investigation process into patient SH's property The report into this review undertaken by Verita was received by the Trust in September 2017 and the report and action plan following the recommendations of this review were presented to Private Board and the Quality & Safety Committee in November 2017. Following a meeting held with SH family it was agreed that the report would be made public and is herewith attached.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Trust Board is asked to receive the Final Independent Patient Care Review Report and note updates to the action plan.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Not Relevant</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☐</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☐</td><td></td><td></td></tr>
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">N/A</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">N/A</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Report was shared at the Private Trust Board and Quality & Safety Committee in November 2017.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Actions to continue to monitored and updated as required.</td></tr>
</table>

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review of the care and treatment provided to Miss H in September 2013

A report for
Walsall Healthcare NHS Trust

September 2017

Authors:
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David Scott

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for regulated organisations.

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Contents

1. Introduction

1.1 This report gives an independent account of the care and treatment Walsall Healthcare NHS Trust ('the trust') gave Miss H during her admission to Walsall Manor Hospital from 28 July to 16 September 2013. The report is the output of an independent review which, in accordance with a set of terms of reference, has examined:

- the nursing and medical care the trust gave Miss H;
- the trust's management of a complaint Miss H's family made; and
- the management of a disciplinary investigation[1] the trust conducted into damage to Miss H's property.

1.2 Miss H was 63 years old during her admission. She was a patient with learning difficulties admitted after she had a fall at Hob Meadow, her care home in Great Wyrley. She was admitted on 28 July to Walsall Manor Hospital ward 1 (a stroke ward) via the A&E department. She was transferred to bay 2 on ward 14 (a general medicine ward) on 29 August 2013. From there she was discharged on 16 September 2013 to a residential unit (Harmony Care Home) in Walsall. During her time on ward 14 Miss H's much loved Reborn doll 'Rachel' was damaged extensively.[2] Her arm was cut, some of her hair pulled out, her eyelashes trimmed and her legs damaged. It is not clear whether the damage arose from single or multiple incidents.

1.3 The doll is likely to have been damaged during the night of Saturday 14 September or early morning of Sunday 15 September 2013. Miss H was deeply attached to Rachel and treated the doll as though it were her own child. A consultant psychiatrist who specialises in patients with learning difficulties told us that possessions and objects, such as dolls like 'Rachel' can hold great significance for patients with learning difficulties. Such possessions provide reassurance and often reduce anxiety.

1.4 Miss H's family identified the damage to Rachel on Sunday 15 September 2013 and complained to ward 14 staff. The nurse in charge notified the on-site manager. On Monday 16 September, the ward manager escalated the complaint to a matron and the trust's head of nursing for the medicine division, who started an investigation into the damage. This

[1]For the purpose of this report we refer to this process as the 'disciplinary investigation' although ultimately no evidence was found to warrant disciplinary action.
[2] Reborn dolls are manufactured vinyl dolls designed to resemble a human baby realistically.

initial investigation involved the trust's Patient and Liaison Service (PALS), a matron and a learning difficulties nurse. Miss H's family raised several concerns at the start of the initial investigation. These were:

- the trust had not told the family that Miss H was transferred from ward 1 to ward 14;
- Miss H's belongings went missing during the transfer;
- ward 14 staff were rude to Miss H and her family;
- Miss H said staff had put their fingers up her nose;
- ward staff nearly scalded Miss H with hot tea;
- ward staff threatened Miss H;
- ward staff had put pressure on Miss H's family to find a placement for Miss H;
- Miss H's pressure mattress did not work properly;
- Miss H had not been washed;
- Miss H had been left in soiled sheets; and
- the doll's arm had been cut off with scissors

1.5 Miss H's family was not satisfied with the outcome of the initial investigation and wrote to the Care Quality Commission (CQC) in September 2013. Miss H's family felt the trust had dismissed their concerns and not taken them seriously. The CQC referred the complaint to the trust's chief executive, and asked for further consideration to be given to the family's concerns. Shortly after, the trust's director of nursing appointed the director of governance at the time, to conduct a formal complaint investigation starting in September 2013.

1.6 The formal complaint investigation concluded in January 2014. The chief executive, chief executive of the trust reported the investigation's conclusions to Miss H's family in a letter dated 28 January 2014. In the letter, the chief executive apologised for the distress caused, accepted that the doll was deliberately damaged and that the standards of nursing care fell short of those the trust expects. The trust then tried to meet Miss H's family to discuss the conclusions but Miss H's family had instructed solicitors Leigh Day, to act on their behalf and prepare to bring civil proceedings against the trust. Leigh Day then became the legal representative of Miss H's family and the trust's point of contact with them. Miss H's family did not attend the proposed meeting to discuss the findings from the formal complaint investigation.

1.7 The trust excluded two members of ward 14 staff on 13 December 2013, pending disciplinary action[1], based on findings from the formal complaint investigation. These were a staff nurse, 'XY' and a bank clinical support worker. The bank clinical support worker's disciplinary case was dismissed because they were deemed not to match a description of the person that allegedly damaged the doll. Miss H and another patient on bay 2 of ward 14 gave the description during the formal complaint investigation. The trust launched a disciplinary investigation into XY in January 2014.

1.8 Miss H's family made a civil claim against the trust via Leigh Day under the Human Rights Act 1988, the Equality Act 2000, and for trespass to goods, assault and/or battery and negligence arising from the poor care and abusive treatment she received on ward 14. Miss H and her family alleged Miss H suffered degrading treatment on ward 14, that she received poor care, including a failure to make reasonable adjustments for Miss H's learning difficulties, that she was assaulted, and that her property had been deliberately destroyed.

1.9 The civil claim was settled out of court at a mediation meeting in London on 27 March 2015. The trust paid Miss H compensation and legal costs. The trust agreed to commission an external investigation into the care and treatment of Miss H as part of the settlement. The Parliamentary and Health Service Ombudsman (PHSO) was originally scheduled to conduct the investigation. However, the PHSO decided not to do so because the issue had been resolved locally and so did not meet its criteria for investigation. The PHSO referred the matter back to the trust on 17 February 2016.

1.10 In June 2016, the trust commissioned Verita to conduct the independent review. Once matters concerning information were resolved, the review started in January 2017. Verita is an independent consultancy that specialises in conducting investigations for regulated organisations. Ed Marsden, managing director, and Charlie de Montfort, senior consultant, led the review. Alison Pointu provided expert nursing input and David Scott provided expert HR input. Verita senior associate Lucy Scott-Moncrieff peer reviewed the report. Lucy is commissioner for standards in the House of Lords. Biographies of the team are included in appendix A.

1.11 Sadly, Miss H passed away on 20 June 2016. Her family gave us evidence during the review. We are grateful for their help and cooperation.

[1] The two members of staff were paid their salaries while they were excluded but they were prevented from working at the trust.

2. Terms of reference

2.1 The trust board commissioned this review as part of their general obligations to ensure the safety of health services and improve the quality of care for patients. The terms of reference were agreed between Miss H's family and the trust prior to the start of the investigation. They are in keeping with the agreement reached at the mediation in 2015. The review had no disciplinary remit.

1. To review and provide opinion on the nursing and medical care provided on ward 14 in September 2013 to include:

    a. Attention to the fact that Miss H has learning difficulties and has communication needs
    b. Medication administration including method of administering oral tablets and giving injections without prescription
    c. Empathy and compassion
    d. Timeliness of attention to physical needs (e.g. left in soiled sheets)

2. To examine and provide opinion upon the Trust's management of Miss H's family's complaint about the physical and psychological abuse of Miss H to include the initial response and ongoing handling.

3. To review the management and outcome of the disciplinary investigation carried out in relation to the damage to Miss H's property to include:

    a. Statements collected and disclosed/not disclosed
    b. Whether referral to the Nursing and Midwifery Council would have been appropriate
    c. Appropriateness of action taken with staff involved
    d. Whether previous and subsequent disciplinary action involving any of the staff was considered/should have been considered when reaching conclusions about appropriate action in Miss H's case

2.2 The recommendations should include measures which can support Walsall Healthcare NHS Trust in improving its response to concerns raised by complainants into practices and concerns regarding standards of care.

2.3 Before the review got underway we satisfied ourselves that the family had been able to contribute to the development of the terms of reference. They said that they had.

3. Executive summary and recommendations

Executive summary

Miss H's nursing and medical care

National context: people with learning difficulties and health needs

3.1 Growing evidence over the last 15 years has suggested that people with learning difficulties admitted to acute health care settings are at increased risk of avoidable harm and death.

3.2 Most patients find admission to hospital a difficult and stressful experience. People with learning difficulties are particularly susceptible to being anxious about the unfamiliar surroundings and activity of a busy general hospital. Miss H was moved between wards during her admission and so had to familiarise herself with two wards, sets of patients and staff. In this context, Miss H needed careful management and anxiety-reducing possessions such as Rachel would have been important to her.

Reasonable adjustments

3.3 Although ward 14 identified Miss H as having a learning difficulty, we found no evidence in the daily clinical records to suggest staff made reasonable adjustments for her.

3.4 Nurses working on ward 14 had limited or no knowledge of supporting people with learning difficulties, and did not meaningfully seek advice or help from Miss H's family or the learning difficulty nurse.

3.5 Miss H's family were inadequately involved in decisions about Miss H's care. A more collaborative approach between the healthcare professionals, Miss H and her family would have likely resulted in an improved experience for Miss H, her family and the staff on ward 14.

Miss H's nursing records

3.6 The notes clinical staff working on ward 14 wrote did not meet the standards of the NMC Code 2015. The clinical notes we reviewed often contained only basic information, did not always include the full date or time of the entry, included abbreviations (e.g. 'NIC' instead of 'nurse in charge') and the handwritten entries were often illegible.

3.7 Good records promote continuity of care through clear communication; demonstrate the quality of care delivered; and provide the evidence necessary for any legal proceedings. Poor records often reflect poor practice.

Medication administration including method of administering oral tablets and giving injections without prescription

3.8 The prescription charts for Miss H are unclear. Her chart for 28 July 2013, the day of her admission to Walsall Manor Hospital, shows haloperidol 1-2mg was prescribed as a 'when required medication', to be given either orally or via intramuscular injection routes.

3.9 The recording of administration of 'when required' medication to Miss H falls short of the standards the NMC sets out.

3.10 Because the route of administration is omitted from some of the records, there are three instances when haloperidol may have been given orally or by intramuscular injection.

Empathy and compassion

3.11 We found little evidence in the nursing notes of staff treating Miss H with appropriate empathy and compassion, particularly in response to her documented episodes of distress, agitation and restlessness.

3.12 The evidence we have reviewed suggests staff missed opportunities to demonstrate and document empathy and compassion in relation to the damage to Miss H's doll, Rachel. Miss H's patient notes record inadequate detail about the damage to Rachel, when it occurred, how it happened or how it had affected Miss H.

3.13 The damage to Rachel was only mentioned once in the clinical notes of the night of 14 September 2013 to morning or 15 September and was not recorded as an untoward incident. This suggests nursing staff on the ward had dismissed it as an unimportant event. This is how Miss H's family thought staff had perceived it.

The trust's management of the family's complaint

The initial complaint investigation

3.14 Miss H's family made an initial verbal complaint on Sunday 15 September 2013 at about 1.30pm with the nurse in charge of ward 14. The complaint concerned the altercation with XY on Friday 13 September 2013 about Miss H's protected meal times, and the damage to Rachel. Miss H and her family were understandably upset and concerned that Rachel was damaged with malicious intent.

3.15 The head of nursing for the medicine division started an investigation into the damage of the doll. This investigation involved the trust's Patient and Liaison Service (PALS), a matron, the ward manager and a trust learning difficulties liaison nurse.

3.16 After about a week and a half of investigation the head of nursing for medicine relayed their lack of findings to the trust's HR department and Miss H's family. HR told the head of nursing for medicine that no further investigations would be carried out due to a lack of evidence, in accordance with policy.

3.17 The trust wrote a formal response to Miss H's family in which it agreed with them that it appeared the doll had been deliberately cut with scissors. The trust agreed several actions with Miss H's family:

- to ensure that ward 14 staff allowed Miss H's family to help Miss H at meal times;
- to follow up the family's concerns with XY; and
- to apologise for the distress caused.

3.18 Our impression is that the initial complaint response and investigation was not as sympathetic as it should have been.

3.19 Ward staff should have notified Miss H's family with a phone call at the earliest opportunity on the morning of Sunday 15 September 2013, so that they were aware of the damage to Rachel before their arrival on the ward at lunchtime. The trust missed opportunities here.

3.20 Although the ward staff on Sunday 15 September did notify the on-site manager, escalation to the ward manager, who was off duty at the time, would have been proportionate and demonstrated a proactive response to the incident with the doll.

3.21 Furthermore, despite the ward staff telling the on-site manager on Sunday 15 September, the significance of Rachel was not conveyed. Our impression is that this is because the ward staff themselves did not adequately understand the significance of Rachel to Miss H.

The formal complaint investigation

3.22 Miss H's family was not satisfied with the outcome of the initial investigation and wrote to the Care Quality Commission (CQC) in September 2013.

3.23 We understand the family were dissatisfied about the initial investigation because trust staff lacked awareness of the significance of Rachel to Miss H and failed to recognise the needs of Miss H regarding her relationship with Rachel.

3.24 The CQC referred the complaint to the chief executive and asked for further consideration to be given to the family's concerns about the care and treatment given to Miss H on ward 14.

3.25 The trust's director of nursing appointed the director of governance at the time, to conduct a formal complaint investigation starting in September 2013.

3.26 The appointment of the trust's director of governance to lead the formal complaint investigation reflected the fact that the trust was taking the allegations seriously. This decision demonstrated that the trust was committed to doing its utmost to ascertain what had happened to Rachel and whether there was evidence for the concerns of Miss H's family.

3.27 Our impression is that the trust's formal complaint investigation was thorough and comprehensive. The depth of the investigation and the appointment of senior personnel to lead it show that the trust was not attempting to cover up the allegations Miss H's family raised.

3.28 Miss H's family acknowledge that they met the former director of governance at the start of the formal complaint investigation at Walsall Manor Hospital. Miss H's family are satisfied with the contact they received from her during the formal complaint investigation.

3.29 The formal complaint investigation concluded in January 2014. The chief executive reported the investigation's conclusions to Miss H's family in a letter dated 28 January 2014. He apologised for the distress caused and accepted that Rachel was deliberately damaged and that the standards of nursing care fell short of those the trust expects.

3.30 The trust excluded two members of ward 14 staff on 13 December 2013, pending disciplinary action[1], based on findings from the formal complaint investigation. These were a staff nurse 'XY' and a bank clinical support worker. The trust launched a disciplinary investigation into XY in January 2014. The bank clinical support worker's disciplinary case was dismissed because they were deemed not to match a description of the person who had allegedly damaged the doll. Miss H and another patient on bay 2 of ward 14 had given the description, during the formal complaint investigation.

3.31 During the formal complaint investigation Miss H's family continued to believe XY had damaged Rachel. This was in part due to the testimonies of Miss H and the other patient on bay 2, ward 14. Both described the physical characteristics of XY and a distinctive coloured bobble she wore in her hair.

3.32 However, during our review, interviewees said that the quality of the testimonies Miss H and the other patient provided would not have stood up in court. Both Miss H and the other patient died by the time we started our review so we could not interview them.

3.33 Miss H's family's view is that the formal complaint investigators themselves believed XY could have damaged the doll, given that they recommended the trust to exclude XY,

[1] The two members of staff were paid their salaries while they were excluded but they were prevented from working at the trust.

pending disciplinary action. Miss H's family allege that the investigators suggested to them that XY had damaged the doll during the formal complaint investigation.

3.34 The formal complaint investigators denied this and told us that based on their analysis it was possible XY damaged the doll, but there was insufficient evidence to conclude she had. This is the reason why the investigators recommended that a further disciplinary investigation should be carried out into XY.

3.35 Several interviewees said they were dissatisfied with how a senior trust nurse treated them in the aftermath of the formal complaint investigation. In light of the testimonies ward 14 staff gave us, we do not believe senior trust staff were encouraging a cover up. Instead it is apparent that senior trust staff were accusatory towards ward 14 staff.

3.36 While we are reassured that senior trust staff took the formal complaint investigation seriously, it is clear that in some cases ward 14 staff interviewed felt unfairly blamed and in some cases bullied.

3.37 In general, interviewees told us they felt excluded from communications about the investigations into Miss H's case. In many cases trust staff first learnt about the status of the trust's internal investigations when Miss H's family released newspaper articles in the local press.

3.38 The trust should have told staff involved with Miss H's case about developments in the investigations.

The trust's conduct and management of the disciplinary investigation

3.39 The trust's director of nursing on 13 January 2014 commissioned the disciplinary investigation during the conclusion of the trust's formal complaint investigation. The director of nursing appointed an investigating manager, the head of nursing and midwifery at the time, and an investigating officer, the head of human resource operations at the time, to conduct the disciplinary investigation and co-author the investigation report.

3.40 The trust appointed appropriate personnel to conduct the disciplinary investigation based on their skills, expertise and distance from the case. This was in line with trust policy.

3.41 The allegations brought against XY for the disciplinary investigation were:

- gross misconduct involving wilful damage;
- misuse of employee's official position; and
- conduct likely to bring the trust into disrepute with respect to the damage to Rachel.

3.42 The disciplinary team examined XY's personnel file, a schedule of staff and shifts for Saturday 14 September 2014, Friends and Family survey results and XY's car pass record.

3.43 The examination of XY's car pass record demonstrates the disciplinary team took appropriate action in the investigation of the case.

3.44 We reviewed the car pass record to determine if we could identify XY's site entrance and exit times, particularly her site exit time on Saturday 14 September 2013.

3.45 We could determine when XY entered the car park she routinely used, but not when she left. The technology does not record exit times. Given the limitations of the car park technology we cannot definitively determine when she left the trust site on Saturday 14 September 2013.

3.46 We asked all our interviewees from the night shift whether they had seen XY or anyone else that should not have been on the ward. Ward staff told us that they had not seen XY or other unexpected personnel.

3.47 We found nothing untoward about XY's site entrance times listed on her car pass record. We also contacted the trust's IT department to get data on when XY logged off her computer on Saturday 14 September 2013. However, the data was no longer available on the system.

3.48 The key findings from the disciplinary investigation were that:

- all interviewees agreed that the damage to Rachel appeared to have been done deliberately;
- none of the interviewees witnessed Rachel being damaged; and

- the ward manager deemed the altercation on Friday 13 September 2013 between the staff nurse and Miss H's family serious enough to discuss with the staff nurse using the trust's monitoring professional attitude form. The ward manager did not raise this as a formal disciplinary issue and it was her first 'offence' relating to attitude.

3.49 The disciplinary team concluded that all three allegations against XY were unproven. Therefore, it took appropriate action in deciding not to refer XY to the NMC in relation to Miss H's case. Miss H's family later referred XY to the NMC in relation to Miss H's case in June 2016.

3.50 The disciplinary team's conclusion about whether the staff nurse wilfully damaged Rachel was appropriate. There was, and still is, not enough evidence to support this allegation against XY.

3.51 While the disciplinary team concluded that no staff members witnessed the damage to Rachel, a patient did claim to witness it. Our view is that the disciplinary team should have re-interviewed this patient, building on the interview with the patient that the former director of governance carried out during the formal complaint investigation. This would have helped to assess the credibility of the patient's testimony.

3.52 The disciplinary team concluded that the Friday 13 September 2013 altercation did not need formal disciplinary action and instead needed a monitoring professional attitude proforma. This is a reasonable conclusion because XY did not have a history of rude behaviour.

3.53 The trust's disciplinary policy requires all parties involved in the disciplinary investigation process be mindful of timescales and that procedures should not be unduly delayed because people involved are unavailable. Our view is that interviewees could have adhered to this policy better because they caused the investigation to be held up.

3.54 Our interviewees told us that the trust's management team had put pressure on the disciplinary team to get to the bottom of what had happened to Rachel and that board challenged the conclusions reached significantly. This included challenges from non-executive directors on the trust board. We are reassured the conclusions from the disciplinary investigation were probed and not simply accepted at face value.

The police investigation

3.55 On 6 September 2014 Miss H's family asked West Midlands Police to investigate their allegations of mental abuse and poor care. This is the first time any party engaged the police in relation to the incident with Rachel.

3.56 As part of our review we spoke to the lead investigating officer at West Midlands Police and reviewed their crime report.

3.57 The police interviewed Miss H who told them that the person who damaged the doll had white hair. This is inconsistent with some of the accounts Miss H provided to the trust in which she described the perpetrator as having blonde hair. However, Miss H's family told us that Miss H would have found it difficult to differentiate between white and blonde hair.

3.58 The police told us that they did not believe that the testimony Miss H gave would have stood up in court.

3.59 Although the police interviewed a member of trust staff they were satisfied that both of the trust's investigations were thorough and that all relevant staff had been interviewed.

3.60 By the end of October 2014, the police concluded that the criminal allegations from Miss H and her family were not supported and that it was not possible to conclude who damaged Rachel because the burden of proof did not pass the criminal threshold. However, like the trust, the police do not dispute that Rachel appears to have been damaged deliberately.

3.61 The police had no concerns that the trust obstructed this case. Their impression was that the trust welcomed the police review as a measure for validating the trust's internal investigations. This reassures us.

Board oversight

3.62 The trust board's oversight of Miss H's case has been comprehensive. There are several extensive accounts in trust board minutes detailing the status of the case.

3.63 We are reassured that in late 2014 a now former trust non-executive director, reviewed the reports and associated materials from the formal complaint and disciplinary investigations. The former non-executive director wished to ensure that these processes had been conducted with rigour and that the trust had not attempted to cover events up.

3.64 The former non-executive director concluded that the investigations were thorough and comprehensive. However, he expressed concerns about the delay in notifying Miss H's family of the damage to Rachel on Sunday 15 September 2013.

3.65 Our overall impression is that the trust board took Miss H's case seriously.

Improvements the trust made

3.66 The trust has implemented a range of initiatives to mitigate the risks posed to patients with learning difficulties in the acute setting since Miss H's case in September 2013. It is in part due to the determination of Miss H's family that these improvements have, or are taking place.

3.67 The trust does not have an electronic alert system for flagging when a person with learning difficulties has been admitted. The trust is reliant on ward staff notifying the learning difficulties liaison nurses and the adult safeguarding team. Referrals come from the ward areas as well as family members.

3.68 Interviewees told us that around three years ago, the wards varied in how long it took them to refer patients with learning difficulties to the learning difficulties team. However today the trust's adult safeguarding assured us that referrals are now submitted in a consistent and timely manner.

3.69 Improvements in the referral process come from the improved education about learning difficulties the trust gives its staff. After the incident with Miss H's doll on ward 14, the trust tasked the adult safeguarding lead with ensuring all ward 14 staff had attended a learning difficulties awareness training session.

3.70 The adult safeguarding lead told us that while this training was first targeted at ward 14 it was later given to the other wards across the trust.

3.71 We asked ward 14 staff involved with the care and treatment of Miss H if they had attended a learning difficulties training session. Interviewees confirmed they had and that they were helpful.

3.72 The trust is working on the development of an electronic flagging system. The trust's medical director is working with local GPs to ensure the trust gets consent from patients with learning difficulties as part of the development of the system.

3.73 The trust uses hospital passports for patients with learning difficulties. A hospital passport is a paper document designed to give hospital staff helpful information about a patient with learning difficulties.

3.74 The trust's adult safeguarding lead told us that the trigger to start using these passports was likely Miss H's case.

3.75 However, several of the ward staff we interviewed did not seem to know what hospital passports were when we asked them.

Recommendations

R1 The trust should as a priority, ensure that all ward staff correctly understand the trust's policy for protected mealtimes.

R2 The trust should ensure that initial complaint responses are dealt with sympathetically and seriously. The trust should assure itself its staff are aware of the appropriate escalation procedures and when to contact relatives and carers.

R3 The trust's learning difficulties team must ensure that ward staff seek a collaborative approach with the families of patients with learning difficulties where possible.

R4 The trust should as a priority, ensure all nursing staff produce clinical records in line with standards set out in the NMC Code 2015. The trust should strengthen its methods for auditing clinical notes.

R5 The trust should as a priority, ensure staff who take MRSA swabs from patients, particularly those with learning difficulties, clearly explain what the process involves to minimise the likelihood of it being misunderstood.

R6 Ward staff should check that equipment is working properly and report immediately when it is not. Wards should have a system for alerting the relevant trust department in a timely way.

R7 The trust should ensure that initial complaint responses are dealt with in a sympathetic and serious way. The trust should assure itself that its staff are aware of escalation procedures and when to contact relatives and carers.

R8 The trust should ensure that it treats its staff with respect when conducting a formal complaint investigation.

R9 The trust should ensure that staff involved with Miss H's case are fully informed of the outcomes of this investigation.

R10 The trust should ensure that patients with learning difficulties are able to access the learning-difficulties liaison nurses in a timely manner.

R11 The trust should over the coming months, continue to develop the learning difficulties electronic flagging system to ensure patients with learning difficulties have prompt access to the learning difficulties liaison nurses.

R12 The trust should as a priority, assess whether the number of adults with learning difficulties admitted is increasing and decide if the learning difficulties training should be made mandatory.

R13 The trust should as a priority, update its learning difficulties training programme to feature dolls and similar objects, their potential significance to patients with learning difficulties and their potential therapeutic value.

R14 The trust should as a priority, ensure that all ward staff are familiar with hospital passports.

4. Approach and structure

Approach to the review

4.1 The review comprised 26 formal interviews, other discussions and an examination of all relevant documents.

4.2 A list of the interviewees is included in appendix B. A full list of documents is included in appendix C. The review team spent half a day at the trust organising Miss H's patient notes into chronological order.

4.3 We conducted interviews with individuals we identified as relevant and who we could access. This included executive and non-executive members of the hospital management team, ward staff and former employees. We invited nurse XY to meet us. She is no longer an employee of the trust and had no reason to participate in the review. She did so willingly and we spoke to her at length. We are grateful for her help.

4.4 We spoke to a representative from West Midlands Police, an expert in Reborn dolls and an independent consultant psychiatrist with expertise in learning difficulties. This was not the same psychiatrist Miss H's family employed as part of their civil claim.

4.5 Before each interview, we sent interviewees a letter of invitation, a guide for interviewees and the terms of reference for the review. We told interviewees that a colleague, friend or a member of a professional body or trade union could accompany them. With the agreement of the interviewees, the interviews were recorded and transcribed. We gave each interviewee a copy of their transcript and offered them the opportunity to review it for accuracy.

4.6 We asked the trust for all documents relating to the care of Miss H and investigations the trust made. This included trust policies and procedures. We also reviewed documents the trust and Leigh Day gave us about the legal case brought against the trust. This documentation is usually withheld under legal privilege. We are grateful that the trust and Miss H's sister, as Miss H's litigation friend, agreed to release these papers. The trust gave us access to all the litigation papers except the witness statements for the trust's disciplinary investigation into the staff nurse, XY. This is because witness statements form part of each individual's personnel file and so cannot be released without their consent.

4.7 Our review team included a nurse with expertise in learning difficulties who has commented on the nursing care Miss H received. They had access to the health records covering the period and trust policies.

4.8 We appointed an HR expert to comment on the disciplinary investigation. They had access to the disciplinary report and trust policies.

4.9 We wrote to West Midlands police in September 2016 to ask for access to their investigation papers. They sent us the crime report. The police told us that a video interview they had taken of Miss H on 24 September 2014 had been destroyed in line with policy, after their decision not to proceed with a full criminal investigation. They decided there was not enough evidence to consider the case criminal. We spoke to the lead investigating officer for the case as part of our review and the detail of this is included in section 11 of our report.

4.10 We spoke to an expert in Reborn dolls for an informed opinion on the structural integrity of Miss H's doll Rachel and Reborn dolls more generally. The expert had made Rachel and knew about the materials used in the production.

4.11 We spoke to the trust's head of quality and performance for the estates division to get an understanding of security at Walsall Manor Hospital in terms of CCTV, monitoring car park access and monitoring site access. We wanted to find out whether we could identify site entrance and exit times for trust staff.

4.12 We have been in close contact with Miss H's family and met her sisters several times. We met them in March 2017 in Bloxwich to discuss the findings and conclusions of our draft report. We sent them a copy of the draft report in advance of that meeting. We have incorporated their verbal comments where possible. We are grateful for the help they gave us during the review.

4.13 We received written comments from Leigh Day on behalf of the family after we had submitted the final report to the trust. We told Leigh Day and the trust that we would take account of these. We have made additions and amendments where we think this is appropriate.

4.14 Our findings, comments and recommendations are based on our interviews and the information made available to us.

Limitations

4.15 We tried to speak to all staff involved in the incident with Rachel. However, one or two members of ward 14 staff had left the employment of the trust or retired and we were unable to trace them. Nonetheless we believe we have been able to establish an accurate and reliable picture of Miss H's care and treatment.

4.16 In building a chronology of Miss H's case it was difficult to verify some events precisely because of the passage of time since September 2013. We have been as comprehensive as possible.

4.17 Miss H and another patient on ward 14 who had given a statement to the complaint investigation had died by the time we started this review. We have not therefore not been able to hear their direct testimony or ask them questions about the ward, the care provided and anything they had said subsequently to the trust's complaint investigators. In Miss H's case, we hoped to have access to the video recording of her interview with West Midlands police. As we mention at paragraph 4.9 this was not possible. We have not therefore been able to hear or test for ourselves what it is that they had to say. The absence of their direct testimony should be borne in mind when reading this report.

Structure of this report

4.18 We provide our comments and analysis on the areas outlined in the terms of reference in the following sections of the report. In sections five to nine we address the terms of reference and review trust policies, procedures and national documentation to make recommendations for supporting the trust to improve its care for patients with learning difficulties as well as its responses to concerns complainants raise. The next sections of the report are:

- Section 5. Background information
- Section 6. Summary of events: Friday 13 September – Monday 16 September 2013

- Section 7. Miss H's nursing and medical care
- Section 8. The trust's management of the family's complaint
- Section 9. Interview with XY and analysis of the complaints statements of Miss H & Ms W
- Section 10. The trust's conduct and management of the disciplinary investigation
- Section 11. The police investigation
- Section 12. Board oversight
- Section 13. Improvements the trust made
- Section 14. Summary of concerns Miss H's family raised

4.19 Our findings from interviews and documents are set out in ordinary text. Our comments and opinions are in ***bold italics***.

5. Background information

Miss H

5.1 Miss H was diagnosed in childhood with a moderate learning difficulty and the local learning difficulties team at Dudley and Walsall Mental Health Partnership NHS Trust had cared for her in recent years.

5.2 Miss H lived with her parents until their death a decade or so ago and later her sister until March 2013[1]. Her mental state had deteriorated over the previous year so she was admitted to the Daisy Bank assessment unit (part of Black Country Partnership NHS Foundation Trust). She was discharged back to the care of her sister in late May 2013.

5.3 In June 2013 Miss H was admitted to Hob Meadow, Great Wyrley for a short-term placement because her sister was struggling alongside other commitments, to provide the support Miss H needed. Miss H was admitted to Walsall Manor Hospital from Hob Meadow on 28 July 2013 after a fall.

5.4 After her discharge from Walsall Manor Hospital on 16 September 2013, Miss H was transferred to Harmony Care Home, a residential unit in Walsall.

5.5 Miss H's family told us Miss H kept dolls throughout her life. She cared for them lovingly, as though they were her children. She had a pram for her doll and liked to shop for baby clothes. When she had been able to do so she would take her doll out in the pram locally. In the evening, she would get the doll ready for bed. A consultant psychiatrist who specialises in patients with learning difficulties told us that possessions and objects such as 'Rachel', often hold great significance for patients with learning difficulties. Rachel was therefore an integral and important part of Miss H's everyday life. Miss H liked to be able to see Rachel at all times.

5.6 During our investigation, we were struck by comments from trust staff who described how much Miss H's family cared for her. Ward staff said:

[1] Although during this period Miss H was intermittently admitted to respite care.

"Miss H had a very caring family. There are patients that regularly will have visitors all the time, other people that hardly have anyone at all, and I do recall that she (Miss H) had a very caring family, she always had a visitor."

"I feel that she was very well-loved and supported by her siblings."

5.7 Miss H's family played a key role in the implementation of improvements the trust made, outlined in section 13 of this report.

5.8 As part of Miss H's family's civil claim against the trust they instructed an independent psychiatrist to produce a medical report in October 2014. The report was produced on 5 December 2014. Via Leigh Day, Miss H's family instructed the psychiatrist to comment on:

- the truth of Miss H's account and her mental capacity to recollect her experience on ward 14;
- Miss H's relationship with her doll;
- if the alleged action of trust staff caused Miss H psychiatric damage;
- Miss H's mental and physical health and prognosis; and
- if Miss H needed treatment because of any harm that trust staff caused her.

5.9 The independent psychiatrist Miss H's family instructed interviewed Miss H on 17 October 2014. He concluded Miss H treated Rachel as if it were her own child and that she would suffer distress if she felt the doll had been hurt, just as she would if she had a living child who had been hurt. The independent psychiatrist concluded that what had happened to the doll on ward 14 caused Miss H psychological harm and that she required treatment for the traumatic experience.

Background of the trust

5.10 Walsall Healthcare NHS Trust is a local district general hospital providing acute and community health services to about 260,000 people in Walsall and the surrounding area.

5.11 Acute services are provided at Walsall Manor Hospital. The trust provides community health services from 60 sites in Walsall and the surrounding area. The trust relies on other healthcare providers for some specialist services.

5.12 The CQC last inspected the trust in January 2016. The trust got an overall rating of inadequate. Medical care, one of the eight services inspected, was judged to require improvement. Ward 14 was a medical ward at the time of Miss H's admission in 2013.

5.13 At interview the chief executive commented about the culture of the trust in 2013, especially when clinical services were under pressure.

> *"My sense here of the culture when I arrived was of a Trust that had for a long time operated in a pretty top down relatively centralised kind of way - we'll issue the instructions and we'll expect teams to follow us. That hadn't particularly encouraged individual teams to take leadership and crack on, and attempted to solve problems by Trust-wide edicts, central initiatives. Edicts is a bit harsh but we're going to fix infection control once and for all for the whole Trust, rather than what are you doing about it in your team and what are you doing about it in your team sort of approaches."*
>
> *"We were starting to shift to a more open, more empowered culture, something that was less defensive and less centralising, but hadn't gone far enough to withstand the pressure."*
>
> *"Part of what happened in two or three of the difficult cases that arose from that period was that defensiveness showed in the initial reaction of teams in the Trust when people tried to say they thought things weren't right. That then generates an understandable reaction about we tried to raise this here, we didn't get a response so we're now not happy, we're going to push this further."*

Ward 14

5.14 In summer 2013, the trust was facing an increase in admissions from A&E and had to open more beds to cope with the pressure. Ward 14 was used as a contingency facility to provide extra beds.

5.15 The ward had been running for several months before Miss H's admission to ward 14 on 29 August 2013. Many of the staff on the ward were from the staff bank or agencies because the ward had been opened rapidly in response to capacity issues. However, the trust tried to reduce the ratio of permanent staff to bank or agency staff by appointing employed staff from elsewhere in Walsall Manor Hospital to ward 14. Ward 14 has not closed since Miss H's admission. The trust's executive team has made it a permanent part of the ward infrastructure rather than just a contingency facility.

5.16 At interview trust staff acknowledged to us the shortcomings of ward 14. A trust manager commented to us about the challenge of staffing the ward appropriately.

> *"I did a couple of risk assessments, I couldn't promise about the time of that, but the action plans coming out of those would have resulted in making sure that you don't fill a whole ward with agency and bank, that you actually move from other wards. You share that out, so that you don't have people who have lack of familiarity with the environment."*

Comment

Because of the high ratio of bank and agency staff on ward 14 the trust was unable to give Miss H continuity of care. Too often staff did not build relationships with her in a way that could have supported her care, for example allowing them to encourage her to take showers.

5.17 Several senior trust staff told us their concerns about the quality of care provided on ward 14 while it was used as a contingency facility during 2012 and 2013. A senior nurse described the ward as follows:

> *"a hotchpotch of bank and agency staff"*

> *"… in April/May time the previous year (2012) … I raised concerns – I was on site shifts back then. When I was on site one night, I went up to ward 14, which wasn't my area, but I went on, and I was appalled at the care that I saw being given, it*

really frightened me. I rang the Director of Nursing from the ward to say, 'This ward scares me. I don't think we should have this – it's really quite concerning.'"

5.18 A senior manager also commented about the ward lacking basic equipment.

"you would have shell of a ward, with no equipment or anything in there, and suddenly it's open, full of patients."

Comment

Ward 14 was brought into use without sufficient attention being paid to its staffing and equipment needs. These deficiencies were not conducive to providing high quality care to patients.

5.19 We reviewed the formal complaints made about ward 14 for 2013. Patients or their relatives made twelve formal complaints. These were about communication failures, appropriateness of discharge, the attitude of one doctor and the quality, timeliness and the suitability of clinical care.

5.20 Patients or their relatives raised twenty-three informal concerns about ward 14 in 2013. These were about communication failures, the attitude of nurses, lost property, delays in and the appropriateness of discharges, and the quality, timeliness and suitability of clinical care.

Reborn dolls

5.21 Reborn dolls are manufactured soft vinyl dolls designed to resemble a human baby realistically. They are painted in fine detail and have real hair. Reborn dolls are commonly weighted with crushed glass or sand to feel like a new-born baby.

5.22 The expert told us that in their experience, wear and tear would not produce the type of damage caused to Rachel. The expert's opinion was that a sharp object and rough

handling was needed to cause this type of damage because the vinyl used to create Rachel is so robust.

5.23 Our expert told us that some people had been hostile towards her for her interest in reborn dolls. This appears to be in part due to their lifelike appearance.

6. Summary of events: Friday 13 September – Monday 16 September 2013

6.1 To help our examination of Miss H's care, we have devised a brief summary of events for Friday 13 September to Monday 16 September 2013. This is based on evidence from trust staff, Miss H's family and documents including Miss H's patient notes. Where appropriate we have added comments.

Friday 13 September 2013

6.2 During the morning, Miss H went for an ultrasound. The hospital record shows that the ultrasound was carried out at 11.15am and Miss H would have returned to ward 14 in time for lunch.

6.3 Between 2pm and 4.45pm XY, who was the nurse in charge for the shift, is alleged to have asked Miss H's family if a placement had been found for Miss H because she was due to be "shipped out" as the trust needed the bed. The staff nurse denies this conversation took place. We found no witnesses for this except Miss H's family.

6.4 At 4.45pm ward staff were distributing meals on ward 14. At about 5pm XY asked Miss H's family to leave the ward so the trust's protected mealtime protocol could be adhered to. Miss H's sister questioned why the family needed to leave the ward and a verbal altercation ensued between her and XY.

6.5 Miss H's sister pointed out a relative of another patient on the ward and asked XY why she had not been asked to leave the ward. XY then asked the other relative to leave the ward.

6.6 Shortly afterwards Miss H's sister explained to XY that she normally helped with feeding Miss H. XY then allowed Miss H's sister to stay on the ward during the meal.

6.7 XY said she did not recall seeing the family after this altercation. XY's shift finished at 7.30pm.

6.8 A nurse in charge witnessed the altercation between XY and Miss H's sister. They told us:

"I remember the nurse in charge was saying to us "It is protected meal times" and I do remember that, she [Miss H's sister] was saying "She can't feed herself" and the nurse in charge said "We will feed her", and I remember there was more shouting. It was around the aspect that she wanted to feed her sister and the nurse in charge… saying that wasn't necessary and XY would rather she [Miss H's sister] left."

"I wouldn't have got into that confrontation. I didn't think that was necessary. I might have had a softer approach, but people have different leadership skills and that is how I would have used it. I would have gone softer. XY was really quite authoritative, but she was nurse in charge and she wanted to maintain the protected mealtime."

"I am sure that XY thought she was acting in the patient's best interest, I am absolutely convinced of that, but I would personally have been just a little bit more tactful, perhaps."

6.9 A senior trust nurse described the trust's policy for protected mealtimes:

"We have a policy for protected mealtimes. Mealtimes are actually protected but all this means is that, if you are coming to do a blood test on me, you cannot, because I am having a protected mealtime, because that is important to me getting better. It doesn't mean that, if I am a lady with learning difficulties, if you are my brother, you cannot come in and coax me to eat – because you know me so well and you know that you can get me to eat that food, whereas with the nurse sitting there, I will argue and say 'I want my brother, thanks'. It is that sort of thing. We welcome families through the protected mealtime, to help people eat.

It is also about maintaining the dignity of people as well. We try to keep the numbers down on the wards but it is about having common sense as well. If we have patients with dementia, we want as many people in there as we can, because for patients with dementia, the first thing they will do is stop eating."

Saturday 14 September 2013

6.10 On Saturday XY worked a long day shift. This lasted from 7am to 7.30pm. XY was the nurse in charge of ward 14 and did not recall noticing Miss H's family or Miss H during the shift.

6.11 XY left the ward at around 8.15pm. Her departure was delayed because she stayed late to complete a bank shift rota, a task that she was unfamiliar with. We tried to find out what time XY logged off her trust computer but the data was not available. The trust only keeps such data from 2015 and beyond.

6.12 One of Miss H's sisters did visit Miss H on Saturday afternoon and noted that Rachel was in the armchair next to Miss H's bed when she left at about 4.45pm. In a statement, Miss H's sister said: *"there was no question of the arm being off or damaged when I left"*.

6.13 A care support worker (CSW) recalls Miss H's sister saying that a member of staff was on duty the previous day who had a bad attitude (XY). Miss H's sister described the staff nurse to the CSW. The CSW was working in bay 2 as a sitter for another patient.

6.14 A bank staff nurse confirmed that they introduced themselves to Miss H's sister during the visit. At approximately 4.45pm a bank staff nurse attempted to give Miss H her teatime medication but Miss H refused and was upset. The bank staff nurse assumed that her upset was due to her imminent discharge from the hospital. The bank staff nurse noted the refusal of medication in Miss H's patient notes at 7pm.

6.15 The CSW corroborated the view of the bank staff nurse in saying that the reason Miss H was upset was because she knew she was being discharged soon and because her other sister did not visit her that afternoon. After Miss H's sister left the ward the CSW recalls Miss H pulled her blanket over her head and said, *"my sister hasn't come to see me"*. The CSW reassured Miss H.

6.16 At approximately 7pm the CSW gave Miss H Rachel to comfort her. Miss H cuddled Rachel and said, *"I love you Rachel I do"*. The CSW confirmed that Rachel was undamaged.

6.17 The night shift started at 7pm with a handover. Four bank workers covered it: two nurses and two CSWs. XY did not work on this shift[1]. One of the CSWs noticed that the doll was in bed with Miss H at the start of the shift and Miss H was settled.

6.18 A bank nurse said that at approximately 10pm they picked up the doll and commented on how beautiful it was to Miss H. The bank nurse said that the doll was dressed and both arms were attached.

Sunday 15 September 2013

6.19 A CSW said that when they turned Miss H, with another CSW, for the last time during the night shift, there was a gritty, sand-like substance on the floor surrounding Miss H's bed and in Miss H's bed. At this point, in the early hours of the morning of Sunday 15 September 2013, the CSWs noticed that one of Rachel's arms was split and that the sand-like substance had come from inside the doll. At this point the Rachel's arm was not fully detached. At least two members of trust staff corroborate this account, a bank CSW and a bank staff nurse. One of our interviewees described the split as "*an inch long*". The split ran across the Rachel's arm and it later became totally detached at that point.

6.20 As the CSWs changed Miss H's bedding Miss H began to cry and take the clothes off Rachel. One of the CSWs reported the damage to the nurse in charge. The nurse in charge taped Rachel's arm with Sellotape to calm Miss H. This calmed Miss H who said, "thank you".

Reporting incident to senior staff and notification of Miss H's family

6.21 The nurse in charge of the night shift handed over to the Sunday long-day shift team explaining that Rachel was broken and that they thought this had happened when the doll fell to the floor.

6.22 At approximately 8am a CSW asked Miss H what had happened to Rachel. Miss H said that she did not know but that Rachel was broken. She was upset. Miss H's family have since told us that Miss H said she did not know what had happened because she did not know the name of the member of staff who had caused the damage.

[1] XY's next shift was the long day shift (7am – 7.30pm) on Tuesday 17 September 2017.

6.23 A nurse in charge started their shift at 1.30pm at which point Miss H's relative visited the ward and complained about what had happened to the doll and the behaviour of XY on Friday 13 September 2013. By this time, Rachel's arm was fully detached. Miss H's relative described XY, who they believed was responsible for the damage to Rachel. The nurse in charge then asked Miss H what had happened to Rachel but did not get an answer, other than that it was broken.

6.24 The nurse in charge contacted the trust's on-site manager about the damage to Rachel. The on-site manager advised the nurse in charge to ask Miss H's family to present the receipt for Rachel if they wished to make a claim. During our discussion with the on-site manager they said they had not appreciated the significance or nature of Rachel when the matter was referred to them. The on-site manager told us that they referred to the incident in their end of shift report.

Monday 16 September 2013

6.25 At the start of the long day shift the nurse in charge told the ward manager about the incident with Rachel and the conversations with Miss H's family on the Sunday.

6.26 Shortly afterwards the ward manager and a CSW asked Miss H what had happened and whether Miss H knew who had damaged Rachel. Miss H described XY's appearance and uniform, including a distinctive coloured bobble that she wore in her hair. Miss H said that Rachel's arm had been cut off. This is the first time a description of XY had been given despite ward staff asking Miss H what had happened to Rachel over the previous 24 hours.

6.27 The ward manager then escalated the incident to the head of nursing for the medicine division, the matron and the PALS team. A meeting was held later that morning on the ward with Miss H's family, PALS, a learning difficulties nurse and the ward manager. The trust staff reassured the family that the allegations would be investigated appropriately. As is standard practice at the trust, staff advised the family to consult the police if they believed that criminal damage had been carried out.

Comment

On the Friday afternoon staff nurse XY and Miss H's family had a serious altercation about whether they could stay on the ward to help Miss H eat.

The evidence suggests that XY did not fully understand the needs of Miss H because she had not been directly caring for her. XY believed she was adhering to the trust's protected mealtimes policy, but as the senior trust nurse described this was not the case. Miss H's family told us that the trust had given them permission before Friday 13 September to help Miss H eat. This permission does not appear to be documented.

It is clear to at least one witness that the conversation between XY and Miss H's sister was conducted in an over-zealous manner by staff nurse XY. The exchange upset Miss H's sister greatly.

Rachel was seriously mistreated on ward 14 at some point in the evening/early morning of Saturday 14 September and Sunday 15 September. The mistreatment of Rachel was significant. While staff were naturally focused on the cut to her arm it appears that other disfigurement had also occurred.

Once the damage to Rachel was discovered ward staff were slow to grasp the significance to Miss H's wellbeing. In turn, the on-site manager didn't realise the importance of what was being reported to her. The family weren't informed of the mistreatment first thing on Sunday morning and should have been. Instead they arrived on the ward to discover the matter for themselves. By this time, Rachel's arm had become fully detached. The other damage would have been clearly apparent to them too.

Miss H was asked on two occasions on the Sunday as to who had damaged Rachel but she was unable to identify anyone. On Monday, she described XY's appearance.

The lack of escalation by ward staff meant that the trust was slow off the mark to investigate this serious incident. They also lost the opportunity to report the mistreatment of Rachel to the police. Had they done so, the police may well have got to the bottom of the matter promptly. They would likely also have gathered helpful physical evidence.

Recommendations

R1 The trust should as a priority, ensure that all ward staff correctly understand the trust's policy for protected mealtimes.

R2 The trust should ensure that initial complaint responses are dealt with sympathetically and seriously. The trust should assure itself its staff are aware of the appropriate escalation procedures and when to contact relatives and carers.

7. Miss H's nursing and medical care

7.1 We have reviewed the nursing care the trust gave Miss H during her admission from 28 July to 16 September 2013. Miss H's family do not have concerns about the nursing and medical care given to Miss H on ward 1. The focus of this review is from 29 August to 16 September 2013 when Miss H was on ward 14.

7.2 Our nurse advisor specialising in learning difficulties conducted an examination of the Miss H's nursing and medical notes from the 28 July to 16 September 2013 admission. The notes reviewed include:

- discharge plan and checklist;
- internal transfer form;
- clinical notes – nursing and MDT;
- adult observation charts;
- bedrails assessments;
- continuous assessment tools;
- fluid charts;
- patient comfort rounds;
- drug charts;
- observational charts;
- IR1 forms1; and
- stool charts.

7.3 Our examination compared the trust's local practice with the national context of care that people with learning difficulties receive within the acute setting. We have also compared local practice with national nursing standards produced by the Nursing and Midwifery Council (NMC).

7.4 In accordance with our terms of reference we review and provide an opinion on the nursing and medical care provided on ward 14 by focusing on the following areas:

- the fact that Miss H had learning difficulties and communication needs and the need for staff to make reasonable adjustments;

[1] A form used to report any unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving NHS-funded health care.

- medication administration including method of administering oral tablets and giving injections without prescription;
- empathy and compassion; and
- timeliness of attention to physical needs.

National context: people with learning difficulties and health needs

7.5 Growing evidence over the last 15 years has suggested that people with learning difficulties are at increased risk of avoidable harm and death when admitted to acute health care settings[1] [2]. In response to this evidence the government commissioned an independent inquiry into the inequalities that people with learning difficulties experienced when accessing healthcare. Sir Jonathan Michael[3] led the inquiry and it was completed in 2008. The confidential inquiry into the premature deaths of people with learning difficulties was completed in 2013[4].

7.6 The key findings of these inquiries were that the identification of a learning difficulty, facilitation of reasonable adjustments, co-ordination across the health and social care systems and keeping records were often poor in acute healthcare settings.

7.7 Considering this evidence acute NHS trusts have implemented a range of initiatives to mitigate the risks posed to patients with learning difficulties in the acute setting. We include details of the initiatives that Walsall Healthcare NHS trust has implemented in section 13 of this report.

7.8 Most patients find admission to hospital a difficult and stressful experience. People with learning difficulties are particularly susceptible to being anxious about the unfamiliar surroundings and activity of a busy general hospital. Miss H was moved between wards during her admission and so had to familiarise herself with two wards, sets of patients and staff. In this context, Miss H needed careful management and anxiety-reducing possessions such as Rachel would have been important to her.

[1] Mencap (2007) *Death by Indifference*. London, Mencap.
[2] Disability Rights Commission (2006) Equal *Treatment: Closing the Gap*. London, Disability Rights Commission.
[3] Michael, J. (2008) *Independent Inquiry into access to Healthcare for People with Learning Difficulties*. London, HMSO.
[4] CIPOLD (2013) *Confidential Inquiry into Premature Deaths of People with Learning Difficulties*. Bristol, Norah Fry Research Centre.

Reasonable adjustments

7.9 Miss H had a learning difficulty and communication needs. Identifying that a person has a learning difficulty and making reasonable adjustments to respond to an individual's difference is especially important in acute settings in view of the national context, as discussed earlier in this section of this report. Although ward 14 staff identified Miss H as having a learning difficulty, we found no evidence in the daily clinical records to suggest that reasonable adjustments were made for her.

7.10 The nursing staff on ward 14 completed the continuous assessment tool for Miss H and reviewed it regularly. This identified that Miss H did not have the mental capacity to make decisions about her care, and that her family needed to be involved in it. This meant the ward staff were aware of Miss H's needs.

Comment

The involvement of the family is important when providing healthcare to an individual who has a learning difficulty especially when they are known to lack capacity for decision-making. A more collaborative approach between the healthcare professionals, Miss H and her family would have likely resulted in an improved experience for Miss H, her family and the staff on ward 14.

Recommendation

R3 The trust's learning difficulties team must ensure that ward staff seek a collaborative approach with the families of patients with learning difficulties where possible.

7.11 Most acute hospitals recognise that they do not have enough knowledge of the needs of patients with a learning difficulty so they employ or have access to a learning difficulty liaison nurse. The learning difficulty liaison nurse can assist with communication issues and mental capacity issues. The trust employed a learning difficulty liaison nurse during Miss H's admission. The learning difficulty nurse visited Miss H on ward 14 on 30 August, 3 September, 4 September, 9 September and 12 September 2013.

Comment

Staff had completed the continuous assessment tool and identified Miss H's care needs. However, the clinical records do not show if the trust made reasonable adjustments to provide Miss H with appropriate nursing care. The patient records suggest that the nurses working on ward 14 had limited or no knowledge of supporting people with learning difficulties, and did not seek advice or help from her family or the learning difficulty nurse.

Although the learning difficulty nurse visited Miss H while she was on ward 14 five times, Miss H was not always awake during these visits. We found no further documented evidence that the learning difficulty nurse made visits between 9 September 2013 and Miss H's discharge on 16 September 2013. However, we are aware from our interviews and from documents about the initial complaint investigation that the learning difficulties nurse attended a meeting on the ward regarding damage to Rachel on Monday 16 September 2013.

Miss H's nursing records

7.12 The overall standard of the written nursing records we reviewed did not meet the Nursing and Midwifery Council (NMC) standards. The NMC code says[1]:

> *"nurses should keep clear and accurate records relevant to their practice, and attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation".*

7.13 Many of the written entries the nursing team completed on ward 14 do not meet this NMC standard. The clinical notes reviewed often contained only basic information, did not always include the full date or time of the entry, included abbreviations (e.g. NIC instead of nurse in charge) and the handwritten entries were often illegible.

[1] Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives. London, NMC.

7.14 Examples from the clinical notes reviewed:

- Date, 31 August no year recorded – entry reads *"Vitals are stable. Prescribed medication given. Calm and sleepy all day, safety maintained.";*
- 'N in a circle *vitals' "stable, settled night slept well.";*
- 29 August 2013 nights – part of this record is illegible;
- night – no date included – "*Vitals stable - slept well.";*
- 2 September 2013 nocte – Part of this recorded entry is illegible;
- 3 September 2013 - am Part of this recorded entry is illegible;
- 15 September 2013, no time documented

Comment

The clinical notes clinical staff working on ward 14 wrote did not meet the standards of the NMC code 2015.

Good records promote continuity of care through clear communication; demonstrate the quality of care delivered; and provide the evidence necessary for legal proceedings. Poor records often reflect poor practice. Reviewing the clinical records for Miss H has raised a number of questions about kindness, compassion, leadership, workforce, training and development, duty of candour, and culture.

Recommendation

R4 The trust should as a priority, ensure all nursing staff produce clinical records in line with standards set out in the NMC Code 2015. The trust should strengthen its methods for auditing clinical notes.

Medication administration including method of administering oral tablets and giving injections without prescription

7.15 Miss H's family raised concerns that Miss H was given undocumented injections. Miss H said that ward 14 staff had put fingers up her nose.

7.16 The NMC[1] produces standards for the management of medicines. We have used these standards to review the medication records and drug charts of Miss H while she was a patient on ward 14.

7.17 The prescription chart for Miss H on the day of her admission to Walsall Manor Hospital, 28 July 2013, was unclear in particular the section that detailed when to administer 'when required drugs'. Haloperidol 1-2mg was prescribed on the chart as a 'when required medication', to be given either orally or via intramuscular injection routes. Haloperidol is a drug that can be administered for the management of behaviour problems, agitation and restlessness[2].

7.18 In the case of Miss H, haloperidol was prescribed as a 'when required' rather than a regular medication. On the medication chart haloperidol was signed for as administered on five occasions: 30 August 2013 (2mg), 1 September 2013 (1mg), 6 September 2013 (1mg), again on 6 September 2013 (1mg), and 8 September 2013 (2mg). The medication chart does not document the route of administration for each of these doses, and the corresponding clinical records only document the administration of 'when required medications' on two of the dates, 30 August 2013 when haloperidol 2mg was administered by intramuscular injection and on 6 September 2013 at 11:50 when haloperidol 1mg was administered orally. We found no entries in the clinical notes to describe the administration of haloperidol on 1 September 2013, 6 September 2013 at 21:15 and 8 September 2013, therefore we do not know what route of administration was used.

7.19 We spoke to a consultant psychiatrist with expertise in the care of people with learning difficulties about the use of haloperidol. She told us that the drug is commonly prescribed to help manage anxiety and the dose was appropriate.

Comment

The recording of administration of 'when required' medication falls short of the standards of the NMC. The entries are unclear.

[1] Nursing and Midwifery Council (2010) Standards for Medicines Management. London, NMC.
[2] https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421-antipsychotic-drugs/first-generation-antipsychotic-drugs/haloperidol

We found no other medications prescribed on the medication chart via an injectable route, and no recorded administration of injections contained in the clinical records other than the one dose of haloperidol 2mg administered to Miss H on 30 August 2013 by intramuscular injection.

Because the route of administration was omitted from some of the records, there are three instances when haloperidol may have been given orally or by intramuscular injection.

7.20 On Tuesday 10 September 2013 ward staff took an MRSA swab from Miss H's nose and groin. MRSA screening is usually carried out on people admitted to hospital. The screening process involves a member of ward staff running a cotton bud (swab) across an area of skin. It is common for swabs to be taken from the inside of the nose, the throat, the armpit, the groin and areas of damaged or open skin. Swabbing is painless but it must last for a few seconds to ensure a measurable sample is taken. When taking an MRSA swab from the nose, both nostrils must be tested. MRSA screens of nostrils can cause the nose to bleed.

7.21 The nurse or care support worker carrying out the screening is responsible for explaining the procedure to the patient.

7.22 The signature on the clinical notes is illegible. The notes state that '*MRSA sent for groin and nose'*. No difficulties taking the swab are recorded in the notes. Nothing is recorded about explanation or consent.

7.23 We have included the record of this in appendix F.

Comment

During the initial complaint investigation and the formal complaint investigation Miss H's family alleged ward staff had put their fingers in Miss H's nose to open her mouth and administer oral medication to her. While we found no evidence that staff put their fingers in Miss H's nose it is possible the MRSA screen of her nose on 10 September 2013 made her believe fingers had been put in her nose. The date of this screen corresponds

with the date Miss H's family gave us when they allege staff put their fingers in Miss H's nose.

If the procedure of taking the MRSA swab had not been explained well to Miss H it is possible she would have misunderstood why they did it.

Recommendation

R5 The trust should as a priority, ensure staff who take MRSA swabs from patients, particularly those with learning difficulties, clearly explain what the process involves to minimise the likelihood of it being misunderstood.

Empathy and compassion

7.24 The NMC code (2015) prioritises 'people', detailing how nurses should put the interests of people using or needing nursing or midwifery services first. Nurses must make care and safety their main concern and ensure the dignity of patients is preserved and that needs are recognised, assessed and responded to. Nurses need to make sure that those receiving care are treated with respect, that their rights are upheld and that discriminatory attitudes and behaviours towards those receiving care are challenged. The NMC also highlights the importance of treating people with kindness, respect and compassion.

7.25 Miss H's clinical records provide some limited examples of empathy and compassion. For example, in an entry dated 14 September 2013 at 19:00, a nurse documented how they sat with Miss H for 15 minutes to give her reassurance:

> *"Patient has refused all her medication this evening. Sat with the patient for 15 minutes as she was tearful, and expressed that they wanted to send her home against her will. Constant reassurance given but patient refused to take her tablets."*

7.26 Several written entries say Miss H was in distress, either crying, shouting or agitated while on ward 14. Despite these written accounts of Miss H's distress, we found no evidence

staff gave her reassurance. Also in examples given below we found no evidence staff assessed the cause of her distress such as pain, fear or missing her family:

- 29 August 2013 – *"Distressed for a while crying and shouting"* – no response documented;
- 31 August 2013, 05:05 – *"Few episodes of shouting"* – no response documented;
- 1 September 2013 – *"Agitated and restless"* – no response documented;
- 2 September 2013, 03:55 – "*Pulling back bedding at times"* – no response documented; and
- 8 September 2013 – *"On and off upset and crying"* – no response documented.

7.27 Miss H's family told us that the team on ward 14 were "*terrible*":

> *"Me and my sister were doing the nurses jobs because we were looking after the other people on the ward who were crying and pressing buzzers for nurses, and they'd just go, 'Tut.'"*
>
> *"They* [ward 14 staff] *were sitting in the ward looking at their phones and swapping wedding photographs."*

7.28 Miss H's family also told us that they had complained to senior staff on the ward about this but "nobody ever came back". We attempted to track down documented evidence of this complaint but we found no record of it.

Comment

We found little evidence in the nursing notes of staff treating Miss H with appropriate empathy and compassion, particularly in response to her documented episodes of distress, agitation and restlessness. These episodes happened in the context of her learning difficulty, having changed ward and her being uncertain about where she would be discharged.

However, we acknowledge that ward 14 staff could have comforted Miss H without recording it in her patient notes.

Empathy and compassion are vital components of the NMC Code; the clinical records we reviewed showed no evidence that these were being offered in every day practice.

7.29 Staff missed opportunities to demonstrate and document empathy and compassion in relation to the damage to Miss H's doll Rachel. For example, the following entry says Rachel had broken the night before. This is the only clinical nursing entry that mentions damage to Rachel. The entry was completed on 15 September 2013 but the time of the entry was not documented. The entry was focused more on the reaction of Miss H's family than the impact of the damage to Rachel on Miss H:

> *"Patient comfortable day. Vitals checked normal but had some issues at night due to her doll hand broken (plastic). So family was not happy at all, NIC* [sic] *sought it out the problem."*

7.30 The multi-disciplinary records show other entries about the damage to Rachel, but these are in response to the complaints Miss H's family made after they discovered Rachel was damaged. Examples include:

- 15 September 2013 14:30 – *"Miss H's sister approached me again re. Miss H's broken doll. Explained that the night staff had handed it over that it was caught in the bed and it was broken.";*
- 15 September 2013 17:00 – "*Spoke to on-site manager about the incident, said to let the ward manager know about it tomorrow and if the relatives claim they just need to provide the receipt.";*
- 15 September 2013 17:30 – *"Spoke to Miss H's brother and explained what had been said to me by the on-site manager. They said they are not after the claim they want to know who did it as it is a form of abuse for them to Miss H."; and*
- 15 September 2013 18:00 – *"Spoke to Miss H's brother said they are not happy with what happened last night and would like to know who did it and what exactly happened."*

Comment

The patient notes record inadequate detail about the damage to Rachel, when it occurred, how it happened or how it had affected Miss H. The damage to Rachel was only mentioned once in the clinical notes of the night of 14 September 2013 and morning of 15 September 2013 and was not recorded as an untoward incident. This suggests nursing staff on the ward had dismissed it as an unimportant event. This is how Miss H's family thought staff had perceived it.

Clinical notes suggest the damage to the doll was included in the verbal handover from the night staff to the day staff. They also suggest staff were more concerned about the reaction of Miss H's family, their complaint and possible claim, than Miss H's loss.

During the initial complaint investigation and the formal complaint investigation Miss H's family alleged Miss H's belongings went missing during her transfer from ward 1 and ward 14. The trust took responsibility for this during the formal complaint investigation but the fact Miss H's belongings went missing is not recorded in the patient notes.

Similarly, Miss H's family alleged during the formal complaint investigation that nursing staff played football with Miss H's doll. We have not found evidence for this. We visited ward 14 as part of our review. Miss H was a patient in bay 2 of ward 14. Bay 2 is visible from the entrance to the ward, the sister's office and the nurse's station. Miss H's bed in bay 2 is visible from the bay door and from an internal waist to ceiling height window. It is unlikely that staff could have played football with Miss H's doll without being seen. However, given that the internal window is from waist to ceiling only, the doll could have been kicked along the floor, below the level of the window.

Given the high quota of agency staff on ward 14, many of the staff were not familiar with one another. While we cannot say definitively there was no collusion amongst ward 14 staff to cover anything up, our impression that staff did not know each other well reduces the likelihood of conspiracy.

7.31 Miss H's family also say staff did not tell them about Miss H's transfer from ward 1 to ward 14:

> *"No-one rang to say, 'We've transferred Miss H. When you come tomorrow she won't be on the ward.'"*

7.32 We reviewed Miss H's internal transfer form dated 28 August 2013, when she was transferred from ward 1 to ward 14. The form says the reason for the transfer was a *"a medical patient capacity issue"*. The form also says Miss H's next of kin were aware of the transfer.

Comment

We are concerned that the trust did not notify Miss H's family about Miss H's transfer from ward 1 to ward 14. It is particularly poor that Miss H's internal transfer form says that Miss H's next of kin were aware of the transfer.

Timeliness of attention to physical needs

7.33 We found no evidence in the clinical notes that Miss H was left in soiled linen. Ward 14 put in place a plan for Miss H to have continence pads and she received regular comfort rounds, typically on a four-hourly basis, which are appropriately recorded in Miss H's patient notes. After the formal complaint investigation, the trust's director of nursing agreed to work with staff to ensure patients with continence problems received more regular checks.

7.34 Miss H's family informed us that they provided ward 14 staff with continence pads for Miss H but they were not used.

7.35 Ward 14 staff said that although they offered Miss H help with showering, she refused and preferred to be given bed-based hygiene.

7.36 During the initial complaint investigation and the formal complaint investigation Miss H's family alleged that Miss H's pressure mattress did not work properly. We found no

evidence of this in the patient notes but we have spoken to trust staff who recall that the mattress did not work properly.

Recommendation

R6 Ward staff should check that equipment is working properly and report immediately when it is not. Wards should have a system for alerting the relevant trust department in a timely way.

8. The trust's management of the family's complaint

The initial complaint investigation

8.1 The family made an initial, verbal complaint on Sunday 15 September 2013 to the nurse in charge of ward 14. The complaint was in relation to the altercation with XY on Friday 13 September 2013 about Miss H's protected meal times and the damage to Rachel. Miss H and her family were understandably upset and concerned that the damage to Rachel was done with malicious intent.

8.2 On Monday 16 September, the earliest point after the damage to the doll at which the ward manager was on duty, the ward manager escalated the complaint to the trust's head of nursing for the medicine division, via a matron. This was in line with trust policy. The head of nursing for the medicine division started an investigation into the damage of Rachel. This investigation involved the trust's Patient and Liaison Service (PALS), a matron, the ward manager and a trust learning difficulties liaison nurse.

8.3 The ward manager met with XY on Tuesday 17 September 2013 and told her that Miss H's family had made a complaint about her in relation to the altercation on Friday 13 September 2013. The ward manager gave XY an attitude proforma on Tuesday 17 September 2013. The ward manager told XY that this would be kept on her personnel file.

8.4 Miss H's family raised several concerns at the start of the initial investigation in a meeting with the ward manager and the learning-difficulties liaison nurse. The meeting took place on the morning of Monday 16 September 2013. Miss H's family took an audio recording of the meeting. Their concerns during the initial investigation were:

- Miss H's family had not been told that Miss H was transferred from ward 1 to ward 14;
- Miss H's belongings went missing during the transfer;
- Behavioural problems and rudeness from ward 14 staff;
- Miss H said that staff had put their fingers up her nose;
- Miss H was left alone with scalding hot tea;
- Miss H was threatened by ward staff;
- XY had pressured Miss H's family to find a placement for her;
- Miss H's pressure mattress did not work properly;

- Miss H had not been washed;
- Miss H had been left in soiled sheets; and
- Rachel's arm had been cut off with scissors.

8.5 This initial investigation was unable to establish who damaged Rachel. The head of nursing for medicine explained:

"Everybody was saying 'I have no idea how this happened' and that was that."

8.6 After about a week and a half of investigation the head of nursing for medicine relayed their lack of findings to the trust's HR department and Miss H's family. HR told the head of nursing for medicine that no further investigations would be carried out due to lack of evidence, in accordance with policy.

8.7 The trust wrote a formal response to Miss H's family in which it agreed with them that it appeared Rachel had been deliberately cut with scissors. The trust agreed several actions with Miss H's family:

- to ensure that ward 14 staff allowed Miss H's family to help Miss H at meal times;
- to follow up the family's concerns with XY; and
- to apologise for the distress caused.

8.8 The trust told the family that Miss H was offered showers but she refused them.

Comment

The initial complaint response and investigation was not as sympathetic as it should have been. Ward staff on Sunday 15 September should have notified Miss H's family and the ward manager of the damage caused to Rachel. Although ward staff on Sunday 15 September did notify the on-site manager, escalation to the ward manager, who was off duty at the time, would have been proportionate and demonstrated a proactive response to the incident with the doll.

Furthermore, despite the ward staff telling the on-site manager on Sunday 15 September, the significance of Rachel was not conveyed. Our impression is that this is

because the ward staff themselves did not adequately understand the significance of Rachel to Miss H.

Ward staff should have notified Miss H's family at the earliest opportunity with a phone call on the morning of Sunday 15 September 2013, so they were aware of the damage to Rachel before their arrival on the ward at lunchtime. The trust missed opportunities here.

Recommendation

R7 The trust should ensure that initial complaint responses are dealt with in a sympathetic and serious way. The trust should assure itself that its staff are aware of escalation procedures and when to contact relatives and carers.

8.9 When the head of nursing for the medicine division described hearing about the damage to Rachel on Monday 16 September 2013, their instinct was to offer to replace it. The sentimental value of Rachel was not conveyed to the head of nursing who told us:

> *"People very much viewed it as a toy even though they realised that it is a life-like one."*

8.10 The trust's clinical claims manager described the trust's initial complaint response:

> *"The initial response was poor, because people failed to appreciate the importance of Rachel to Miss H, I think there was a failure to see how important that would be to her. I know the family were very upset about the fact that it'd been taped back together, but the nurse who did that did that to try and calm her down – I think that response was right, to do that at the time. The family found out about the incident when they arrived on the ward, they hadn't been told previously, which would have been very upsetting."*

Comment

We believe Miss H's family was dissatisfied by the initial investigation because trust staff did not appreciate the importance of Rachel to Miss H or take the damage seriously. We believe that the family were justified in this view.

Staff failed to recognise the needs of Miss H regarding her relationship with Rachel. Had ward staff and trust management appreciated Rachel's significance, a more extensive and comprehensive investigation would have taken place. This might have brought about a prompt and more satisfactory outcome. It is likely that evidence would have been taken from staff and other patients immediately, which would have made the task of the complaints investigation more straightforward.

We have devised R13 to help the trust ensure that its staff appreciate the significance of objects such as dolls to patients with learning difficulties.

The formal complaint investigation

8.11 Miss H's family was not satisfied with the outcome of this initial investigation and wrote to the Care Quality Commission (CQC) in September 2013. The CQC referred the complaint to the trust's chief executive and asked for further consideration to be given to the family's concerns about the care and treatment given to Miss H on ward 14. The trust's director of nursing appointed the director of governance at the time, to conduct a formal complaint investigation starting in September 2013.

8.12 The trust appointed an executive level member of staff to conduct the formal complaint investigation due to the severity of the allegations. Interviewees described appointing a member of trust staff at the executive level to lead a complaint investigation as a *"rarity"*. The trust's head of patient relations described the trust's decision to appoint the former director of governance to the complaint investigation as:

> *"one, because of the level of seriousness of the allegation but, two, to offer that reassurance to the family because I didn't think they felt reassured with the investigation that had already been undertaken."*

"It is a rarity to ask a director to investigate themselves but we do it in cases where we feel it's necessarily required to offer some transparency in the process."

8.13 We spoke to the former director of governance about her appointment as the formal complaint investigator:

"it was unusual [for an executive level member of staff to conduct a complaint investigation]. *I think that the reason why I was asked to undertake the investigation and certainly the reason that I felt that on this occasion it would be appropriate was because the allegations were so significant, highly unusual and, clearly, needed very robust review and quite an extensive approach to the investigation process."*

Comment

The appointment of the trust's director of governance to lead the formal complaint investigation reflected the fact that the trust was taking the allegations seriously. This decision demonstrated that the trust was committed to doing its utmost to ascertain what had happened to Rachel and whether there was evidence for the concerns of Miss H's family. We have no concerns about the competency of the former director of governance to undertake the investigation.

8.14 The former director of governance wanted to ensure that the formal complaint investigation started anew, given that Miss H's family was not satisfied with the initial investigation. She met Miss H's family at the start of the investigation to consult them about the terms of reference. She told us:

"I was aware that the family had raised concerns at ward level [the initial complaint] and they shared with me the response that had been given to them after they had raised those concerns … Rather than going back and revisiting that, I started with a clean sheet because I needed to be completely objective and I didn't want any previous perceptions from other employees within the organisation to colour my view, so I started with a clean sheet of paper."

8.15 She described their impression of how Miss H's family saw the initial investigation:

"Very negatively, I think. I think the family felt that they hadn't been taken seriously. I think that the family felt that the robustness of looking into the issues that they had raised was just not there and that there was, more or less, a general perception that 'This is so extreme that it couldn't possibly happen.' I don't think they felt that the rigour was there and they certainly didn't feel assured that it had been investigated to the level that they would expect, hence the concerns that were made to the Care Quality Commission."

8.16 The trust's head of patient relations supported the former director of governance in the formal complaint investigation. The investigation process included:

- initial written statements from all staff working on ward 14 on Saturday 14 September 2013;
- face-to-face interviews that the former director of governance chaired, with staff working on ward 14 on Friday 13 September, Saturday 14 September and Sunday 15 September 2013;
- a home visit to interview Miss H in the presence of Miss H's family;
- a face to face interview with a patient who was in the same bay of ward 14 as Miss H at the time of the alleged incident relating to Miss H's doll;
- written reports from each of the above interviews;
- written statements from Miss H's family who witnessed concerns about staff on ward 14;
- a full examination of Rachel;
- a conversation with a Reborn doll expert;
- clinical photography of the damage caused to Rachel;
- a review of Miss H's health records; and
- a review of an audio recording Miss H's family made of a meeting between themselves and ward staff on Monday 16 September 2013.

8.17 The range of the concerns investigated included:

- Miss H's overnight bag going missing during her transfer between ward 1 and ward 14;
- Whether there were trained staff available to represent Miss H and her learning difficulties throughout her time on ward 14;

- meal menus were left in front of Miss H despite the fact that Miss H could not read;
- there appeared to be no handover and liaison with staff between nursing shifts;
- staff on ward 14 were prioritising using their mobile phones and over patients pressing buzzers for help;
- nursing staff had pressured Miss H's family to find a placement for Miss H;
- XY had spoken to Miss H's family in an aggressive tone and instructed them to leave the ward during protected mealtimes on one occasion;
- Miss H refused her medication and a nurse put their fingers up her nose until it bled;
- nursing staff played football with Rachel to make Miss H cry;
- a member of nursing staff cut Rachel's arm off with a pair of scissors from the top pocket of their blue uniform;
- nursing staff had wrapped the doll in a slip sheet so that Miss H's family wouldn't see that it was damaged;
- another patient on the bay witnessed the above and spoke to Miss H's family members;
- on discharge to a care home Miss H's hair was matted and she had not been showered during her time on the ward;
- Miss H's family found Miss H in soiled bed linen;
- Miss H was given scalding hot tea; and
- a staff nurse gave Miss H an injection despite the ward sister advising against it.

8.18 The former director of governance described the method for the formal complaint investigation:

> *"there was a very thorough review of the health records of Miss H, so we looked at all of the entries during that particular period. I also interviewed all of the staff that were certainly on the night shift on ward 14 when it was alleged that the incident had occurred, I interviewed some of the staff, the majority of the staff that had been on the long shift the day before, so they would have been finishing shift round about seven o'clock in the evening. I interviewed some of the staff that were on the shift the subsequent morning after the alleged day that the incident had happened as well. These were all face-to-face interviews, conducted by myself in the presence of the patient relations manager… following those, there was a written statement from those interviews which was sent out to all of the individuals for them to sign, which they did, so signed copies were returned back to me.*

"When I first met with Miss H in that preliminary meeting and she had the doll with her I suggested that it would probably be a good idea for us to take some photographs of the doll. We went to medical photography, just so that we could capture the condition of the doll at that time, so there was medical photography undertaken.[1]

"I also had some letters from the family that came in, giving their views, thoughts, perceptions of what may have happened, and I also went to the family home with the patient relations manager, Miss H was present, as was her family. We went to the home to interview Miss H [on 23 November 2013] and whilst we were there we were talking about the filling that goes inside the arm of the doll to weigh it down and there was a difference in opinion about what this content might be inside the arm, because we knew by that stage that a sandy substance had been found by the side of the bed. My feelings were that this could have been part of the content of the arm, the family were pretty confident that it was more like a cotton wool type of stuffing that was in the arm. After some discussion and with their absolute consent we agreed that we would remove the other arm of the doll. It also gave an opportunity for us to understand how easily the arm could be removed, i.e. could it have been removed with a pair of nursing scissors, could it have been removed simply by, for example, trapping the arm in the bed rails, twisting the arm, pulling the arm or did it need something a little bit more substantive? … the only way that we were able to remove the arm was with a pair of kitchen scissors actually.

"I also went to visit some of the patients that had been in the bay that Miss H was in. There was one particular patient who had been in the bay and I took the photographs with me of the doll and I went to see the patient with our Safeguarding Nurse for Older Adults, just to ensure that the patient had capacity really to be able to answer any questions. The patient did have capacity and was able to answer my questions and she recognised the doll. In fact, I didn't have to question the patient very much at all. As soon as I started sharing the photographs with the patient she voluntarily started to talk about an experience that the patient recollected, which had happened on one of the wards that the patient had been in, in the hospital."

[1] Clinical photographs of Rachel are included as Appendix H

Comment

When the former director of governance and head of patient relations removed the second arm from Rachel with scissors with the consent of Miss H's family, the same 'sandy substance' fell from the arm. Having spoken to a Reborn doll expert our understanding is that this substance is ground glass, used to provide weight to the dolls.

8.19 The former director of governance also spoke to a Reborn doll expert for an informed opinion on how the damage could have happened:

> *"The lady that I spoke to assured me that that* [the damage] *is not going to happen easily… it may be years and years and years' worth of use before you get to the stage where the limbs start to become more fragile."*

8.20 Miss H's family told us that Rachel belonged to Miss H for some years. They had bought Rachel new from a local shop.

Comment

The trust's formal complaint investigation was thorough and comprehensive. The depth of the investigation and the appointment of senior personnel to lead it shows that the trust was not attempting to cover up the allegations Miss H's family raised.

8.21 The trust's findings and responses to the range of concerns were as follows.

8.22 Some of Miss H's belongings did go missing during her transfer between ward 1 and ward 14. The trust apologised and reinforced its policy to staff to ensure that patient's belongings are kept with them at all times. The trust offered to reimburse Miss H for the cost associated with loss of belongings.

8.23 A representative from the trust's vulnerable adults team saw Miss H several times while she was on ward 14 with health record entries on 30 August, 3 September, 4

September, 9 September and 12 September. The entries show Miss H was sleeping on several of these occasions so there was limited direct interaction between Miss H and the learning difficulties nurse. In response to this the trust reinforced the use of its 'ten key messages' (included in appendix D) for patients with learning difficulties. Learning difficulties awareness sessions were also delivered to staff on ward 14. The trust also introduced a new bedside folder for all inpatients which contains a section called 'about me' to state their preferences relating to eating and to outline special needs. The trust also introduced hospital passports. These are documents that patients with learning difficulties keep and that contain key information on how the patient prefers to communicate and what their special needs are.

8.24 The trust apologised that Miss H had been presented with meal menus without assistance to read them. The initiatives outlined above were intended to prevent future recurrence.

8.25 The trust accepted that they needed to review nursing handover arrangements and the matter was referred to the director of nursing.

8.26 The trust apologised that staff failed to respond appropriately to the buzzer system. It conducted an audit on the responsiveness to patient buzzers and routine checks on the quality of care provided. The trust also reinforced the message that staff should never prioritise mobile phone use over responding to patient buzzers.

8.27 The trust apologised that pressure had been put on Miss H's family to find a placement for Miss H. This matter became part of the disciplinary investigation into XY.

8.28 The trust acknowledged that the protected mealtimes protocol had been waived for Miss H and her family. This was to support Miss H with eating and drinking. The trust apologised that a member of ward 14 staff was "aggressive" to Miss H's family in relation to this protocol. This matter became part of the disciplinary investigation into XY.

8.29 The investigation failed to find evidence that staff members had put their fingers in Miss H's nose. The trust asked Miss H's family if they had further evidence to substantiate the concern.

8.30 The investigation concluded that Rachel's arm had been cut with a pair of scissors. The trust said that Miss H would not have had access to scissors while she was in hospital and therefore she could not have caused the damage. The findings from the investigation, in relation to the damage to the doll, led to the trust excluding two members of staff. This was based on statements Miss H and another patient on bay 2, ward 14 provided, giving the same description of the incident and of the individual involved. This matter became part of the disciplinary investigation into XY and was relayed to the trust board. The trust board extended their full and sincere apologies to Miss H and her family for the distress caused. The trust, at this point, understood the emotional significance of Rachel to Miss H. While it acknowledged that it was unable to fully compensate her for this significant loss, it offered to financially recompense Miss H for the damage caused to Rachel.

8.31 Ward 14 staff said that while they offered Miss H the opportunity to be given assistance with showering, Miss H refused and preferred to be given bed based hygiene.

8.32 The trust apologised that Miss H's family found her in soiled sheets. Ward 14 put a plan in place for Miss H to have continence pads and she received regular comfort rounds, typically on a four-hourly basis. The director of nursing agreed to work with staff to ensure that patients with continence problems received more regular checks.

8.33 During the investigation, the trust reviewed the temperature of hot drinks served to patients on wards. After this it requested that ward-based staff ensured that no patients are served drinks that are hot enough to cause scalding. Again, the trust apologised that Miss H had been offered scalding hot tea.

8.34 The investigation was unable to clarify the details of the injection the staff nurse provided. This matter became part of the disciplinary investigation into XY.

8.35 The formal complaint investigation concluded in January 2014. The chief executive reported the investigation's conclusions to Miss H's family in a letter dated 28 January 2014. The trust apologised for the distress caused and accepted that Rachel was deliberately damaged and that the standards of nursing care fell short of those the trust expects.

8.36 The trust offered to meet Miss H's family to discuss the conclusions but by then Miss H's family had instructed solicitors, Leigh Day, to act on their behalf and prepare to take civil proceedings against the trust in January 2014. Leigh Day then became the point of

contact for the trust as the legal representation for Miss H's family. Miss H's family did not attend the proposed meeting to discuss the findings from the formal complaint investigation in January 2014.

Comment

Miss H's family have said they were disappointed that they did not meet the chief executive at the close of the formal complaint investigation. However, we understand Miss H's family were invited to a meeting but did not attend. It is likely that Miss H's family would have attended the meeting had their lawyers not suggested that all future contact with the trust be through them.

Miss H's family acknowledge that they met the former director of governance at the start of the formal complaint investigation at Walsall Manor Hospital. Miss H's family are satisfied with the level of contact they had with the former director of governance during the formal complaint investigation.

8.37 As a result of findings produced during the formal complaint investigation, the trust excluded two members of ward 14 staff in December 2013 pending disciplinary action. These were a staff nurse XY and a clinical support worker. The trust launched a disciplinary investigation into XY in January 2014. The clinical support worker's disciplinary case was dismissed because they did not match a description of the person who had allegedly damaged the doll. Miss H, and another patient on bay 2 of ward 14 had given these descriptions during the formal complaint investigation. We review the trust's management of this disciplinary investigation in section 10 of this report.

Comment

During the formal complaint investigation Miss H's family continued to believe that XY had damaged Rachel. This was in part due to the testimonies of Miss H and the other patient on bay 2, ward 14. Both described the physical characteristics of XY and a distinctive coloured bobble she wore in her hair.

However, during our review, interviewees said that the quality of the testimonies Miss H and the other patient provided would not have stood up in court. Unfortunately, both Miss H and the other patient died by the time we started our review so we could not interview them. However, we comment on the complaints statements of Miss H and the other patient in the next section.

Miss H's family's view is that the formal complaint investigators themselves believed XY could have damaged the doll, given that they recommended the trust to exclude XY pending disciplinary action. Miss H's family believe that the investigators suggested to them that XY had damaged the doll during the formal complaint investigation.

The formal complaint investigators denied this and told us that based on their analysis it was possible XY damaged the doll, but there was insufficient evidence to conclusively demonstrate that she had. This is why the investigators recommended that a further, disciplinary investigation should be carried out into XY.

8.38 Several interviewees expressed dissatisfaction about how a senior trust nurse treated staff in the aftermath of the formal complaint. The impression they gave us was that ward 14 staff were treated as though they were *"guilty until proven innocent"*. A member of the ward 14 team told us that they were *"interrogated"*:

> *"I felt that the nurses didn't believe us, they didn't trust us – I am talking about… the directors."*
>
> *"We were spoken to like rubbish, like "You are liars"."*

8.39 Miss H's family told us they were concerned that senior trust staff had told ward 14 staff to cover up the incident with Rachel and not reveal what happened to investigators.

Comment

Given what ward 14 staff have told us, we do not believe that senior trust staff were encouraging a cover up. Instead it is apparent that senior trust staff thought ward 14 staff were to blame for the damage to Rachel.

While we are reassured that senior trust staff took the formal complaint investigation seriously, it is concerning that ward 14 staff interviewed as part of the process felt unfairly blamed and in some cases bullied.

Recommendation

R8 The trust should ensure that it treats its staff with respect when conducting a formal complaint investigation.

8.40 A member of the senior nursing team told us they were *"disappointed"* they had been *"totally uninvolved"* in the decision making or communication about the formal complaint investigation.

8.41 In general, interviewees told us they felt excluded from communications about Miss H's case. In many cases trust staff first discovered the status of the trust's internal investigations into the case when Miss H's family released newspaper articles via the local press.

8.42 A member of ward 14 staff told us:

> *"nurses collapsed on the ward with panic attacks, because it is in the papers. Nobody told us. A relative came on the ward and pointed it out to us."*

Comment

We are concerned the trust did not take the initiative to notify staff involved with Miss H's case about developments in the investigation. This led to ward 14 staff being underprepared and upset when they encountered Miss H's family and read the related articles in the local press.

Recommendation

R9 The trust should ensure that staff involved with Miss H's case are fully informed of the outcomes of this investigation.

9. Interview with XY and analysis of the complaints statements of Miss H & Ms W

9.1 In this section, we report on our interview with staff nurse XY. We also comment on the complaints statements of Miss H and Ms W (the other patient in bay 2).

Staff nurse XY

9.2 We interviewed XY on 17 March 2017. She was accompanied by her Unison representative.

9.3 We have summarised below some of the points from the interview.

9.4 XY came into nursing in the early 90s as a degree-qualified nurse. She was offered employment at the trust after qualification in the mid-90s. During her time in the trust she had worked on acute admissions and medical admissions. She said that she had 'a completely unblemished record' until these allegations.

9.5 Her substantive role prior to joining ward 14 had been on ward 3. She couldn't recall precisely when she was seconded to ward 14 but it was when it was joined with ward 12. (Eventually, the wards were separated). She confirmed that the ward was run with a core of experienced staff, supported by agency nurses and support workers.

9.6 She was regularly nurse in charge of a shift and didn't therefore provide much direct nursing care. She didn't recall ever giving Miss H direct nursing care though she did know of her and said that the care support workers talked about Rachel. She said that she recalled one occasion when Miss H was upset.

9.7 XY acknowledged that there had been '*altercation*' with Miss H's sister on Friday 13 September. She explained that she was '*trying to uphold Trust policy*' about protected mealtimes and '*didn't know whether SH was capable of feeding herself*'.

9.8 She said that she had '*remonstrated*' with her ward manager about the use of the attitude pro forma and wrote to HR to contest it. XY said that she had not been subject to an attitude pro forma in the past.

9.9 She said that she had *'never as much as lifted the doll or touched the doll at all, in the entire time that SH was with us'*.

9.10 XY told us that there were two other qualified nurses on the ward with blonde hair at the time of the incident.

9.11 XY was interviewed by the trust complaint investigation team in November 2013. She told us that she was excluded from the trust in December 2013. She returned to work on ward 15 in May 2014. In October 2014 XY was told by the trust that the police were investigating. She was told she might be interviewed.

9.12 Some months after being notified of the police investigation XY was told by the trust that she would not be interviewed. She had to make an enquiry to find this out.

9.13 In November 2014, the trust directed XY to another job in the hospital so that there was no possibility of contact between Miss H, her family and XY. She worked in an administrative capacity.

9.14 She had periods of sickness because of stress and anxiety.

9.15 She told us about the local and national press coverage the story had received.

9.16 In concluding her interview, XY said that: "*At the time when the damage was supposedly done to the doll, I wasn't even on duty.*"

9.17 XY has since confirmed that she had not worked on ward 1 and could not recall ever having visited ward 1.

Miss H's statement

9.18 The former director of governance and the head of patient relations visited Miss H at home on 23 November 2013 in order to take a statement from her. This was some 10 weeks after the incident on ward 14. Miss H's sister and her granddaughter were present. The head of patient relations made a contemporaneous handwritten note of the discussion. This was prepared as a typed record after the meeting.

9.19 In her evidence to the former director of governance and the head of patient relations, Miss H said the following:

- She described a pair of scissors in the pocket of the overall of the nurse
- She had been for an x-ray and that when she came back she picked up Rachel (the doll) and the arm had dropped off
- The nurse had cut off the doll's arm with scissors and swung it about
- The nurse was being naughty
- Rachel had been on the bed with her at night time
- The nurse was wearing a blue uniform with white hair (blonde colour)
- The nurse's hair was in a bun
- She had seen the nurse on ward 1

9.20 In her evidence, Miss H said that the damage to Rachel had happened after her X-ray. She said staff were throwing Rachel about.

9.21 Miss H said she was told she was a naughty girl for not taking her medication. She also reported that she had had a tube put up her nose.

9.22 During the visit, the former director of governance and the head of patient relations examined Rachel and, with the family's agreement, cut off the other arm to enable a comparison to be made to the damage to the other arm.

9.23 Miss H's statement is included in its entirety at appendix I.

Comment

It is evident from the statement that Miss H recalls details of her care and treatment though possibly not the details and precise timing of events. This is not surprising given the trauma she had experienced and the passage of time between the mistreatment of Rachel and the trust team taking her statement.

It seems likely to us from Miss H's statement that she witnessed at first hand the mistreatment of Rachel. No doubt, damaging Rachel in front of her was deliberate and would have been traumatic and extremely upsetting given the nature of her close relationship with the doll.

Miss H recalls in her statement that she had returned from X-ray and picked up Rachel and the arm had dropped off. We know from hospital records that Miss H had had an ultrasound on the Friday morning. Her statement therefore suggests that the damage was done to Rachel on the Friday morning. However, we know from other witnesses that Rachel was intact on Saturday during the day so this seems unlikely. Further, XY had not had the altercation with Miss H's family at this point so her alleged 'grudge' would not have been a motivation.

Miss H's statement suggests that the arm was completely detached on the Friday. Other witnesses say that the arm had sustained a cut on Sunday early morning. It appears to have become fully detached at some point on Sunday late morning.

Miss H recalled that she had seen the nurse who had damaged Rachel while she was on ward 1. We know that XY had been working on ward 14 for some time by September 2013 and her substantive ward before that had been ward 3. She said to us she had never worked on ward 1 and could not recall ever visiting it. She also said she had not provided direct patient care to Miss H while she was on ward 14.

Had we been able to speak to Miss H we may have been able to resolve some of these inconsistencies in her statement.

Ms W's statement

9.24 The head of patient relations interviewed Ms W on 13 December 2013 during an admission to ward 8. The former director of governance and the lead nurse for older adults and vulnerable adults were also at the interview. This was 13 weeks after the incident. The head of patient relations made a contemporaneous handwritten note of the discussion. This was prepared as a typed record after the meeting.

9.25 In her evidence to the head of patient relations, Ms W said the following:

- When shown a picture of Rachel, Ms W said that when she was a patient on ward 14 a lady in the other bed had a doll like that. She said that she had watched the nurses pull the arm off the doll and that the night nurse did it. She had blonde hair.
- Ms W recalled that Miss H was crying and screaming when Rachel was damaged and that the nurse threatened her *'to keep her mouth closed or she will close it for good'*.
- She described the nurse as having blonde hair with a fringe and that she had seen this nurse a lot as she worked on the ward regularly.
- Ms W said the member of staff *'gives patients hell'*.
- The 'girl' (presumably Miss H) who was screaming *'was hit across the mouth and told to stop crying shut up and say nothing'*. She described another member of staff with dark hair and a fringe. Both where white members of staff.
- She said, '*the staff were temporary as they had told her'*.

9.26 Ms W's statement is included at appendix J.

Comment

We think it is highly likely that Ms W witnessed the mistreatment of Rachel in bay 2. It also seems that more than one member of staff was involved.

She says that she watched the nurses pull the arm off the doll but we know from other evidence that the arm was found cut during the night rather than detached.

She reports that the damage happened at night and that two members of the night staff were responsible.

Ms W suggests that at least one of the nurses worked on the ward regularly but also says they were temporary.

We would have liked the opportunity to talk to Ms W about her statement.

10. The trust's conduct and management of the disciplinary investigation

10.1 Our expert HR advisor examined the trust's management of the disciplinary investigation into trust staff nurse (XY). Miss H and another patient on ward 14 at the time, identified that XY's uniform and physical appearance matched the person who had damaged Rachel. We were given access to trust's disciplinary investigation report into XY. The trust did not give us access to the witness statements collected for the disciplinary report. The trust's lawyers explained the rationale for this:

> *"Witness statements relating to potential disciplinary proceedings of nursing staff who may have been involved in Miss H's care have not been disclosed. The witness statements form part of an individual's personnel file and the trust cannot disclose them without specific authority from those individuals"*

10.2 On 13 January 2014, the trust's director of nursing commissioned the disciplinary investigation after the conclusion of the trust's formal complaint investigation. She appointed the then head of nursing and midwifery and an experienced HR manager to conduct the disciplinary investigation.

10.3 We were told that the head of nursing and midwifery was appointed for her seniority and reputation for being rigorous and fair. The head of human resource operations was appointed because of her experience conducting disciplinary investigations in accordance with HR policy.

10.4 The trust's disciplinary policy says:

> *"The appointment of the Investigating Manager is a crucial aspect of the investigation process and it is essential that a suitable candidate be identified to ensure that the investigation is carried out in a fair and reasonable manner. Advice from the Human Resources department can always be sought. In normal circumstances, the role of Investigating Manager will be assigned to the next in line manager of the employee being investigated. However, it is essential that the Investigating Manager can be independent and impartial to the case. So far as is possible, there should be no history of disputes between the employee and those conducting the investigation.*

It is highly desirable that the Investigating Manager will have relevant experience or training to enable them to carry out the investigation interviews effectively however they should always be supported by an experienced human resources colleague to guide and advise them accordingly. This may include training relating to interview technique or legal issues around the investigation process and the actual or potential allegation."

Comment

The trust appointed appropriate personnel to conduct the disciplinary investigation based on their skills, expertise and distance from the case. This was in line with trust policy.

Was the investigation carried out properly?

10.5 We have reviewed the final disciplinary report the disciplinary team produced, which concluded in March 2014. The investigation report outlines whether or not the allegations were proven and whether there was a case to answer under the trust's disciplinary policy.

10.6 The allegations brought against XY for the purposes of the disciplinary investigation were:

- gross misconduct involving wilful damage;
- misuse of an employee's official position; and
- conduct likely to bring the trust into disrepute with respect to the damage to Miss H's doll.

10.7 The disciplinary team undertook 21 interviews with 19 members of trust staff. The first of the interviews took place on 29 January 2014 and the last on 6 March 2014. Only trust staff were interviewed. Interviewees were selected based on whether they might have been able to give evidence about what happened to Rachel and who was involved. The disciplinary team also consulted the statements taken from staff and patients during the complaint investigation. The disciplinary team, following guidance from the trust's director

of nursing, did not interview Miss H or her family during the disciplinary investigation because the trust did not want to cause further distress. The disciplinary team also examined the staff nurse's personnel file, a schedule of staff and shifts for Saturday 14 September 2014, Friends and Family survey results and the staff nurse's car pass record.

Comment

The examination of XY's car pass record demonstrates the disciplinary team took appropriate action.

10.8 We reviewed the car pass record to determine if we could identify XY's site entrance and exit times, particularly her site exit time on Saturday 14 September 2013.

10.9 We could determine when XY entered the car park she routinely used, but not when she left. The technology does not record exit times. Given the limitations of the car park technology we cannot definitively determine when she left the trust site on Saturday 14 September 2013.

10.10 We asked all our interviewees from the night shift whether they had seen XY or anyone else that should not have been on the ward. Ward staff told us that they had not seen XY or other unexpected personnel.

Comment

There is nothing untoward about XY's site entrance times listed on her car pass record. Given the limitations with the car park technology we cannot definitively determine when XY left the trust site on Saturday 14 September 2013. We also contacted the trust's IT department to get data on when XY logged of her computer on Saturday 14 September 2013. However, the data was no longer available on the system. The trust only keeps such data from 2015 and beyond.

10.11 Before the start of the disciplinary investigation, the work the complaint investigation team conducted identified two members of trust staff, XY and a bank CSW, who could have been involved in damaging Rachel. This was based on evidence in the statement Miss H gave as part of the complaint investigation on 23 November 2013, and from a statement taken on 13 December 2013 from another inpatient who was on ward 14 and in the same bay as Miss H the time of the alleged damage to Rachel. The statement that the trust's patient relations manager took at the home of the Miss H's sister, said:

> *"Miss H described the nurse as wearing a blue uniform with white hair, she then pointed to her niece's hair which was a blonde colour and said, 'like this'. She stated it was up like a pony tail/in a bun."*

10.12 The formal complaint investigation led to the exclusion of XY and the bank CSW on 13 December 2013, pending disciplinary action. However, at the start of the disciplinary process the disciplinary team dismissed the case against the clinical support worker because they "*didn't match the description*". The investigating officer explained:

> *"We physically met the clinical support worker as part of it and she didn't match anything."*

10.13 The disciplinary report says:

> *"When the disciplinary investigation team met with the clinical support worker they did not match the description given by the patient and her exclusion from the Bank was lifted."*

10.14 The disciplinary team did not have doubts about whether the physical appearance of the staff nurse matched Miss H's description:

> *"She seemed to match what had been described."*

10.15 We asked interviewees if the bank CSW's physical appearance matched the description Miss H provided. While one person believed that there was a match, the overwhelming majority of interviewees told us that the bank CSW's physical appearance did not match the description Miss H gave. We were not able to interview the CSW because they had left the trust and we were unable to trace them.

10.16 Senior trust staff told us that the trust examined staff photos to decide who should be subjected to a disciplinary proceeding. Their decision to dismiss the case against the bank CSW was appropriate.

10.17 The key findings from the disciplinary were that:

- all interviewees agreed that the damage to Rachel appeared to have been done deliberately;
- none of the interviewees witnessed Rachel being damaged; and
- the altercation on Friday 13 September 2013 between the staff nurse and Miss H's family was deemed serious enough to discuss with the staff nurse using the trust's monitoring professional attitude monitoring form. This was not raised as a formal disciplinary issue and was her first 'offence' relating to attitude.

10.18 The disciplinary team concluded that no one admitted to witnessing Rachel being thrown about or damaged. The authors wrote:

> *"Wilful damage - unproven in respect to the doll. Conflict of evidence between patient and staff/workers on the ward. There is no direct link involving XY or any other members of staff"*

10.19 The disciplinary team were unable to prove the allegation of wilful damage because they lacked evidence. The disciplinary team concluded that there was no evidence to corroborate that the staff nurse had damaged Rachel.

Comment

The disciplinary team's conclusion on whether the staff nurse wilfully damaged Rachel was appropriate. There was, and still is, an absence of evidence to support this allegation against XY

While the disciplinary team concluded that no staff members witnessed the damage to the doll, a patient did claim to witness it. Our view is that the disciplinary team should have re-interviewed this patient, building on the interview with the patient the former

director of governance carried out during the formal complaint investigation. This would have helped to assess the credibility of their testimony.

Interaction of investigation team with staff

10.20 The treatment of the other allegations against the staff nurse, of misuse of employee's position and conduct likely to bring the trust into disrepute, was more difficult to evaluate because assessment of these allegations would rest on the subjective views of the staff nurse's professionalism, conduct and attitude.

10.21 In the disciplinary report, the authors say:

> *"The altercation on the Friday (13 September 2013) evening with the family and the staff nurse was deemed serious enough to discuss with the staff nurse utilising the (trust's) "Monitoring Professional Attitude" monitoring form. This was not raised as a disciplinary issue and was the first 'offence' relating to attitude."*

10.22 As part of the disciplinary investigation the disciplinary team examined issues relating to XY's behaviour, personality and manner. The disciplinary team encountered some examples of poor practice in these areas but there were no formal concerns or complaints about XY before the altercation on Friday 13 September 2013. The disciplinary team concluded there was insufficient justification to proceed with formal disciplinary action against the staff nurse in relation to the altercation on the Friday 13 September 2013 and that monitoring XY with a professional attitude proforma was appropriate action.

10.23 Furthermore, the disciplinary team concluded that the allegation of conduct likely to bring the trust into disrepute was unproven.

Comment

It is reasonable to conclude that the Friday 13 September 2013 altercation did not need formal disciplinary action and instead needed the use of a monitoring professional attitude proforma. XY did not have a history of rude behaviour.

The disciplinary team concluded that the allegations of misuse of official position and of conduct likely to bring the trust into disrepute were unproven. This is a reasonable conclusion to have reached given the absence of previous incidents of this nature relating to XY.

Because the disciplinary team concluded that all three allegations against XY were unproven, the trust took appropriate action in deciding not to refer XY to the NMC in view of Miss H's case. Miss H's family later referred XY to the NMC in relation to her case in June 2016.

10.24 The disciplinary report included conclusions on staffing mix, organisational culture, leadership, calibre of individuals and adherence to organisational processes on the ward.

10.25 We examined the trust's disciplinary policy to identify if due process was followed. The disciplinary investigation had problems getting interviewees to meet them. The investigating officer acknowledged this in an interview:

> *"It was difficult to meet some of them (the interviewees), it took several attempts to get them to come to interview."*
>
> *"I did struggle to get them to engage."*

10.26 The investigation report says individuals had delayed the disciplinary investigation by *"just not attending scheduled meetings"*.

10.27 However, the investigating officer was clear that XY *"cooperated from the start"* and *"didn't object"*.

10.28 We asked the investigating officer if she thought interviewees were being honest with the disciplinary team:

> *"I thought they were being honest, I didn't have any reason to doubt them. It was difficult because they didn't all know each other, so even just describing each other in the statements, because … they weren't all necessarily familiar with each other.*

I think they just told me in isolation what they experienced, there was no collaboration because they didn't know each other."

Comment

The trust's disciplinary policy requires all parties involved in the process be mindful of timescales and that procedures should not be unduly delayed because people involved are unavailable. Managers could have done more to ensure that individuals participated in a timely way.

10.29 We found no record of the trust taking disciplinary action against XY before Friday 13 September 2013.

10.30 A senior member of the trust's HR team told us that although the trust subsequently took disciplinary action against XY about another matter, the content of this action was unrelated to the disciplinary investigation relating to Miss H's case. A senior member of HR staff told us:

"It wasn't around something malicious like this. It was just general nursing practices."

10.31 XY was not dismissed after this disciplinary action. XY no longer works at the trust, having resigned voluntarily.

10.32 During our review, Miss H's family expressed concerns that XY had received a pay-out from the trust and knew the chief executive. The chief executive told us that he had never met XY and a senior member of HR staff confirmed that XY did not receive a financial settlement.

10.33 Furthermore, Miss H's family told us that the chief executive had told them at the mediation meeting in March 2015, that it would cost the trust a significant amount of money to dismiss XY. We put this to the chief executive who explained that if the trust had dismissed XY without due cause, and was subsequently challenged on this decision, the trust would then be liable to pay compensation.

Comment

Interviewees told us that the trust's management team had put pressure on the disciplinary team to get to the bottom of what had happened to Rachel and that there was significant challenge to the conclusions reached. This included from non-executive directors on the trust board. We are reassured the conclusions from the disciplinary investigation were probed and not simply accepted at face value. The evidence was not clear enough to dismiss XY after the disciplinary investigation.

10.34 The trust's disciplinary policy says:

> *"Where it is considered that the matter should* ***not*** *be referred to a disciplinary hearing, the Disciplinary Manager will advise the employee accordingly, as soon as possible and in writing"*

Comment

We saw evidence that it was not until 9 May 2014 that the disciplinary manager told XY about the outcome of the disciplinary investigation. Given that the disciplinary investigation report was concluded in March 2014, we find there was an unexplained delay in informing XY that the disciplinary action would not be referred to a hearing. This contravened trust policy, which asserts that employees should be told "as soon as possible".

11. The police investigation

11.1 On 6 September 2014 Miss H's family asked West Midlands police to investigate their allegations of mental abuse and poor care. This is the first time any party engaged the police in relation to the incident with Rachel. Miss H's family told the police that although the trust had dealt with matters internally they were not happy with the outcome and believed that there was a criminal element. As part of our review we spoke to the lead investigating officer at West Midlands Police and reviewed their crime report.

11.2 In the first instance the police met with Miss H and her family at the home of Miss H's sister. The meeting took place on 24 September 2014 and two police officers conducted a video recorded interview[1] of Miss H who described her recollections of how Rachel became damaged. Miss H described a nurse in blue uniform with white hair using scissors to cut Rachel's arm off. Miss H did not know the nurses name and found it difficult to recall details when the police asked follow-up questions. The police told us they struggled to have a freely flowing conversation with Miss H.

Comment

Miss H told the police that the perpetrator had white hair. This is inconsistent with some of the accounts she provided to the trust in which she described the perpetrator as having blonde hair.

However, Miss H's family told us that Miss H would have found it difficult to differentiate between white and blonde hair. She had previously confused white and blonde hair in an interview with the trust.

The police told us that they did not believe that the testimony Miss H gave would have stood up in court.

[1] Unfortunately, the police informed us that a video interview they had taken of Miss H on 24 September 2014 had been destroyed, in line with policy, following their decision not to proceed with an investigation. This decision was based on a lack of evidence to meet the criminal threshold.

11.3 The police then consulted CCTV footage at the trust and reviewed unredacted trust documents covering the formal complaint investigation and the disciplinary investigation. The CCTV footage was inconclusive[1].

11.4 On 13 October 2014 and 21 October 2014 one of the police officers visited the trust and met the former director of governance and the trust's investigating manager responsible for the disciplinary investigation. The officer asked for full details of the staff believed to be involved and for details of the patient witness in the formal complaint investigation.

11.5 Although the police interviewed a member of trust staff they were satisfied that both of the trust's investigations were thorough and that all relevant staff had been interviewed.

11.6 By the end of October 2014, the police concluded that the criminal allegations from Miss H and her family were not supported and that it was not possible to conclude who damaged Rachel because the burden of proof did not pass the criminal threshold. However, like the trust, the police do not dispute that Rachel appears to have been damaged deliberately.

11.7 The police had no concerns that the trust obstructed this case. Their impression was that the trust welcomed the police review as a measure for validating the trust's internal investigations.

Comment

We are reassured that West Midlands Police told us the trust was not obstructive during the brief police investigation and that the trust welcomed the potential for validation from the police.

[1] The trust routinely destroys CCTV footage approximately one month after it is captured. Should a need arise, during the one-month period, to keep the CCTV footage the trust does so. Trust CCTV footage is restricted to public areas and is not installed in wards.

12. Board oversight

12.1 We reviewed trust board minutes from 30 January 2014, the earliest entry in the board minutes relating to Miss H's case, until 22 February 2017, the latest available notes at the time of writing this report. We did this to assess how aware the trust board was of Miss H's case and the actions it took to investigate her family's concerns of a cover up. We also spoke to a former trust non-executive director, who conducted a desktop review of both the formal complaint investigation report and supporting evidence and the disciplinary investigation report and supporting evidence.

12.2 Private board minutes from 30 January 2014 include a CQC whistleblowing concerns update, which the director of nursing presented. One of the cases discussed was Miss H's. The minutes say:

> *"a full investigation has been undertaken into the events described by the CQC including interviews with SH, another patient on the ward at the time and the staff involved"*

12.3 The investigation had concluded that there was *"deliberate damage to Miss H's doll"* and that at the time two members of staff were suspended pending a decision about disciplinary action. The minutes say:

> *"the Board expressed their significant concern that this incident could have occurred on a busy ward and urged rapid completion of the disciplinary investigation"*

12.4 The board noted a range of improvement actions: substantive staff had been recruited to ward 14 and a member of the professional development unit was working with the ward to support and develop professional standards. The director of nursing confirmed:

> *"she would be taking the most serious action if an individual is found* [as a result of the disciplinary investigation] *to have caused damage to the doll, threatened the patient or worked outside the professional code of practice"*

12.5 The director of nursing presented the outcome of the disciplinary investigation in the private section of the board meeting on 31 July 2014. We reviewed the dedicated report given to the board which says:

> *"it was noted that the disciplinary investigation had failed to identify the individual who had damaged the doll despite extensive investigation under the Trust's disciplinary policy".*

12.6 However, it noted that the damage to Rachel could not have been accidental and therefore the following action was taken:

- agency nurses who had worked on the ward around the time of the incident were suspended;
- all members of staff on duty from the day on Saturday 14 September 2013 through to Sunday 15 September 2013 had to attend a formal meeting with the director of nursing and a letter was placed on their files as a result of the meetings; and
- all these staff received specific training on caring for patients with learning difficulties and their families.

12.7 A former non-executive director, who we spoke to as part of our review, asked if patients who were on the ward at the time of the incident had been interviewed. The former director of governance confirmed that one had been interviewed as part of the formal complaint investigation and that their description of the person who damaged the doll (XY) corresponded with Miss H's.

12.8 However, the disciplinary investigation did not find evidence suggesting XY was on ward 14 at the time of the incident nor that she had caused damage to the doll. The minutes say the chief executive had invited Miss H's family to a meeting to discuss the outcome of the disciplinary investigation in March 2014 but they had not attended. The former non-executive director recommended:

> *"the board meet with the family at the close of legal proceedings to apologise formally to the family and Miss H for the distress caused".*

12.9 The chief executive advised the trust board in the private section of the 28 August board meeting that Leigh Day had sent letters to the trust detailing the next steps of the

civil claim. He advised the board that the case had been referred to the NHS Litigation Authority (NHSLA) who were appointing a panel solicitor to represent the trust. The chief executive,

> *"reiterated the failings delivered to Miss H and advised that the trust continued to wish to seek fair and reasonable resolution with the family and Leigh Day in recognition of the distress caused to Miss H".*

12.10 The former non-executive director requested a report be presented to the board in October 2014 providing an update on the implementations arising from the complaints investigation as well as wider assurance on how the trust cares for people with learning difficulties.

12.11 In the private section of the 30 October 2014 board meeting the trust's director of nursing presented a report to the board about learning from Miss H's case. We have reviewed this report, titled *"Investigation outcomes – Miss H"*. The director of nursing confirmed that all staff working on ward 14 at the time of the incident had completed agreed levels of training and education for patients with learning difficulties. The same staff group had also taken part in a one-to-one meeting with the director of nursing about the seriousness of the incident and a record of these discussions was placed on personnel files for six months. All agency staff working on the ward at the assumed time of the incident with the doll had been prevented from working in the trust again.

12.12 The former director of governance advised the board that the NHSLA had appointed Bevan Brittan as the panel solicitor. The director of nursing advised the board that the police had visited the trust twice in the month after the family brought allegations of criminal damage to them. Staff who had taken part in the complaint and disciplinary investigations were notified that the trust was disclosing their unredacted statements to the police to assist in their investigation. The notes say:

> *"the police had completed the review of both files including all the statements and had commended the trust on the thorough approach that had been applied internally to both investigations."*

12.13 The trust chair at the time, advised the board that the former non-executive director had reviewed *"all paperwork"* relating to this incident because of its *"very serious nature"*.

The chair reported that while the former non-executive director had *"felt very uncomfortable"* about what they had read, they concluded that there was *"insufficient evidence to identify the responsible individual and that as a result the right decisions had been taken by the trust."*

12.14 In the private section of the 26 February 2015 board meeting the former director of governance gave the board a verbal update on Miss H's case. She advised them that Miss H's family was pursuing legal action. It was noted that mediation would take place on 27 March 2015 and the chief executive would attend.

12.15 At the private board meeting on 30 July 2015 the chief executive updated the board on a small number of complex and longstanding complaints, including Miss H's case. We reviewed a dedicated report the chief executive and the head of patient relations produced to update the board on this matter. By this time the board was familiar with Miss H's case and the chief executive told the meeting's attendees that compensation had been agreed with Miss H and her family. Not only was a financial settlement reached but also an agreement to refer the case to the Parliamentary and Health Service Ombudsman (PHSO)for an external investigation of the care and treatment given to Miss H. This agreement was reached at a mediation meeting that the chief executive attended on 27 March 2015.

12.16 The chief executive explained that the theme connecting the complex complaints in all the cases was engagement with families and relatives at critical points in the patient's pathway. The board agreed to ask the PHSO to independently review the cases, including Miss H's case.

12.17 A board meeting took place on 29 October 2015. The chief executive and the head of patient relations presented another report with an update on complex complaints. We have reviewed this report. Miss H's case was included on the list of complex complaints but we found no further updates on the status of the PHSO referral.

12.18 In the private section of the board meeting on 3 March 2016 the chief executive presented a further report updating on complex complaints. The chief executive explained to the board that the PHSO had declined to conduct an external investigation into the Miss H case because it did not meet their criteria as the matter had been resolved locally. The PHSO recommended the trust seek an independent investigation. The chief executive therefore told the board that the trust would need to commission an independent review.

The chief executive made it clear that the next steps would need to be agreed with Miss H and her family.

12.19 In the private section of the board meeting on 4 August 2016 the chief executive presented the latest update on complex complaints from a dedicated report which we reviewed. In relation to Miss H's case, the chief executive said that a further external investigation was to be completed. At this meeting, he told the board that Verita had been commissioned to conduct the independent investigation and that the terms of reference had been drafted and agreed with Miss H's family. He advised that the next stage would involve Verita interviewing trust staff and that the NMC was investigating a complaint Miss H's family made against XY. In June 2016, Miss H's family had contacted the NMC to refer XY under the fitness to practice procedure.

12.20 In the private section of the board meeting on 1 December 2016 the chief executive presented a further update on complex complaints. In relation to Miss H's case, he told the board that a set of legal difficulties about the disclosure of documents to Verita had delayed the start of the investigation but that these difficulties would be resolved in the following two weeks.

12.21 In the private section of the board meeting on 2 March 2017 the chief executive presented a further complex complaint update report. He told the board that the legal difficulties had been resolved and that the investigation had started.

12.22 At the time of writing this report there were no further complex complaints updates to the board. The next one was due in the summer.

Comment

The trust board's monitoring of Miss H's case has been comprehensive. As listed above, there are numerous and extensive accounts in trust board minutes detailing the status of Miss H's case.

We are reassured that a trust non-executive director reviewed the reports and associated materials from the formal complaint and disciplinary investigations. The former non-executive director wished to ensure that these processes had been

conducted with appropriate rigour and that there had been no attempt to cover events up.

He concluded that the investigations were thorough and comprehensive. However, he expressed concerns about the delay in notifying Miss H's family of the damage to Rachel on Sunday 15 September 2013.

Our overall impression is that the trust board took Miss H's case seriously.

13. Improvements the trust made

13.1 NHS trusts have implemented a range of initiatives to mitigate the risks posed to patients with learning difficulties in the acute setting. Below we include details of the initiatives that Walsall Healthcare NHS Trust has implemented since the Miss H case in September 2013. We spoke to senior members of the trust's nursing team, including the trust's adult safeguarding lead, to investigate this. It is in part due to the determination of Miss H's family that these improvements have, or are taking place.

13.2 Since 2008 the trust has had one learning-difficulties liaison nurse. The post holder originally worked five days a week before reducing this to two and a half days a week. In December 2014, the trust recruited another learning difficulties acute liaison nurse but the two nurses job-shared, and continue to job-share a single full-time post. Their role is to support adults with learning difficulties as they enter acute services. The trust's lead for adult safeguarding explained:

> *"There have been two* [learning difficulties liaison nurses] … *but before that it was just one person. Although they are in acute liaison within the hospital, they are not always in the hospital, they are not here every single day. They are out in the community working with the PALS team doing things within the service there."*

Recommendation

R10 The trust should ensure that patients with learning difficulties are able to access the learning-difficulties liaison nurses in a timely manner.

13.3 The trust does not have an electronic alert system for flagging when a person with learning difficulties has been admitted. It is reliant on ward staff notifying the learning difficulties liaison nurses and the adult safeguarding team. Referrals come from the ward areas as well as family members. Sometimes referrals are made from community based learning difficulties nurses. The trust's lead for adult safeguarding said:

> *"Those are the referral pathways but it is not as streamlined as we would hope".*

13.4 The trust is developing an electronic flagging system. However, there are problems with information sharing between the trust and primary care providers because of issues with patient consent. At the time of writing this report, the trust told us a consent process is being developed.

13.5 Interviewees told us that around three years ago, the wards varied in how long it took them to refer patients with learning difficulties to the learning difficulties team. The trust's director of nursing who produced a board report titled *"Improving services for patients with learning difficulties"* in December 2014 noted the variation.

13.6 However, today the trust's adult safeguarding lead assured us that referrals are submitted in a consistent and timely manner:

> *"I get referrals from all the ward areas, there isn't one ward that wouldn't … I am more confident now"*

Comment

The trust's learning difficulties team is working on a method for obtaining consent from patients with learning difficulties so that they can be automatically flagged to the trust on admission. The trust's medical director is working with local GPs to ensure that the trust will acquire consent from patients with learning difficulties as part of the development of the electronic flagging system. It is our impression that the system could provide better outcomes for patients with learning difficulties, reduce complaints from them and their relatives and reduce their length of stay and increase satisfaction.

The PHSO's 2009 'Six Lives' report investigated the deaths of six people with learning difficulties first highlighted by Mencap in its 2007 report 'Death by Indifference'. The 'Six Lives' report recommended the development of an electronic flagging system for patients with learning difficulties.

Miss H was appropriately referred to the learning difficulties team during her admission.

Recommendation

R11 The trust should over the coming months, continue to develop the learning difficulties electronic flagging system to ensure patients with learning difficulties have prompt access to the learning difficulties liaison nurses.

13.7 Improvements in the referral process come from the improved education about learning difficulties the trust gives its staff. The trust's head of adult safeguarding explained:

> "*In terms of education we have targeted around our key messages, the must-dos for adults with a learning difficulty*[1]*. The staff have been involved in desensitisation visits* [for people with learning difficulties as well as staff], *so the learning difficulties nurses support the schools, community nurses, patients who access services. They do visits where they are exposed to A&E, they are exposed to imaging, just get exposed to the environment, so people get used to seeing people and visiting the sites. Our security guards attend the visits as well, the porters attend the visits, everybody is quite keen to engage now with what the LD nurses are doing, so I think all of that has been quite useful."*

13.8 The trust's deputy director of nursing also described the desensitisation visits:

> *"The other thing they do here, which I think is good, is a desensitisation programme, so the LD nurses in the community will bring in small groups of service users, a handful or fewer at a time. Sometimes when you have a learning difficulty there are physical things that go with that, so you may access healthcare more routinely than perhaps any other teenager or young adult."*
>
> *"It's things like getting them to put a blood pressure cuff on and knowing what that's all about, and a finger probe for saturations, and a three-armed gown, and taking groups through an outpatients' department - this is why you have to wait here. I think that is really good for this organisation, but I haven't encountered that anywhere else in this way."*

[1] The ten key messages campaign was launched by the trust December 2016 and is aimed at raising awareness amongst staff on the 'must dos' for patients with learning difficulties. The ten messages are included at appendix D.

13.9 After the incident with Miss H's doll on ward 14, the trust tasked the adult safeguarding lead with ensuring that all ward 14 staff had attended a learning difficulties awareness training session. The adult safeguarding lead explained:

> *"We put all the staff on that ward through briefing sessions around learning difficulties and that was done with the acute liaison nurse."*

13.10 The adult safeguarding lead told us that while this training was initially targeted at ward 14 it was subsequently given to the other wards.

13.11 The adult safeguarding lead explained the training to us:

> *"It went through each key message and then just told them what the priorities are. Each ward has a leaflet[1] explaining the role of the learning difficulties nurse and the resources"*

> *"It is not mandatory - it is desirable at the moment. They offer the briefing sessions on the ward area, so they go into the department as well. They have gone into A&E and done sessions with A&E staff. They have gone into therapies, imaging, porters, security and we have been doing one-day workshops, so we can accommodate up to around 25 people."*

Comment

We asked ward 14 staff who were involved with the care and treatment of Miss H about whether they had attended a learning difficulties training session. Interviewees confirmed they had and that they were helpful.

Our interviewees said that learning difficulties training should be mandatory instead of desirable. Interviewees informed us that there has been an increase in the number of adults with learning difficulties admitted to the trust.

[1] We have included the leaflet at appendix E

Recommendation

R12 The trust should as a priority, assess whether the number of adults with learning difficulties admitted is increasing and decide if the learning difficulties training should be made mandatory.

13.12 Interviewees told us that on some occasions, when patients with dementia are admitted to the trust, the mental health team issued them with a regular children's doll (not a Reborn doll) or a soft toy.

13.13 A trust nurse told us:

> *"Some patients will adapt quite well to a doll because it is a comfort to them."*
>
> *"The Mental Health Team are the ones who would do that because they have specialist knowledge and they have that consultation with the family members, so the family know why you have issued the doll. Therapeutically, it can work quite well and it is better than using medication."*

Comment

We were told that the therapeutic value of dolls is not tackled in the learning difficulties training sessions the trust provides. The mental health team uses dolls for patients with dementia. In light of Miss H's case learning and understanding of the role of dolls and other therapeutic aids should be shared in other clinical settings.

Recommendation

R13 The trust should as a priority, update its learning difficulties training programme to feature dolls and similar objects, their potential significance to patients with learning difficulties and their potential therapeutic value.

13.14 The trust uses hospital passports for patients with learning difficulties. A hospital passport is a paper document designed to give hospital staff helpful information about a patient with learning difficulties. This information is not only medical. For example, it can include lists of what the person likes or dislikes e.g. food or drink, and their interests.

13.15 Hospital passports are an NHS wide scheme and are available from community learning difficulty teams, GPs, hospitals and online. The trust's adult safeguarding lead explained the trust's use of hospital passports:

> *"We try to get a hospital passport so the patient should come in with a hospital passport or a purple handbook which details things that we need to know about them. It could be how that person displays they are in pain, it could be how they like their food, how they like their medication, it is all detailed in that book. It is up to the ward staff to have that initial conversation, which should then put everything else in place."*

> *"The hospital passport should come with them* [the patient] *if it has been done in the community but the LD nurses within the acute trust are going into the supported living facilities and getting the passports done prior to their admission, so it is completed and the LD nurses keep a copy here as well."*

> *"The LD nurses issue the copy* [of the passport] *to the patients and their carers and then they keep a copy here, so if the patient comes in without it, they can print one off to make sure it is visible in the ward areas."*

13.16 In terms of when the trust first started using hospital passports, the trust's adult safeguarding lead told us:

> *"It is hard to say but I would probably say the trigger was this incident* [the Miss H case], *if I had to say something."*

Comment

We were concerned that several of the ward staff we interviewed did not seem to know what hospital passports were when we asked them.

Recommendation

R14 The trust should as a priority, ensure that all ward staff are familiar with hospital passports.

13.17 The trust now also offers enhanced visiting to relatives and carers of patients with learning difficulties. The trust's adult safeguarding lead explained:

> *"The other thing is around enhanced visiting. I know we have visiting as such but allowing people to come outside visiting hours, asking them whether they want to be engaged in the person's care or not, any hobbies or interests with which we can engage with them while the person is on the ward, attending doctors' ward rounds to ensure that the communication is there. They are small things but things we probably wouldn't think about for any other person but for that cohort of adults it is quite crucial."*

13.18 We discussed the trust's learning difficulties strategy with the deputy director of nursing who explained that Miss H's case was instructive:

> *"I suspect it* [the Miss H case] *did raise to the attention of senior management the gaps in how we take account of those kinds of particular and special needs, and to be fair, it's an ongoing challenge in an acute trust in particular. To take account of individualised care planning requirements is a challenge. I think we have an improved awareness, I think the visibility of the Learning Difficulties Team is quite reasonable."*
>
> *"That's the kind of approach we would take, that I would get involved if things don't appear to be going well, or if the family have any particular concern, and I think I'd welcome that opportunity to carry on doing that."*

14. Summary of concerns Miss H's family raised

14.1 This section draws together in one place the concerns Miss H's family during this review and the earlier internal investigations the trust carried out.

14.2 We summarise the findings from our investigation of these concerns in the following paragraphs.

14.3 Miss H's family say staff did not tell them about Miss H's transfer from ward 1 to ward 14. We find this particularly concerning because Miss H's internal transfer form says Miss H's next of kin were aware of the transfer.

14.4 During the initial complaint investigation and the formal complaint investigation, Miss H's family alleged Miss H's belongings went missing during her transfer from ward 1 to ward 14. The trust took responsibility for this during their formal complaint investigation but Miss H's belongings going missing is not recorded in the patient notes. The trust offered to reimburse Miss H for the loss of her belongings.

14.5 The family allege that XY had spoken to Miss H's family in an aggressive tone and once told them to leave the ward. There was an altercation between XY and Miss H's sister about the protected mealtime on the evening of Friday 13 September 2013.

14.6 The evidence suggests XY did not fully understand the needs of Miss H because she had not been directly caring for her. XY believed she was adhering to the trust's protected mealtimes policy when she asked Miss H's family to leave ward 14 on Friday 13 September. This was not the case. The trust had given Miss H's family permission to help Miss H eat and drink. However, this was not documented in her notes.

14.7 At least one witness thought XY was over-zealous during the altercation. The exchange upset Miss H's sister.

14.8 The trust apologised that XY was "aggressive" to Miss H's family. This matter became part of the disciplinary investigation into XY.

14.9 Miss H's family allege ward staff put their fingers in Miss H's nose to make her open her mouth and giver her oral medication. We found no evidence that staff put their fingers

in Miss H's nose, but it is possible the MRSA screen of her nose on 10 September 2013 caused her to believe they had been. The date of this screening corresponds with the date Miss H's family allege staff put their fingers up Miss H's nose.

14.10 The process involves a member of ward staff running a cotton bud (swab) across her skin. When taking an MRSA swab from the nose, both nostrils must be tested. MRSA nostril screening can cause the nose to bleed.

14.11 If the procedure of taking the MRSA swab had not been explained well to Miss H it is possible she would have misunderstood why they did it.

14.12 Miss H's family claim that Miss H was nearly scalded with hot tea while she inpatient on ward 14.

14.13 The trust apologised to Miss H and her family that she had been offered scalding hot tea. During the formal complaint investigation, the trust reviewed the temperature of hot drinks served to patients on wards. After this the trust asked that ward staff ensure no patients are served drinks hot enough to cause scalding.

14.14 Miss H and her family alleged that ward staff threatened Miss H. However, we have found no evidence that ward staff threatened Miss H.

14.15 Between 2pm and 4.45pm on Friday 13 September 2013, XY (who was nurse in charge for the shift) is alleged to have asked Miss H's family if a placement had been found for Miss H as she was due to be "shipped out" because the trust needed the bed. The family felt that XY was pressuring them to find a placement for Miss H. XY denies this conversation took place and we found no witnesses for it except Miss H's family. The trust apologised that pressure had been put on Miss H's family to find a placement for Miss H. This matter became part of the disciplinary investigation into XY.

14.16 Miss H's family allege Miss H's pressure mattress did not work properly. We found no evidence of this in the patient notes but trust staff recall the mattress did not work properly.

14.17 The family claimed that while Miss H was a patient on ward 14, she had not been washed. Ward 14 staff said that although they offered Miss H help with showering, she refused and preferred to be given bed-based hygiene.

14.18 We found no evidence in the clinical notes that Miss H was left in soiled linen. Miss H's family firmly believe she was. During the formal complaint investigation, the trust apologised that Miss H had been left in soiled sheets. Ward 14 put a plan in place for Miss H to have continence pads and to receive regular comfort rounds, typically on a four-hourly basis. These were recorded in Miss H's patient notes. After the formal complaint investigation, the trust's director of nursing agreed to work with staff to ensure patients with continence problems received more regular checks.

14.19 Miss H's family complained about the damage caused to Miss H's doll Rachel. The trust concluded Rachel's arm had been cut with a pair of scissors. The trust said Miss H would not have had access to scissors while she was in hospital so she could not have caused the damage. The disciplinary investigation into XY investigated if she damaged the doll as Miss H's family allege.

14.20 Our finding, the formal complaint investigators, the disciplinary investigators and West Midlands Police found this was not enough evidence to conclude that XY cut Rachel with the scissors.

14.21 The trust board gave full and sincere apologies to Miss H and her family for the distress Miss H suffered when Rachel was damaged. The trust could not fully compensate her for the loss, but offered to financially compensate her for the damage to Rachel.

14.22 The family were concerned that no trained staff were available to represent Miss H and her learning difficulties throughout her time on ward 14.

14.23 Health record entries show a learning difficulties nurse saw Miss H on ward 14 on 30 August, 3 September, 4 September, 9 September and 12 September. The entries show Miss H was asleep on several of these occasions so there was not much direct interaction between her and the learning difficulties nurse. Furthermore, ward staff did not tell Miss H's family when the learning difficulties nurse intended to visit and so they could not be present.

14.24 Furthermore, Miss H's family claimed that Miss H was given meal menus, without assistance to read them although she could not read. After the formal complaint investigation, the trust apologised to Miss H's family that Miss H had been given meal menus without help read them.

14.25 Miss H's family were concerned that there appeared to be no handover and liaison with staff between nursing shifts.

14.26 After the formal complaint investigation, the trust accepted nursing handover arrangements needed reviewing and they referred the matter to the director of nursing.

14.27 We have seen evidence that handovers did take place on ward 14 during Miss H's admission. Miss H's patient notes from the 15 September 2013 suggest the damage to the doll was included in the verbal handover from the night staff to the day staff. Our ward staff interviewees confirmed this.

14.28 Miss H's family alleged that ward staff prioritised using their mobile phones over patients pressing buzzers for help while Miss H was inpatient in ward 14. After the formal complaint investigation, the trust apologised to Miss H's family for staff failing to respond appropriately when the patient buzzer system was used. The trust conducted an audit on the responsiveness to patient buzzers alongside routine checks on the quality of care provided. The trust also reinforced the message that staff should never prioritise mobile phone use over responding to patient buzzers.

14.29 Miss H's family allege that nursing staff played football with Miss H's doll. We found no evidence for this. We visited ward 14 as part of our review. Bay 2, where Miss H stayed, is visible from the entrance to the ward, the sister's office and the nurse's station. Miss H's bed in bay 2 is visible from the bay door and from an internal waist-to-ceiling height window. It is unlikely that staff could have played football with Miss H's doll without being seen by others. However, given that the internal window is from waist to ceiling only, the doll could have been kicked along the floor, below the level of the window.

14.30 Miss H's family allege that Miss H was given undocumented injections by ward staff.

14.31 On Miss H's medication chart dated July 2013, different nurses signed for haloperidol[1] administration on five occasions. The medication chart does not document the route of administration for each of these doses, and the corresponding clinical records only document the administration of 'when required medications' on the 30 August 2013 when

[1] https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421-antipsychotic-drugs/first-generation-antipsychotic-drugs/haloperidol

haloperidol 2mg was administered via intramuscular injection and on 6 September 2013 at 11:50 when haloperidol 1mg was administered orally.

14.32 We found no entries in the clinical notes to describe the administration of haloperidol on 1 September 2013, 6 September 2013 (21:15) and 8 September 2013, therefore we do not know what route of administration was used.

Appendix A

Team biographies

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's managing director with an active role in leading complex consultancy. He worked with Kate Lampard on a lessons learnt report for the Secretary of State for Health arising from the publication of the Jimmy Savile investigations and is currently carrying out an independent investigation into concerns raised about Yarl's Wood immigration removal centre. He has recently advised the Jersey government about the inquiry into historical child abuse. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

Charlie de Montfort

Charlie has led and supported a wide range of investigations since joining Verita in November 2013. Charlie has a BSc from the University of Bristol, an MSc from the London School of Economics and has worked and volunteered across private and public-sector organisations in the UK and abroad. He has recently been involved with delivering a governance review for a large mental health trust, conducting a review into a conflict of interest at a CCG and developing an adverse incident handbook for governance managers at an acute trust in London.

Alison Pointu

Alison is a recently retired executive nurse with a varied nursing career that spans 35 years. Alison is regarded as a knowledge expert in learning difficulties, providing advice and support to the London Strategic Health Authority, Cabinet Office, NHS England and the Department of Health.

Alison spearheaded one of the first acute liaison projects, which influenced the National Strategy for learning difficulties. These changes brought benefits and improvements in patient outcomes. This work was cited as good practice in various publications. Alison also designed a programme of quality improvement through a series of observational visits to commissioned services across the whole patient pathway.

She has also completed a Masters in Health Science (Learning Difficulties Studies) and is currently in the final stages of writing up her thesis of a qualitative research study with women with learning difficulties that will lead to the award of Doctor in Health Research.

David Scott

David Scott is an experienced human resources director, having operated at board/executive level for 15 years in private and public-sector organisations. He is effective in managing employee relations in challenging environments, and is highly skilled in delivering cultural and performance improvements in complex organisations. His most recent appointments include interim CEO of the Duke of Edinburgh's Award where he remains a trustee, an executive level position at First Group Buses London, and between 2004 and 2005 interim director of workforce and strategic HR at Kent and Medway Strategic Health Authority.

Lucy Scott-Moncrieff

Mental health and human rights lawyer, Lucy Scott-Moncrieff is a long-term associate of Verita. Lucy has carried out a number of complex and high-profile reviews including, a report into the death of a patient during routine day surgery for the States of Jersey, an investigation for the secretary of state for health into the action of a SHA in relation to the dismissal of a trust chief executive and, for NHS England, an investigation into paediatric cardiac surgery in Leeds Teaching Hospitals NHS Trust after concerns were raised by another NHS trust. In May 2016 Lucy was appointed the House of Lords commissioner for standards, which requires her to investigate complaints that peers or their staff have breached the House of Lords' code of conduct.

Appendix B

List of interviewees

Walsall Healthcare NHS Trust

Current staff

- Adult safeguarding lead
- Chief executive
- Deputy director of nursing
- Ward manager (ward 14)
- Unison representative
- Head of nursing (medicine division)
- Ward sister (ward 14)
- Ward sister (ward 1)
- Care support workers (3) (ward 14)
- Staff nurses (2) (ward 14)
- Head of HR operations
- Head of patient relations
- Clinical claims manager
- On-site manager
- Head of quality and performance for the estates division

Former staff

- Former director of governance
- Former director of nursing
- Former non-executive director
- Former staff nurse (ward 14)

Others

- Police officer from West Midlands Police
- A Reborn doll expert
- A consultant psychiatrist with learning difficulties expertise
- Miss H's sisters

Appendix C

Documents reviewed

Policies and processes

- Complaints and concerns policy (April 2015)
- Consent for examination or treatment policy (July 2015)
- Disciplinary policy (October 2013)
- Medicines policy (July 2015)
- Raising concerns at work policy (August 2013)
- Safeguarding adults policy (April 2015)
- Safekeeping of patient's monies and property policy (October 2015)

Reports

- XY's disciplinary investigation report (March 2014)
- Formal complaint investigation report (January 2014)
- West Midlands Police crime report
- Confidential psychiatric report on Miss H (December 2015)

Miss H's patient records

- discharge plan and checklist;
- internal transfer form;
- clinical notes – nursing and MDT;
- adult observation charts;
- bedrails assessments;
- continuous assessment tools;
- fluid charts;
- patient comfort rounds;
- drug charts;
- observational charts;
- IR1 forms; and
- stool charts.

Litigation files

- Claim form (August 2014)
- Particulars of claim form (December 2014)
- Defence form (February 2015)
- Position statement (March 2015)
- Order on settlement form (July 2015)

Minutes

- Handwritten meeting notes – initial complaint investigation (September 2013)
- Board minutes (July 2015)
- Board minutes (August 2014)
- Board minutes (January 2014)
- Board minutes (July 2014)
- Board minutes (February 2015)
- Board minutes (October 2014)
- Board minutes (December 2014)
- Board minutes (December 2016)
- Board minutes (March 2016)
- Board minutes (August 2016)
- Board minutes (October 2015)
- Board minutes (November 2014)
- Board minutes (February 2017)

Statements

- 2 x Miss H's sister (November 2013)
- Miss H's brother (November 2013)
- Miss H's sister in law (November 2013)
- Miss H's niece (November 2013)
- Miss H (November 2013)
- 3 x Bank CSW (September 2013)
- 2 x CSW (September 2013)
- Bank staff nurse (September 2013)

- 2 x Nurse (September 2013)
- Bank CSW (November 2013)
- 4 x CSW (November 2013)
- 3 x Staff nurse (November 2013)
- A patient's statement (December 2013)

Other documents

- 2 x Complaint investigation letter (January 2014)
- XY's car pass record
- Staff rota – ward 14 (w/c 9 September 2013)
- Medical photography of Rachel
- Data on learning difficulties concerns (2013)
- Data on serious incidents reported (2009-2014)
- Data on ward 14 formal complaints (2013)
- Data on ward 14 informal concerns (2013)
- Learning difficulties liaison leaflet (July 2014)
- Hospital passport template
- Learning difficulties training poster
- Learning difficulties ten key messages

Appendix D

The trust's ten key learning difficulties messages

Walsall Healthcare NHS

Making the safety of patients everyone's highest priority

Our vision is of an NHS with no avoidable death and no avoidable harm

Ten Messages Campaign

The top ten 'must dos' for Patients with a Learning Disability.

For many people with a Learning Disability going into hospital can be a frightening and confusing experience. They are faced with a new environment, unfamiliar people and often do not understand why they need to be here.
Please ensure that reasonable adjustments are made in order to support patients and their carers to receive the highest quality of care possible. Observe the ten must do for patients with a Learning Disability.

1. Refer to the Acute Liaison Nurse for Learning Disabilities at the earliest opportunity Bleep [redacted] Ext [redacted], Mobile [redacted]. Please ensure you leave a message and contact number.
2. Ask if the patient has a Health Action Plan / Hospital Passport and use it actively. Listen to all of the information given to you by their families and carers; these are the people that know the patient well.
3. Find out how the patient is going to communicate with you as it may be verbal or non-verbal, they may also use a communication aid.
4. Make reasonable adjustments, **and document,** eg more time, meeting carer needs, scheduling of appointments, flexible visiting, to reassure the patient and their carers.
5. Diagnostic overshadowing, Never assume that all the symptoms the patient presents with are linked to their Learning Disability.**see the person not the disability.**
6. Give patients clear explanations for any procedure or treatment to be carried out. Use Simple sentences using signs, symbols and pictures to aid your explanation wherever possible. Avoid using medical terminology.
7. Listen to and involve the family and carers,
8. Don't .make assumptions about mental capacity; Check the Mental capacity Act for information regarding capacity to consent. Never ask carers to sign consent forms.
9. Keep uptodate with learning disability education and training
10. If you get it right for people with a learning disability you will get it right for everyone.

(Updated August 2016)

The trust's learning difficulties leaflet

How to contact us:

Black Country Partnership NHS
NHS Foundation Trust

Manor Hospital
Moat Road
Walsall
WS2 9PS

Telephone:

Manor hospital: 01922 721172

Direct Line: [redacted]

Named nurse 1 : [redacted]

Named nurse 2 : [redacted]

Bleep: [redacted]

Author: Helen Munro | Department: PWMHS Team | Issued Date: 2015 | Review Date: 2016

Learning Disabilities Acute Liaison Nurses

The Manor Hospital

Makaton PHOTO SYMBOLS

Learning Disabilities

Who are we?

Named nurse 1 picture

Named nurse 1

Named nurse 2 picture

Named nurse 2

We are Nurses who work at the Manor Hospital. We are trained to support people with learning disabilites when they are at the hospital.

How can we help you?

We can arrange for you and your family to visit the ward and meet staff

We will work with you, your family and staff to make sure they know how to support you during your stay

We work with you and your family to help staff understand how you communicate

We can support you if you need to come to accident and emergency department (A&E)

We can help answer any questions you, your family or carers may have about your stay in hospital.

We can help you complete a Hospital Passport or a Health Action Plan while you are in hospital

Learning Disabilities

Appendix F

MRSA section in patient notes

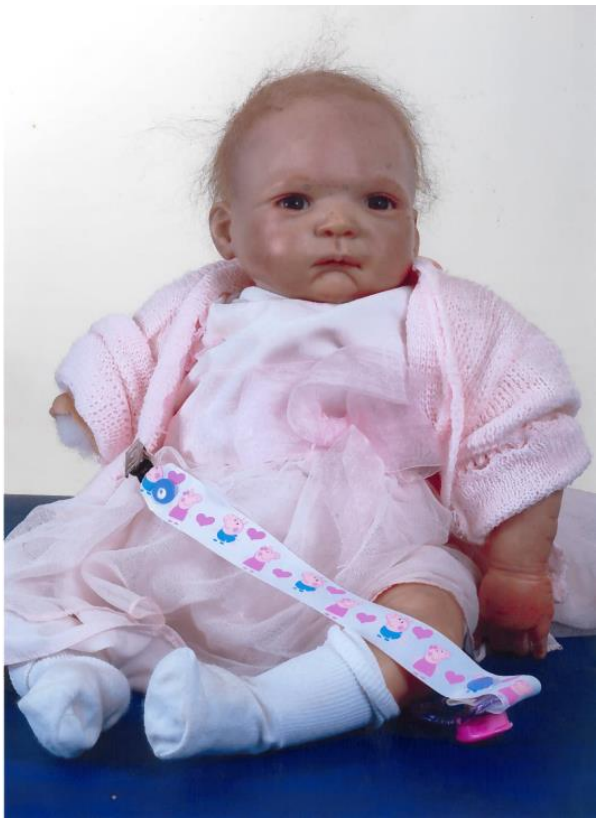
10/9/13	Susan vitals stable, settled all day.
DTD	MRSA sent from Groin and Nose.

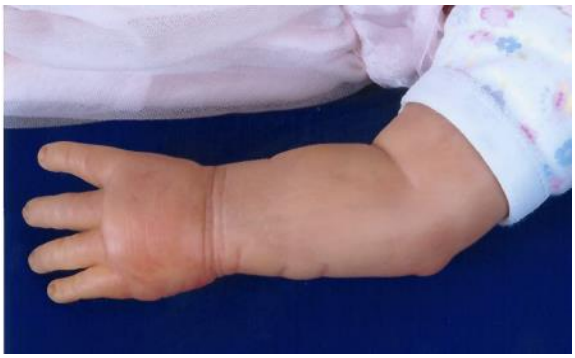
Appendix G

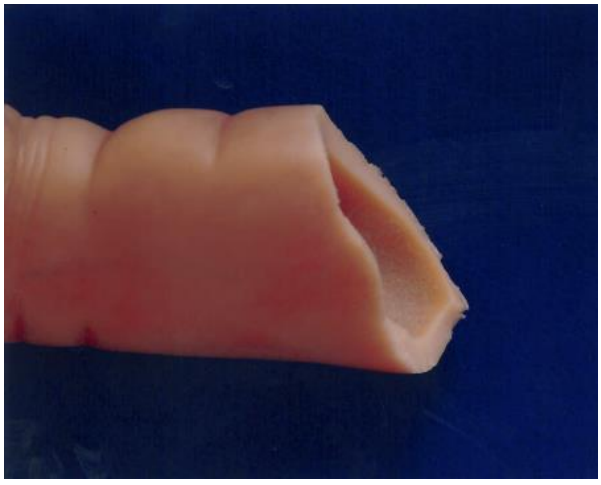
Haloperidol section in drug chart

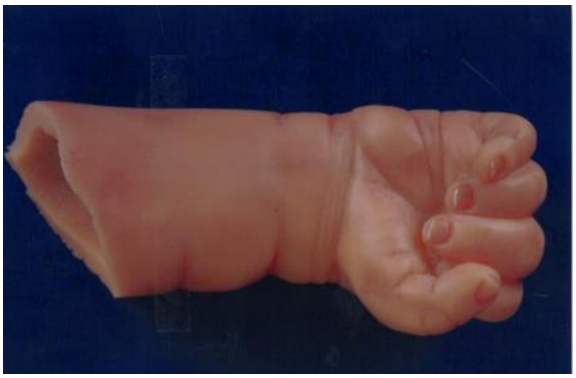
Drug Approved Name	Dose	Route				
HALOPERIDOL	1-2 mg	PO / IM				
Date	**Instructions and Maximum Frequency**	**Continue on TTO Y / N**				
30/8/13	6 hourly PRN	**Duration ..... days**				
Prescriber Signature (Print Name)		**Pharmacy**	**Pre-admission** ☐			
signature		WS 9				
			30/8/13	16:30	2mg	sign
			1/9/13	14:52	1mg	sign
			6/9/13	11:80	1mg	sign
			6/9/13	21:15	1mg	sign
			8/9/13	21:50	2mg	sign

Clinical photography of Rachel









Miss H's statement

Walsall Healthcare NHS
NHS Trust

Complaint Investigation Documentation

Statement

Reference Number:

Statement of : Miss H

Name Head of patient relations

Location or address : Patient Relations, Route 102, Manor Hospital, Walsall, WS2 9PS

Designation : Patient Relations Manager

This statement (consisting of ( ) pages, each signed by me, is true to the best of my knowledge and belief.

Date the 23rd Day of November 2013

The statement was taken following a home visit which took place at 11.00am, Bloxwich,
Those present, The former director of governance & Patient Relations Manager. Miss H , Miss H's sister (and carer) & Miss H's great niece.

Miss H was aware why we were in attendance and went on to describe a pair of scissors in the pocket of the overall of the nurse. Miss H stated that she went for an x-ray when she came back she picked up the doll (Rachel) and the arm had dropped off. Miss H said the nurse took Rachel – she cut the arm off with a pair of scissors and was swinging the doll around. She said the nurse was being naughty and cut the arm with scissors. Miss H can remember Rachel being on the bed with her at Night time. Miss H described the nurse as wearing a blue uniform with white hair, she then pointed to her Niece's hair which was a blonde colour and said like this. She stated it was up like a pony tail/in a bun. Miss H said that she had seen this nurse before when she was on Ward 1.

When the nurse cut the arm Miss H said she was crying and upset and she picked Rachel up. Miss H repeated it was after she ahd an x-ray. She described a nurse with glasses on and a blue overall with brown hair putting celiotape back on Rachel's arm. This was after tea time she then stopped crying. Rachel was put back on the chair with a blanket on her. Miss H does not recall undressing the doll. Miss H repeated the description of the nurse again and said the staff were throwing Rachel about.

Miss H when questioned about her nose being held to take medication she said she was told she was a naughty girl for not taking her medication. Miss H said they put the tube up her nose. Miss H repeated this twice.

During this home visit the doll (Rachel) was examined. In the presence of the family the other arm was cut off to enable a comparison to made with the arm alleged to have been cut off by a nurse and the amount of sand/ground glass in the arm was collected.

Discussion took place regarding the process for investigation and reassurance was provided to the family that the matter was being dealt with most seriously and further interviews of staff would now take place.

Ms W's statement

Walsall Healthcare NHS
NHS Trust

Complaint Investigation Documentation

Statement

Reference Number:

Statement of : Ms W

Name **Patient Relations Manager**

Location or address : Patient Relations, Route 102, Manor Hospital, Walsall, WS2 9PS

Designation : **Patient Relations Manager**

This statement (consisting of (1) pages, each signed by me, is true to the best of my knowledge and belief.

Date **13th December 2013**

Ms W currently a patient on Ward 8. Interviewed in the presence of , Director f Corporate Affairs and , Lead Nurse for Older Adults and Vulnerable Adults.

Ms W was shown a picture of the doll belonging to Miss H who was a patient in the opposite bed to Miss H on the night of the incident – 14th September 2013. Ms W commented that the doll was lovely, she said she had a large doll herself at home and a teddy bear. Ms W said she had not said the doll in the picture.

However without prompting via question, Ms W said that when she was a patient on Ward 14 a lady in the other bed had a doll like that. She said she had watched the nurses pull the arm off the doll. She said it was the night nurse that did it. She had blonde hair.

She said Miss H was crying and screaming when the doll had been damaged and the nurse told her to keep her mouth closed or she will close it for good. She described the nurse again as having blonde hair with a fringe – she had seen this nurse a lot as she worked on the ward a lot.

Ms W said the member of staff gives patients hell. When it is night and the doors are closed patients shake with fear.

The 'girl' who was screaming was hit across the mouth and told to stop crying shut up and say nothing. She described another member if staff with dark hair and a fringe. Both where white members of staff.

She said the staff were temporary as they had told her.

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review of the care and treatment provided to Miss H in September 2013

Executive summary

A report for
Walsall Healthcare NHS Trust

September 2017

Authors:
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Charlie de Montfort
Alison Pointu
David Scott

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3. Executive summary and recommendations

Executive summary

Miss H's nursing and medical care

National context: people with learning difficulties and health needs

3.1 Growing evidence over the last 15 years has suggested that people with learning difficulties admitted to acute health care settings are at increased risk of avoidable harm and death.

3.2 Most patients find admission to hospital a difficult and stressful experience. People with learning difficulties are particularly susceptible to being anxious about the unfamiliar surroundings and activity of a busy general hospital. Miss H was moved between wards during her admission and so had to familiarise herself with two wards, sets of patients and staff. In this context, Miss H needed careful management and anxiety-reducing possessions such as Rachel would have been important to her.

Reasonable adjustments

3.3 Although ward 14 identified Miss H as having a learning difficulty, we found no evidence in the daily clinical records to suggest staff made reasonable adjustments for her.

3.4 Nurses working on ward 14 had limited or no knowledge of supporting people with learning difficulties, and did not meaningfully seek advice or help from Miss H's family or the learning difficulty nurse.

3.5 Miss H's family were inadequately involved in decisions about Miss H's care. A more collaborative approach between the healthcare professionals, Miss H and her family would have likely resulted in an improved experience for Miss H, her family and the staff on ward 14.

Miss H's nursing records

3.6 The notes clinical staff working on ward 14 wrote did not meet the standards of the NMC Code 2015. The clinical notes we reviewed often contained only basic information, did not always include the full date or time of the entry, included abbreviations (e.g. 'NIC' instead of 'nurse in charge') and the handwritten entries were often illegible.

3.7 Good records promote continuity of care through clear communication; demonstrate the quality of care delivered; and provide the evidence necessary for any legal proceedings. Poor records often reflect poor practice.

Medication administration including method of administering oral tablets and giving injections without prescription

3.8 The prescription charts for Miss H are unclear. Her chart for 28 July 2013, the day of her admission to Walsall Manor Hospital, shows haloperidol 1-2mg was prescribed as a 'when required medication', to be given either orally or via intramuscular injection routes.

3.9 The recording of administration of 'when required' medication to Miss H falls short of the standards the NMC sets out.

3.10 Because the route of administration is omitted from some of the records, there are three instances when haloperidol may have been given orally or by intramuscular injection.

Empathy and compassion

3.11 We found little evidence in the nursing notes of staff treating Miss H with appropriate empathy and compassion, particularly in response to her documented episodes of distress, agitation and restlessness.

3.12 The evidence we have reviewed suggests staff missed opportunities to demonstrate and document empathy and compassion in relation to the damage to Miss H's doll, Rachel. Miss H's patient notes record inadequate detail about the damage to Rachel, when it occurred, how it happened or how it had affected Miss H.

3.13 The damage to Rachel was only mentioned once in the clinical notes of the night of 14 September 2013 to morning or 15 September and was not recorded as an untoward incident. This suggests nursing staff on the ward had dismissed it as an unimportant event. This is how Miss H's family thought staff had perceived it.

The trust's management of the family's complaint

The initial complaint investigation

3.14 Miss H's family made an initial verbal complaint on Sunday 15 September 2013 at about 1.30pm with the nurse in charge of ward 14. The complaint concerned the altercation with XY on Friday 13 September 2013 about Miss H's protected meal times, and the damage to Rachel. Miss H and her family were understandably upset and concerned that Rachel was damaged with malicious intent.

3.15 The head of nursing for the medicine division started an investigation into the damage of the doll. This investigation involved the trust's Patient and Liaison Service (PALS), a matron, the ward manager and a trust learning difficulties liaison nurse.

3.16 After about a week and a half of investigation the head of nursing for medicine relayed their lack of findings to the trust's HR department and Miss H's family. HR told the head of nursing for medicine that no further investigations would be carried out due to a lack of evidence, in accordance with policy.

3.17 The trust wrote a formal response to Miss H's family in which it agreed with them that it appeared the doll had been deliberately cut with scissors. The trust agreed several actions with Miss H's family:

- to ensure that ward 14 staff allowed Miss H's family to help Miss H at meal times;
- to follow up the family's concerns with XY; and
- to apologise for the distress caused.

3.18 Our impression is that the initial complaint response and investigation was not as sympathetic as it should have been.

3.19 Ward staff should have notified Miss H's family with a phone call at the earliest opportunity on the morning of Sunday 15 September 2013, so that they were aware of the damage to Rachel before their arrival on the ward at lunchtime. The trust missed opportunities here.

3.20 Although the ward staff on Sunday 15 September did notify the on-site manager, escalation to the ward manager, who was off duty at the time, would have been proportionate and demonstrated a proactive response to the incident with the doll.

3.21 Furthermore, despite the ward staff telling the on-site manager on Sunday 15 September, the significance of Rachel was not conveyed. Our impression is that this is because the ward staff themselves did not adequately understand the significance of Rachel to Miss H.

The formal complaint investigation

3.22 Miss H's family was not satisfied with the outcome of the initial investigation and wrote to the Care Quality Commission (CQC) in September 2013.

3.23 We understand the family were dissatisfied about the initial investigation because trust staff lacked awareness of the significance of Rachel to Miss H and failed to recognise the needs of Miss H regarding her relationship with Rachel.

3.24 The CQC referred the complaint to the chief executive and asked for further consideration to be given to the family's concerns about the care and treatment given to Miss H on ward 14.

3.25 The trust's director of nursing appointed the director of governance at the time, to conduct a formal complaint investigation starting in September 2013.

3.26 The appointment of the trust's director of governance to lead the formal complaint investigation reflected the fact that the trust was taking the allegations seriously. This decision demonstrated that the trust was committed to doing its utmost to ascertain what had happened to Rachel and whether there was evidence for the concerns of Miss H's family.

3.27 Our impression is that the trust's formal complaint investigation was thorough and comprehensive. The depth of the investigation and the appointment of senior personnel to lead it show that the trust was not attempting to cover up the allegations Miss H's family raised.

3.28 Miss H's family acknowledge that they met the former director of governance at the start of the formal complaint investigation at Walsall Manor Hospital. Miss H's family are satisfied with the contact they received from her during the formal complaint investigation.

3.29 The formal complaint investigation concluded in January 2014. The chief executive reported the investigation's conclusions to Miss H's family in a letter dated 28 January 2014. He apologised for the distress caused and accepted that Rachel was deliberately damaged and that the standards of nursing care fell short of those the trust expects.

3.30 The trust excluded two members of ward 14 staff on 13 December 2013, pending disciplinary action[1], based on findings from the formal complaint investigation. These were a staff nurse 'XY' and a bank clinical support worker. The trust launched a disciplinary investigation into XY in January 2014. The bank clinical support worker's disciplinary case was dismissed because they were deemed not to match a description of the person who had allegedly damaged the doll. Miss H and another patient on bay 2 of ward 14 had given the description, during the formal complaint investigation.

3.31 During the formal complaint investigation Miss H's family continued to believe XY had damaged Rachel. This was in part due to the testimonies of Miss H and the other patient on bay 2, ward 14. Both described the physical characteristics of XY and a distinctive coloured bobble she wore in her hair.

3.32 However, during our review, interviewees said that the quality of the testimonies Miss H and the other patient provided would not have stood up in court. Both Miss H and the other patient died by the time we started our review so we could not interview them.

3.33 Miss H's family's view is that the formal complaint investigators themselves believed XY could have damaged the doll, given that they recommended the trust to exclude XY,

[1] The two members of staff were paid their salaries while they were excluded but they were prevented from working at the trust.

pending disciplinary action. Miss H's family allege that the investigators suggested to them that XY had damaged the doll during the formal complaint investigation.

3.34 The formal complaint investigators denied this and told us that based on their analysis it was possible XY damaged the doll, but there was insufficient evidence to conclude she had. This is the reason why the investigators recommended that a further disciplinary investigation should be carried out into XY.

3.35 Several interviewees said they were dissatisfied with how a senior trust nurse treated them in the aftermath of the formal complaint investigation. In light of the testimonies ward 14 staff gave us, we do not believe senior trust staff were encouraging a cover up. Instead it is apparent that senior trust staff were accusatory towards ward 14 staff.

3.36 While we are reassured that senior trust staff took the formal complaint investigation seriously, it is clear that in some cases ward 14 staff interviewed felt unfairly blamed and in some cases bullied.

3.37 In general, interviewees told us they felt excluded from communications about the investigations into Miss H's case. In many cases trust staff first learnt about the status of the trust's internal investigations when Miss H's family released newspaper articles in the local press.

3.38 The trust should have told staff involved with Miss H's case about developments in the investigations.

The trust's conduct and management of the disciplinary investigation

3.39 The trust's director of nursing on 13 January 2014 commissioned the disciplinary investigation during the conclusion of the trust's formal complaint investigation. The director of nursing appointed an investigating manager, the head of nursing and midwifery at the time, and an investigating officer, the head of human resource operations at the time, to conduct the disciplinary investigation and co-author the investigation report.

3.40 The trust appointed appropriate personnel to conduct the disciplinary investigation based on their skills, expertise and distance from the case. This was in line with trust policy.

3.41 The allegations brought against XY for the disciplinary investigation were:

- gross misconduct involving wilful damage;
- misuse of employee's official position; and
- conduct likely to bring the trust into disrepute with respect to the damage to Rachel.

3.42 The disciplinary team examined XY's personnel file, a schedule of staff and shifts for Saturday 14 September 2014, Friends and Family survey results and XY's car pass record.

3.43 The examination of XY's car pass record demonstrates the disciplinary team took appropriate action in the investigation of the case.

3.44 We reviewed the car pass record to determine if we could identify XY's site entrance and exit times, particularly her site exit time on Saturday 14 September 2013.

3.45 We could determine when XY entered the car park she routinely used, but not when she left. The technology does not record exit times. Given the limitations of the car park technology we cannot definitively determine when she left the trust site on Saturday 14 September 2013.

3.46 We asked all our interviewees from the night shift whether they had seen XY or anyone else that should not have been on the ward. Ward staff told us that they had not seen XY or other unexpected personnel.

3.47 We found nothing untoward about XY's site entrance times listed on her car pass record. We also contacted the trust's IT department to get data on when XY logged off her computer on Saturday 14 September 2013. However, the data was no longer available on the system.

3.48 The key findings from the disciplinary investigation were that:

- all interviewees agreed that the damage to Rachel appeared to have been done deliberately;
- none of the interviewees witnessed Rachel being damaged; and

- the ward manager deemed the altercation on Friday 13 September 2013 between the staff nurse and Miss H's family serious enough to discuss with the staff nurse using the trust's monitoring professional attitude form. The ward manager did not raise this as a formal disciplinary issue and it was her first 'offence' relating to attitude.

3.49 The disciplinary team concluded that all three allegations against XY were unproven. Therefore, it took appropriate action in deciding not to refer XY to the NMC in relation to Miss H's case. Miss H's family later referred XY to the NMC in relation to Miss H's case in June 2016.

3.50 The disciplinary team's conclusion about whether the staff nurse wilfully damaged Rachel was appropriate. There was, and still is, not enough evidence to support this allegation against XY.

3.51 While the disciplinary team concluded that no staff members witnessed the damage to Rachel, a patient did claim to witness it. Our view is that the disciplinary team should have re-interviewed this patient, building on the interview with the patient that the former director of governance carried out during the formal complaint investigation. This would have helped to assess the credibility of the patient's testimony.

3.52 The disciplinary team concluded that the Friday 13 September 2013 altercation did not need formal disciplinary action and instead needed a monitoring professional attitude proforma. This is a reasonable conclusion because XY did not have a history of rude behaviour.

3.53 The trust's disciplinary policy requires all parties involved in the disciplinary investigation process be mindful of timescales and that procedures should not be unduly delayed because people involved are unavailable. Our view is that interviewees could have adhered to this policy better because they caused the investigation to be held up.

3.54 Our interviewees told us that the trust's management team had put pressure on the disciplinary team to get to the bottom of what had happened to Rachel and that board challenged the conclusions reached significantly. This included challenges from non-executive directors on the trust board. We are reassured the conclusions from the disciplinary investigation were probed and not simply accepted at face value.

The police investigation

3.55 On 6 September 2014 Miss H's family asked West Midlands Police to investigate their allegations of mental abuse and poor care. This is the first time any party engaged the police in relation to the incident with Rachel.

3.56 As part of our review we spoke to the lead investigating officer at West Midlands Police and reviewed their crime report.

3.57 The police interviewed Miss H who told them that the person who damaged the doll had white hair. This is inconsistent with some of the accounts Miss H provided to the trust in which she described the perpetrator as having blonde hair. However, Miss H's family told us that Miss H would have found it difficult to differentiate between white and blonde hair.

3.58 The police told us that they did not believe that the testimony Miss H gave would have stood up in court.

3.59 Although the police interviewed a member of trust staff they were satisfied that both of the trust's investigations were thorough and that all relevant staff had been interviewed.

3.60 By the end of October 2014, the police concluded that the criminal allegations from Miss H and her family were not supported and that it was not possible to conclude who damaged Rachel because the burden of proof did not pass the criminal threshold. However, like the trust, the police do not dispute that Rachel appears to have been damaged deliberately.

3.61 The police had no concerns that the trust obstructed this case. Their impression was that the trust welcomed the police review as a measure for validating the trust's internal investigations. This reassures us.

Board oversight

3.62 The trust board's oversight of Miss H's case has been comprehensive. There are several extensive accounts in trust board minutes detailing the status of the case.

3.63 We are reassured that in late 2014 a now former trust non-executive director, reviewed the reports and associated materials from the formal complaint and disciplinary investigations. The former non-executive director wished to ensure that these processes had been conducted with rigour and that the trust had not attempted to cover events up.

3.64 The former non-executive director concluded that the investigations were thorough and comprehensive. However, he expressed concerns about the delay in notifying Miss H's family of the damage to Rachel on Sunday 15 September 2013.

3.65 Our overall impression is that the trust board took Miss H's case seriously.

Improvements the trust made

3.66 The trust has implemented a range of initiatives to mitigate the risks posed to patients with learning difficulties in the acute setting since Miss H's case in September 2013. It is in part due to the determination of Miss H's family that these improvements have, or are taking place.

3.67 The trust does not have an electronic alert system for flagging when a person with learning difficulties has been admitted. The trust is reliant on ward staff notifying the learning difficulties liaison nurses and the adult safeguarding team. Referrals come from the ward areas as well as family members.

3.68 Interviewees told us that around three years ago, the wards varied in how long it took them to refer patients with learning difficulties to the learning difficulties team. However today the trust's adult safeguarding assured us that referrals are now submitted in a consistent and timely manner.

3.69 Improvements in the referral process come from the improved education about learning difficulties the trust gives its staff. After the incident with Miss H's doll on ward 14, the trust tasked the adult safeguarding lead with ensuring all ward 14 staff had attended a learning difficulties awareness training session.

3.70 The adult safeguarding lead told us that while this training was first targeted at ward 14 it was later given to the other wards across the trust.

3.71 We asked ward 14 staff involved with the care and treatment of Miss H if they had attended a learning difficulties training session. Interviewees confirmed they had and that they were helpful.

3.72 The trust is working on the development of an electronic flagging system. The trust's medical director is working with local GPs to ensure the trust gets consent from patients with learning difficulties as part of the development of the system.

3.73 The trust uses hospital passports for patients with learning difficulties. A hospital passport is a paper document designed to give hospital staff helpful information about a patient with learning difficulties.

3.74 The trust's adult safeguarding lead told us that the trigger to start using these passports was likely Miss H's case.

3.75 However, several of the ward staff we interviewed did not seem to know what hospital passports were when we asked them.

Recommendations

R1 The trust should as a priority, ensure that all ward staff correctly understand the trust's policy for protected mealtimes.

R2 The trust should ensure that initial complaint responses are dealt with sympathetically and seriously. The trust should assure itself its staff are aware of the appropriate escalation procedures and when to contact relatives and carers.

R3 The trust's learning difficulties team must ensure that ward staff seek a collaborative approach with the families of patients with learning difficulties where possible.

R4 The trust should as a priority, ensure all nursing staff produce clinical records in line with standards set out in the NMC Code 2015. The trust should strengthen its methods for auditing clinical notes.

R5 The trust should as a priority, ensure staff who take MRSA swabs from patients, particularly those with learning difficulties, clearly explain what the process involves to minimise the likelihood of it being misunderstood.

R6 Ward staff should check that equipment is working properly and report immediately when it is not. Wards should have a system for alerting the relevant trust department in a timely way.

R7 The trust should ensure that initial complaint responses are dealt with in a sympathetic and serious way. The trust should assure itself that its staff are aware of escalation procedures and when to contact relatives and carers.

R8 The trust should ensure that it treats its staff with respect when conducting a formal complaint investigation.

R9 The trust should ensure that staff involved with Miss H's case are fully informed of the outcomes of this investigation.

R10 The trust should ensure that patients with learning difficulties are able to access the learning-difficulties liaison nurses in a timely manner.

R11 The trust should over the coming months, continue to develop the learning difficulties electronic flagging system to ensure patients with learning difficulties have prompt access to the learning difficulties liaison nurses.

R12 The trust should as a priority, assess whether the number of adults with learning difficulties admitted is increasing and decide if the learning difficulties training should be made mandatory.

R13 The trust should as a priority, update its learning difficulties training programme to feature dolls and similar objects, their potential significance to patients with learning difficulties and their potential therapeutic value.

R14 The trust should as a priority, ensure that all ward staff are familiar with hospital passports.

Walsall Healthcare NHS
NHS Trust

RESPONSE TO RECOMMENDATIONS OF THE INDEPENDENT REPORT INTO THE CARE OF SH (complaint reference:4110/2014)
UPDATE – NOVEMBER 2017

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
R1.	The trust should as a priority, ensure all ward staff understand the trust's policy for protected mealtimes.	In progress	Wendy Lear, Divisional Director of Nursing MLTC	Completed	At the time the HoN reminded all staff of the need to ensure support at meal times. Relatives are now encouraged to stop and assist at mealtimes and visiting hours have been extended
				31st January 2018	Establish programme across Divisions to audit Protected Mealtimes to include family/carers involvement
				Nov 2017	Revised signage for every ward in relation to Protected Mealtimes to be displayed in all areas
				Completed	Guidance has been in place since 2015

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
R2.	The trust's learning disabilities team must ensure ward staff seek a collaborative approach with the families of patients with learning difficulties, where possible	In Progress	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	Completed	As part of their initial contact with patients the team have developed a new document which includes the date of first contact with the family, initial meeting (within 3 days of admission) and mid-stay meeting and a pre-discharge meeting date. These meetings are to feedback on: • Initial diagnosis • Treatment plan • Reasonable adjustments that need to be made • Schedule follow up meetings This will be promoted through the training sessions
				31st January 2018	A carer contract is also being developed and will be implemented in the clinical areas from January 2018.
R3.	The trust should as a priority, ensure all nursing staff produce clinical records in line with standards set out in the NMC Code 2015. The trust should strengthen its methods for auditing clinical notes.	In Progress	Barbara Beal Director of Nursing Amir Khan Medical Director	Completed	New nursing documentation has been introduced and regular peer review audits of patient notes are undertaken. These are reviewed by the Ward Sisters and any actions required are taken. A review of the Peer Review audits is currently being undertaken with the Divisional Directors of Nursing and the Performance Team.

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
				31st January 2018	Internal audit have recently undertaken a review of clinical records and made a set of recommendations for improvement. Actions to address documentation standards across all disciplines is being undertaken in line with Professional Bodies Standards. This will be monitored through our Medical Records Committee chaired by the Trust Medical Director
R4.	The trust should as a priority, ensure staff who take MRSA swabs from patients, particularly those with learning disabilities, clearly explain what the process involves to minimise the likelihood of it being misunderstood.	Completed	Wendy Lear, Divisional Director of Nursing MLTC	Completed (Training process remains on-going)	This was completed at the time of incident. Learning Disability training includes awareness raising around the explanation of ALL procedures. Learning Disability Training entitled "Getting it Right", have been run across the Trust 4 times annually for all Health care professionals to access. Bespoke sessions have also been provided by the LD team to the wards and other departments including A&E, Therapies, Outpatients and Imaging Department. Concerns and Complaints regarding patients with LD's and other cognitive conditions are monitored quarterly by the Safeguarding Adults Lead. These reviews of complaints to date have shown no similar complaints/issues raised

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
R5.	The trust should ensure that initial complaint responses are dealt with sympathetically and seriously. The trust should assure itself their staffs are aware of the appropriate escalation procedures and when to contact relatives and carers.	Completed	Garry Perry Head of Patient Relations	Completed (Training and Complaints Satisfaction Survey remain on-going)	The Trust carried out a review of its complaints process in July 2016. This included a focus on both the timeliness and quality of complaint responses. Complaints investigation training has been initiated and includes a master-class for senior staff most likely to be called upon to investigate a complaint. A lay complaints monitoring panel is in place and their work includes oversight of the complaints satisfaction survey and recommendations for service improvements and table top reviews of cases difficult to resolve. The Trust has adopted the User Led Vision – My Expectations approach to complaints handling and this is included in training and in Trust policy. The Trust produces an Annual report in line with statutory requirements. This has highlighted an improvement in complaint response times and in the quality of the complaints responses. Our Complaints satisfaction survey monitors compliance against the standard and asks specific questions based on the user led 'I' statements

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
					produced by the PHSO. Recent quarter 2 findings demonstrate that of those who responded to our survey: • 76% of service users felt making a complaint was straight forward. • 82% knew they had the right to complain • 91% felt that their care would not be compromised by raising a concern • 83% felt that staff who spoke to them about their concern were polite and helpful • 82 % felt they were informed about the complaints process and timescales • 82% of service users felt we kept them informed and updated on the process • 91% of service users stated they felt a resolution was received in a time period relevant to their case • 82% of service users stated they were happy with the overall response time. • 80% of service users feel their comments were taken on board and scored us 3 or above
R6.	The trust should ensure it treats	Completed	Garry Perry	Completed	As above – principles of supporting staff

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
	its staff with respect when conducting formal complaint investigations.		Head of Patient Relations	(Complaints Investigation Training initiated and training on going)	policy covered in training.
R7.	The trust should ensure staff involved with SH case are fully informed of the outcomes of this investigation.	Completed	Barbara Beal, Director of Nursing Garry Perry Head of Patient Relations	Completed	Staff were invited to attend a de-brief on the 26.10.2017.The outcome of the investigation was shared and discussed at this meeting
R8.	The trust should ensure patients with learning disabilities are able to access the learning disabilities liaison nurses in a timely manner.	Completed	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	Completed (promotion of leaflet is on-going)	The current learning disabilities leaflet has been revised to add the safeguarding lead contact details as an alternative option for carers to contact. This is currently being promoted to care providers across the borough and is being provided to the wards by the Learning Disability Acute Liaison nurses.
R9.	The trust should, over the coming months, continue to develop the learning difficulties electronic-flagging system to ensure patients with learning difficulties have prompt access to the learning difficulties liaison nurses.	In progress	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	31st January 2018 (Completed within boundaries of IG protocols)	Due to information governance regulations and awaiting national policy for the flagging system the Trust will be utilising a consent form devised by the Black Country Partnership NHS Foundation Trust to obtain consent from the patient (or family) who are known to the Trust with a diagnosis of LD. The patient will then be flagged on the

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
					hospital systems. This will commence following agreement from Information Governance and aim for this to be in place from end January 2018
R10.	The trust should as a priority, assess whether the number of adults with learning difficulties admitted is increasing and decide if learning difficulties training should be made mandatory for staff.	Completed	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	Completed (on-going review of content of Safeguarding training and achieving Trust target for Safeguard training continues	A review of data received from information services for Q1 and Q2 has been undertaken and has identified an increase in the number of patients admitted who have been coded as having a Learning Disability. LD is currently included within the Safeguarding training, with LD being acknowledged as a risk factor to vulnerability and includes a national video made available following the death of Steven Hoskins. The Trust Adult and Children Training and the contents of this training will be reviewed again in April 2018; this will include reviewing the LD aspects delivered within this training. Adult and Children Safeguarding Training is already mandated training for staff. Trust training figures for Q2 demonstrated 52% compliance for Level 2 training and 49% for Level 3 training. Safeguarding training figures in relation

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
					to the staff booked for Safeguarding training between Oct-Dec means the Trust would achieve 82% in Q3
R11.	The trust should as a priority, update its learning-difficulties training programme to feature dolls (and similar objects), their potential significance to patients with learning difficulties and their potential therapeutic value	Completed	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	Completed	The current programme for training has been amended to include the recognition of 'lifelike dolls' as a therapeutic intervention for some clients with a learning disability.
R12.	The trust should as a priority, ensure that all ward staff are familiar with hospital passports.	Completed	Di Rhoden, Senior Corporate Nurse - Quality and Safeguarding Jennifer Robinson, Lead Nurse Safeguarding Adults	Completed (Quarterly audit of passport on-going)	Hospital passports are currently included in the resource folders available within each ward areas. A presentation at the senior nursing forum and the identification of funding has enabled the team to resource more suitable resource boxes to enable effective storage of all resources related to supporting an adult with a learning disability. The new referral form is able to capture data regarding the use of the passport A snapshot audit of the patients receiving care at Walsall Healthcare Trust has shown that all patients had a passport, however, the sample for this audit was small. The audit will be repeated quarterly with the results included in the Safeguarding

Ref	Action Required	Action Progress	Responsibility	Deadline date	Comments
					Report reported via TQE.

EVIDENCE TABLE

Please include any evidence of changes made and where available

Evidence	Where available
Complaints Training Programme in place	Book via MLCC or with Pt Relations Team direct.  Complaints masterclass training.p  Walsall Slides for Cascade Training.ppt
Annual Report, Quarter 2 2017/2018 Analysis	 July-Sep 17 Survey's.docx  Annual Report 2016.2017.docx
Training sessions delivered	

Table top events scheduled for 2017/18 Ward based 2015/16 1 day workshop 2015/16, 2016/17 and 2017/18 Programme of 1 day workshop Training data from MLCC	
Contents of ward resource box • Communication tools • Hospital passport • Learning disabilities acute liaison leaflet • 10 key messages • Easy read information • Easy read key rings	 ten-messages---learning-disability-patient  getting-it-right-for-us-open-day-21st-dec  LD Awareness week 2017.docx  getting-it-right-for-us-2017-dates.docx
Reports regarding patients with a learning disability Comparison reports 2017/18	
Electronic identifier	
Mealtimes guidance	 protected-mealtimes.docx
R3. The trust should as a priority, ensure all nursing staff produce clinical records in line with standards set out in the NMC Code 2015. The trust should strengthen its methods for auditing clinical notes.	 INF - DQ - Patient Records Audit Summa

ACTION PLAN SIGN OFF

For completion when all actions have been implemented

Divisional lead	Signature	Date of completion

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board (Public)			**Date: 01/02/2018**
Report Title	Serious Incident Report			**Agenda Item: 11** **Enclosure No.: 9**
Lead Director to Present Report	Barbara Beal – Director of Nursing (Interim)			
Report Author(s)	Chris Rawlings – Head of Clinical Governance			
Executive Summary	1. There were 13 new Serious Incidents reported in December 2017 o 7 Pressure Ulcers (4 Community acquired and 3 Hospital Acquired) o 4 Infection Control incidents o 1 Diagnostic Issue o 1 Treatment Delay 2. There has been a slight decrease in the number of Acute and Community acquired pressure ulcers reported during December 2017 compared with previous months. 3. There were 4 Infection Control incidents reported in December 2017 (3 instances of ward closures due to Norovirus and 1 case of a confirmed C-Difficile death). 4. In response to the Board's discussion and actions following a previous report: a. Information on near miss versus no harm reporting is included in this report including NRLs data to provide a comparison with other Acute Trusts. A note on benchmarking SI reporting between Trusts is also provided. b. The format of this report will be reviewed and revised to include more detail on incident trends and detail on learning from incidents c. The Q3 Incident Thematic Review Report is in preparation. Comments will be used to revise it and a discussion at the Q&S Committee of the full report would be welcomed to determine the content of both the SI Report and the Quarterly Incident Review Report			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☐	**Note for Information** ☒
Recommendation	The Board is recommended to NOTE THE REPORT FOR INFORMATION.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
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<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☐</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Linked to Corporate Risk 423:
Failure to recognise and respond to the deteriorating patient and those with early signs of sepsis</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Not applicable</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Health & Social Care Act
CQC Regulations</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Trust Quality Executive</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Monthly report provided on an ongoing basis</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Serious Incident Report – December 2017

Executive Summary

1. Introduction

Walsall Healthcare NHS Trust recognises that the prompt identification, initial management, reporting and review of Serious Incidents is important for improving patient care and staff welfare through lessons learned.

Walsall Healthcare NHS Trust also recognises the need to ensure that our staff are open and honest with patients and their families when something goes wrong and is committed to ensuring that this happens.

Serious Incidents in the NHS are defined as:

- Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare[1]

Never Events are defined as:

- Wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

The purpose of this report is to inform Public Board of the:

- Total number of incidents reported in December 2017, to include severity of actual impact
- Total Serious Incidents reported in December 2017 and during the previous 12 months
- Key themes in Serious Incidents reported in December 2017
- Category of Serious Incidents reported in December 2017
- Lessons learned from Serious Incidents closed in December 2017

2. Total Incidents

There were a total of 1107 incidents reported in December 2017
The breakdown of harm is shown below:-

Actual Impact	**Incidents reported**
Near Miss	31 (2.8%)
No Harm/Low Harm	1022 (92.3%)
Moderate Harm	46 (4.2%)
Severe Harm	7 (0.6%)
Catastrophic Harm (Death)	1 (0.1%)
TOTAL	**1107**

[1] NHSE Serious Incident Framework 2015

2.1 Near Miss reporting

The Trust uses Ulysses Safeguard to collect incident reports electronically. It's configuration separates near miss reporting from incident reporting and from the variance observed, staff default to reporting 'no harm' incidents rather than a 'near miss'. This may account for the very low numbers of near miss events being reported.

The analysis needs to be undertaken to confirm this supposition, but many level 1 'no harm' incidents will in fact be 'near misses'.

2.2 Incident reporting rates

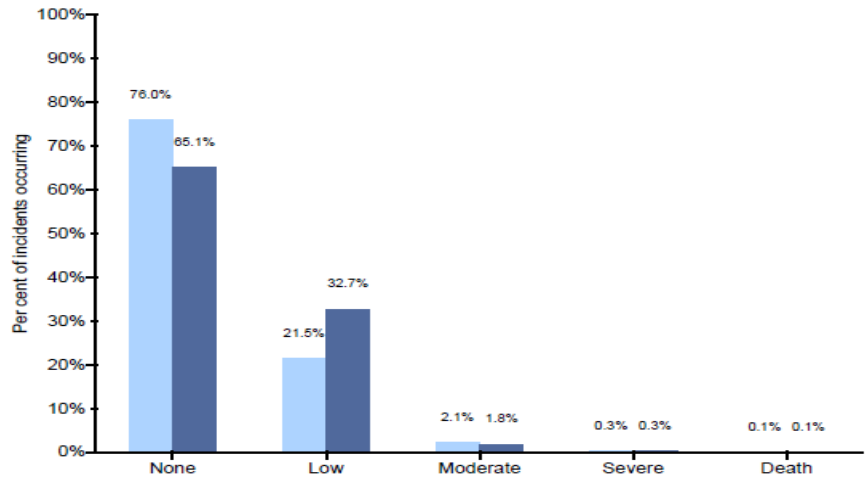
Walsall Healthcare reports all its patient safety incidents to the National Reporting and Learning System (NRLS). This provides some limited means of benchmarking reporting rates against other Trusts.

For the six month reporting period October 2016 to March 2017, the Trust reported 5,429 incidents equating to 63.96 incidents per 1,000 bed days. The Trust is the second highest reporter out of a cluster of 136 acute (non-specialist) organisations. As high levels of incident reporting is encouraged to promote openness and learning, this is a good thing. As the NPSA said, "Organisations with a culture of high reporting are more likely to have developed a strong reporting and learning culture".

The latest available report does show that in percentage terms this Trust reports fewer 'no harm' incidents than our peers (65.1% Vs 76% - which will include near misses) but more low harm incidents (32.7% Vs 21.5%) – so our reporting is a little skewed. The percentage is a ratio of the number of incident reports is

The NRLS notes: "However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult."

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations



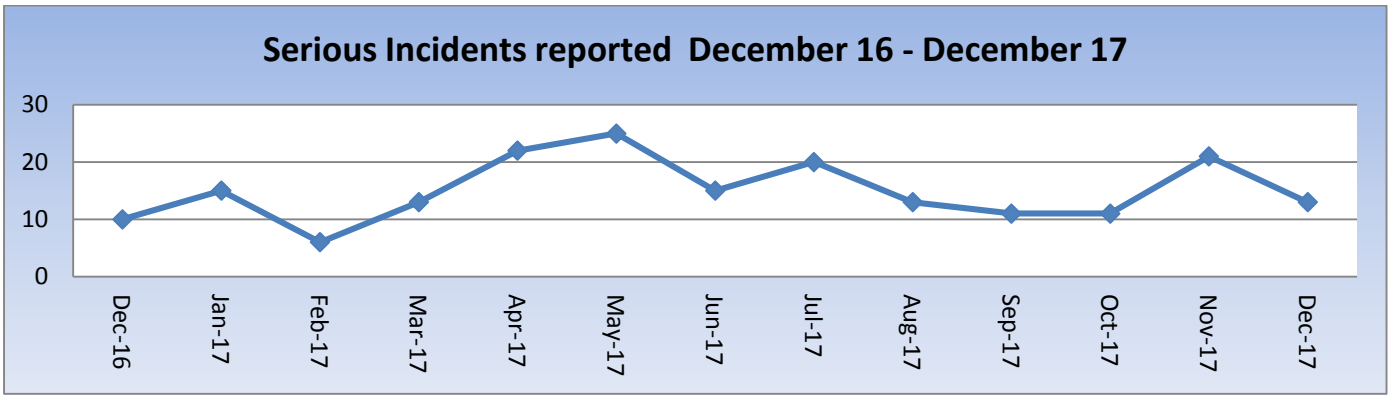
Degree of harm

	None	Low	Moderate	Severe	Death
Your figures:	3,535	1,775	97	16	6

2.3 Incident analysis

The Board receives this monthly SI Report with limited statistical analysis included. The quarterly incident review report is the vehicle for the reporting of incident analysis and learning.
The Quarter 3 report is in preparation and the Board's comments will be used to enhance it. A discussion of the full report at the Q&S Committee as opposed to the short summary provided to the committee via TQE will allow for the information provided to be explained and further information needs identified.

3 Serious Incidents reported in December 2017 and the previous 12 months



4 Key Trends/Themes in new Serious Incidents

- There were 4 Infection Control incidents reported in December 2017 (3 instances of ward closures due to Norovirus and 1 case of a confirmed C-Difficile death).
- The development of unstageable pressure ulcers acquired within the Hospital and Community continue to be reported.

A review of serious incidents reported by the West Midlands Trusts for the seven month period April to November 2017 using data extracted from STEIS has been reported to the Risk Management Committee in full and the Trust Quality Executive in summary form. It shows wide variation in reporting between Trusts and in the same categories.

NHSE acknowledges that the varying application of the SI Framework and decision making in individual Trusts makes benchmarking between Trusts and the use of reported SIs as a performance indicator of limited value. However, ongoing comparison of SIs for an Trust is of value as presumably the decision making and application of the SI Framework guidance will vary less over time.

The prime example of this variation is the highest reported category of SIs - pressure ulcers.

- The Royal Wolverhampton NHS Trust reported 119 pressure ulcers in this time.
- University Hospital Birmingham reported 4
- Worcestershire Health & Care Trust reported 173 in the previous period compared with 17 between April and November 2017
- Walsall Healthcare commenced reporting unstageable pressure ulcers as SIs from April 2018 and this explains the increase in reporting to 75 in this period, meaning that the Trust is the second highest reporter.

The SI Framework is under revision and due to be published in 2018. it is hoped that some of the variance in reporting will be addressed by this and the introduction of the replacement for

STEIS (into which SIs are reported) and the NRLS) into which all patient safety incidents are reported) by the Patient Safety Incident Management System (DPSIMS)

5 New Incidents

There were 13 new Serious Incidents reported in December 2017:

- 7 Pressure Ulcers (4 Community acquired and 3 Hospital Acquired)
- 4 Infection Control incidents
- 1 Diagnostic Issue
- 1 Treatment Delay

6 Closed Incidents – Lessons Learned

Note: This section extracts information from the Serious Incident Investigation Reports. The format of the reports will be revised so that to include further details on the implementation of the learning from the incident, rather than just the 'lesson'. This will take several months to feed into practice and future reports.

	2017/15547		**Patient Fall**
	A patient suffered a fall during a non-compliant episode on the ward and consequently sustained a serious head injury. The patient was transferred to another specialist healthcare provider but not deemed fit for surgery and received palliative care and treatment. The patient has died.		
Lessons Learned	There were some unrelated practice issues: • Falls Care Plan not initially dated and signed in line with GMC/NMC guidelines • A&E CAS Card not completed on 12/06/2017 • Bedrails assessment not completed appropriately on admission. • Patient wrongly assessed as a medium risk of falls on admission even though patient met the high risk criteria.		
Key Changes to Practice	• Reinforce documentation as a part of Lessons Learnt Bulletin • Review of incident at Emergency & Acute Care Quality Team Meeting. • 1:1 with the Consultant who did not document in ED • Reinforce Bedrail assessment and falls care plan at Acute Quality Team • Audit of Bedrail assessments Undertaken on AMU • Audit Falls Care Plans undertaken on AMU		

	2017/20143		**Patient Fall**
	A patient suffered a fall whilst self-mobilising on the ward and sustained a fractured hip. The patient did not receive any surgical intervention and died a few days post fall.		
Lessons Learned	Unrelated practice issues: • Falls care plan was not reassessed on arrival to Ward 14 • Falls Assessment documentation was incomplete when patient was assessed • Medical review did not highlight the patient's fractured neck of femur		
Key Changes to Practice	• Reinforce the need to fully complete falls assessments in line with the Falls Prevention Policy and reassess falls assessments on patient transfer • Audit to be undertaken of compliance for completion of falls assessments in MLTC wards (NB Ward 14 is now closed) • Reinforce the symptoms of a fractured neck of femur to junior Doctor to be able to diagnose		

	2017/24142		**Patient Fall**
	A patient suffered an unwitnessed fall and sustained a fractured right hip. The patient underwent hip surgery and was discharged home.		
Lessons Learned	Unrelated practice issues: • Falls care plan was not reassessed on arrival to Ward 14 • Falls Assessment documentation was incomplete when patient was assessed • No documented evidence in patient records that patient was given cord to pull for assistance		
Key Changes to Practice	• Reinforce the need to fully complete falls assessments in line with the Falls Prevention Policy and reassess falls assessments on patient transfer • Audit to be undertaken of compliance for completion of falls assessments in MLTC wards • Matron for Elderly Care to reinforce principles of good record keeping		

	2016/24457		**Lost to follow-up Urology**
	Patient had received a previous cancer diagnosis and was receiving palliative treatment. The patient was lost to follow-up for a considerable period of time causing a delay in significant investigations not being reviewed. The patient was referred for further oncology evaluation but has now died.		
Lessons Learned	• Reinforce with the Urology Consultants the expectation that electronic outcomes are completed for all patients in real time and Adopt a Zero Tolerance to non-compliance. • Reinforce with Clinic Clerks the expectation that electronic outcomes are completed for all patients in real time and Adopt a Zero Tolerance to non-compliance. AW to provide evidence • Weekly compliance report to be undertaken to determine compliance with electronic – out coming. • Weekly validation of the cancer tracking report (0205) must continue and any patient identified as lost to follow up reported as an incident so patient safety are able to review. • Develop a monthly progress report to provide divisional and corporate assurance that movement against these actions is being made. • Weekly audit to be carried on cancer patients attending clinics to determine booked status. (Fully booked).		
Key Changes to Practice	• There is a live dashboard in place to be able to see the out-coming in clinic in real time. All staff have received training on appropriate use of the system. • The medical records manager is accountable for the clinic clerks to ensure the tasks are completed to ensure that that the next appointment is booked for the patient • Compliance report undertaken to determine compliance with electronic out coming. • Manual validation commenced. Request to Information Services for a report to be developed. • Trust wide Urology action plan in place and being monitored at Divisional/Corporate level. Weekly action plan attached for WC 2/6/17 • The live dash board shows all patients that should have been fully booked and any that are outstanding. This is looked at on a daily basis and problem solved. It is discussed weekly at the Corporate team meeting		

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			Date: 1st February 2018
Report Title	Hospital Mortality			**Agenda Item: 12** **Enclosure No.: 10**
Lead Director to Present Report	Mr Amir Khan Medical Director			
Report Author(s)	Mrs J Adams Business Manager to the Medical Directorate			
Executive Summary	**In Month Performance** • HSMR September 2017 78.27 • SHMI August 2017 95.43 **Year to Date 2017/18** • HSMR September 93.69 • SHMI august 2017 95.46 **Reviewing and Learning** The revised approach to Learning from Deaths continues to be developed aligning to the National Quality Board recommendations. Representatives from the Trust will attend RCP mortality review training, 11 places have been secured up to February 2018. The Trust wide Policy, Learning form Deaths has been ratified and is available internally and externally. Further minor developments have been made to incorporate processes developed by the Oncology and Mental Health Teams. The development of a multipurpose data set is complete including the functionality to provide information relating to prevalence, demographics, flagging, tracking, review outcomes and a suite of reports. Since June 13 deaths have been escalated as requiring secondary reviews. 1 has been escalated as a Serious Incident and subsequently referred to the coroner **Acting on Lessons Learnt** • Review of patients dying in the community within 30 days of discharge • Review of COPD deaths • Review of Elderly Care Deaths • Review of deaths for patients admitted with a fractured neck of femur • Review of a shared care death • Review of deaths in ED • Review of the death of a patient receiving chemotherapy			
Purpose	**Approval** ☒	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	1. NOTE the Trust's current hospital mortality performance and associated learning points and actions to be taken			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Embed continual service improvement as the way we do things linked to our improvement plan</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
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</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Quality and Safety- to identify lessons learnt from hospital deaths and amend practice and process to improve clinical outcomes, patient experience, reduce hospital deaths and improve mortality performance. Shared learning and improve education and training for clinical staff.
Reduce Hospital Mortality
Assure performance against SHMI
Ensure correct coding to assure appropriate income is received
Collaborative working with the CCG to support the implementation and desired outcomes of the Living Longer in Walsall Strategy</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Ineffective coding resulting in loss of income
Reduce LOS</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Reducing mortality rates</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">This report is produced on a monthly basis updating performance against the national indicators and activities relating to findings form the review of deaths</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">Respond to the CQC Accountability , Candour, Learning recommendations
Respond to NHS NQB recommendations in relation to governance and reporting and transparency
Provision of education and development for medical staff in relation to accurate documentation
GMC led education sessions for medical staff relating to documentation and duty of candour.
Partnership working with the CCG to review causation of death across the health economy
Implement processes to identify deaths of patients with LD and MH issues
Reinforce and embed qualitative approach to reviewing deaths
Demonstrate lessons learnt
Ensure responsibility is taken for developing action plans and revising care pathways.
Develop a process for involving families and carers in investigations</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Mortality Report
Trust Board January 2018

Introduction

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

How We Are Performing

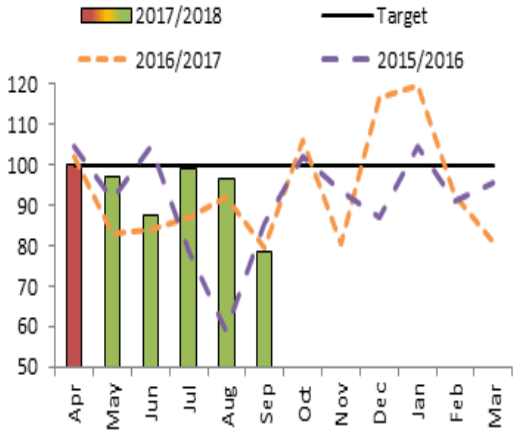
The Trust performance against the two key national indicators for mortality Hospital Standardised Mortality Rate and Standardised Hospital Mortality Index has been variable during the year 2017/18 (Appendix 1)

Performance in month for the current reporting period as below identifies that HSMR has improved since January reporting below 100 in month for all months with the exception on April. SHMI for the reporting period has been reported at below 100 for 2 consecutive months achieving a YTD performance of below 100.

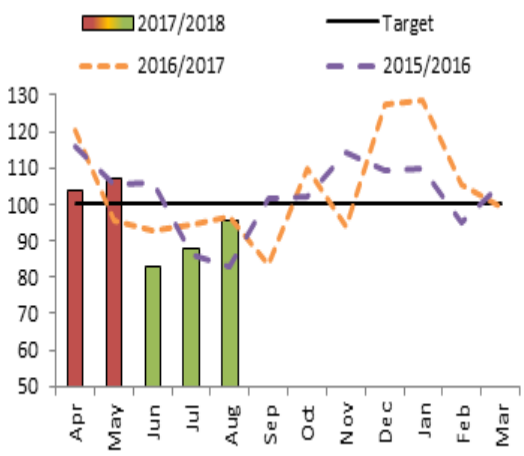
Walsall Healthcare Hospital Mortality – Headline Indicators

Measure	Period (latest available)	Month	Year to Date	Comment
HSMR (index)	Sep 2017	78.27	93.69	HSMR has remained below 100 since April for the year in month and YTD position.
SHMI (index)	August 2017	95.43	95.46	SHMI has reduced significantly in June resulting in a performance of below 100 which has been maintained for July and August for the month and YTD
Crude Mortality Rate/ 1000 bed days	Dec 2017	8.4	N/A	Q1 and Q2 saw an average crude mortality of 5.4, this remained static for the first part of Q3 but has since risen significantly in December which is reflective of the same period for the previous year.
Actual Deaths (no.)	Dec 2017	138	803	September saw a significant fall in the number of deaths compared to previous months with a rise again in October; this is a similar trend to the previous year. November recued but December has seen a significant rise.

HSMR Performance 2016-2017



SHMI Performance 2016-2017



Regional Comparison

The following diagrams show the Trust performance for HSMR and SHMI compared to other Trusts within the region for 2017/18. This demonstrates a significant improvement for SHMI from the previous months

The graphs show the Trust HSMR performance has improved regionally since the previous month and remains below 100.
The Trust regional position for SHMI has been maintained.
The number of deaths overall for the year are at a similar level for the same period in the previous year.
The number of deaths in December has risen significantly to 138. Analysis will be undertaken to determine any specific themes and inform specific local reviews to be undertaken in addition to those determined via the trust process.

Appendix 2

SHMI data for the month of May 2017 shows the number of deaths have outside of hospital within 30 days of discharge has increased. As SHMI does not discern between in hospital and out of hospital deaths this reflects in the trusts performance. During May out of hospital deaths contributed to 37% of all deaths recorded within SHMI. A review of this group of patients identifies 79% were receiving end of life, palliative care and were cared for in their preferred place of care the review of the remaining patients did not identify any areas of concerns. A report has been provided by the community Teams. Appendix 4.1

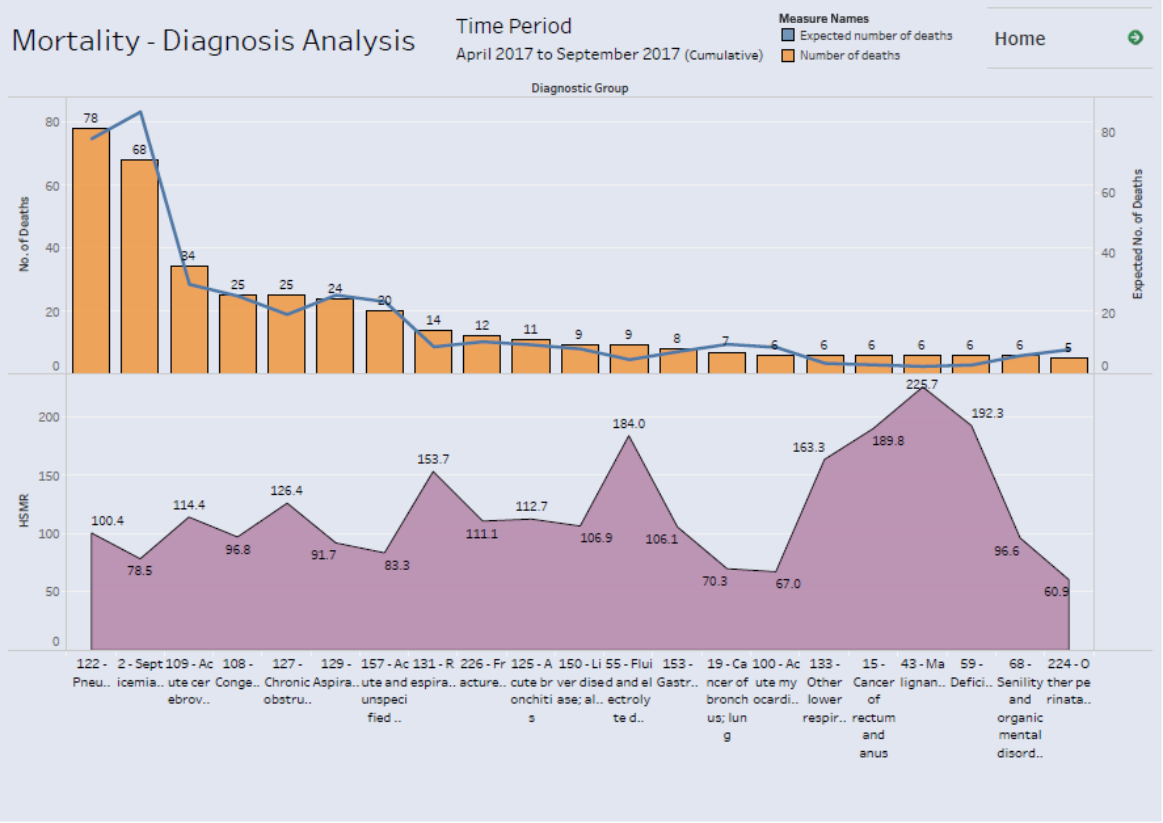
Deaths within Elderly Care have also seen a significant rise in April, May and June compared to the same period last year when historically during May and June a fall is seen. As per the revised process triggers have been applied to these deaths to ensure reviews are undertaken and lessons are learnt as appropriate. Deaths occurring in Elderly Care for June show a specific prevalence relating to patients

admitted out of hours and dying within 5 days of admission. A review has been undertaken by a senior clinician, presenting at the MSG. The review identified a number of issues relating to the quality of documentation, completion of DNARCPR records and escalation of changes in clinical condition. These findings and the development of an action plan will be presented at the Care Group Quality Meeting in February.

Deaths in the ED. A presentation was received at the MSG relating to all deaths occurring in Q3.. Key findings related to the quality of documentation. A further review of 1 patient has been requested to determine the timeline of care

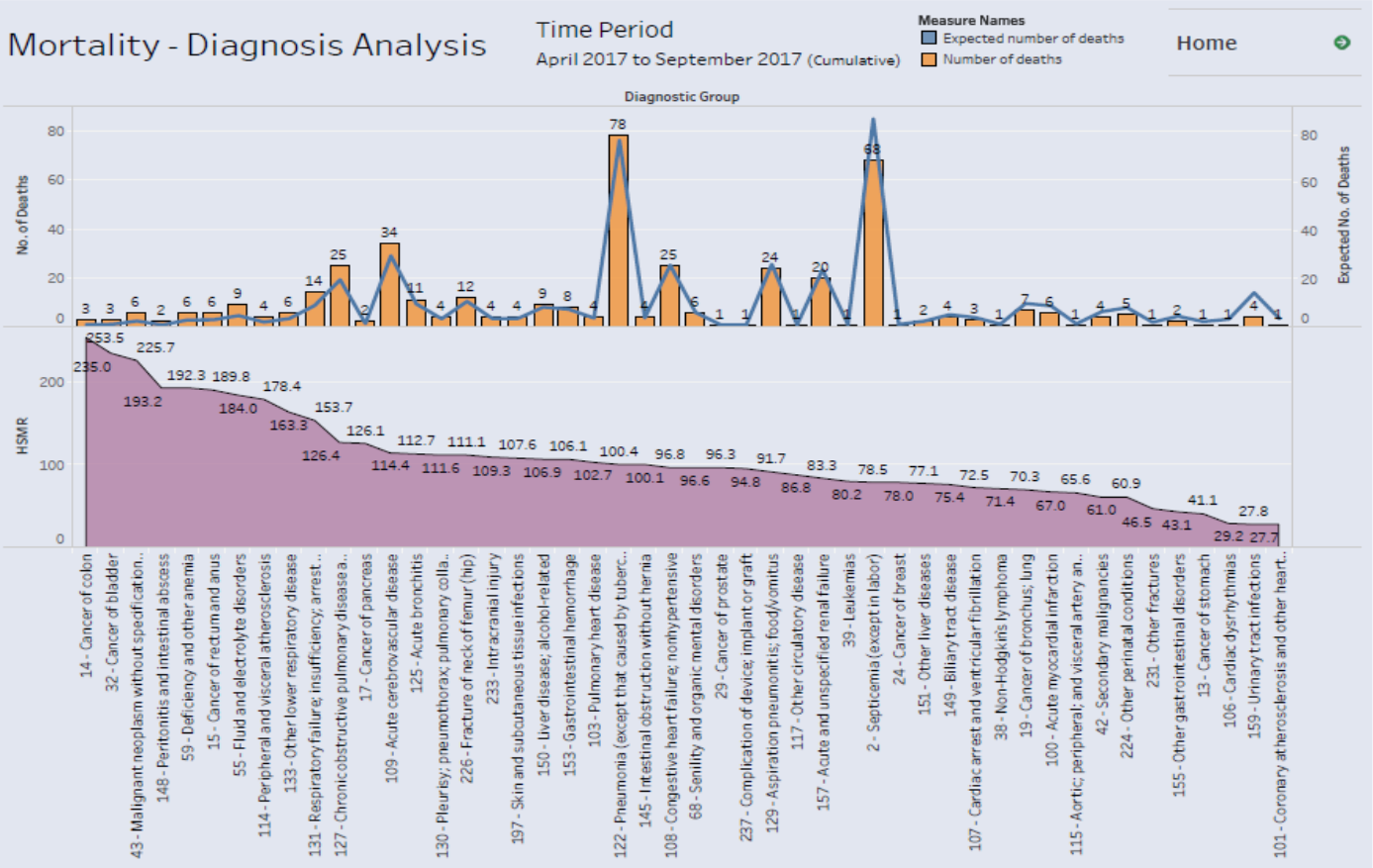
Diagnosis Specific Triggers and Alerts, CuSum

The following diagram identifies the highest number of deaths by diagnostic groups and associated HSMR for months 1-6.The diagram demonstrates the variance between expected and observed deaths.
The most significant variances from expected to actual has been seen as the months have progressed are for patient deaths relating to respiratory diagnosis.



A review of these patients will be undertaken by a respiratory physician. The following diagram identifies the highest HSMR by diagnostic group. The highest HSMR does not represent an area of concern as they relate to 3 single patient episodes over a period of 4 months. These patients diagnostic relates to Colon Cancer, following review of the patient record all three patients were admitted as emergency admissions with well advanced carcinoma. All three patients unfortunately developed acute clinical conditions resulting in their death.

A slight variance is expected to be seen for patients with a fracture neck of femur. The orthopaedic team have reviewed these deaths; their presentation identified a theme relating to hospital acquired pneumonia. The Matron and Clinicians as part of a multidisciplinary review are undertaking a second review to identify lessons learnt and actions that can be put into place to support in the reduction of HAP in this group of patients.



Performance alerts, CuSum, are produced to provide trusts with data relating to deaths in specific diagnostics groups. These alerts identify where specific diagnostic groups trigger alert indicators when the number of deaths for that diagnosis occur more frequently than expected.

A CuSum trigger for overall performance is 5, the trust performance for CuSum is currently 0.00, suggesting that there are no specific concerns identified through this route relating to the number of deaths for any diagnostic group.

Any key themes

Respiratory and sepsis and related diseases continue to contribute significantly to the numbers of deaths and higher HSMR.

Our Process for Learning from Hospital Mortality

During 2016 The National Mortality Case Record Review Programme in conjunction with the Royal College of Physicians (RCP) introduced a standardised methodology

for reviewing case records of deaths in hospital using a qualitative analysis approach.
The recommended tool was launched within the trust in January 2017.A further review of the tool has been undertaken and is currently in the consultation phase. The revised tool supports the identification of gaps in key elements of clinical assessment and care that may have contributed to a patient death. Appendix 5.
This tool is also being adapted by the MLTC DHON for use during table top exercises and RCAs relating to patient care.

This approach was further endorsed in December 2016 by the CQC and national recommendations referencing this process were published by the National Quality Board in March 2017.
The key recommendations from the national publications are to be implemented within the trust. This will require a move towards a revised process.

The development of these recommendations has commenced. A senior clinician has been identified as the lead for mortality and specialty leads have been nominated.
The RCP training programme has commenced with training available for 11 clinicians during October 2017.The RCP have also agreed to present on 19 October during the trust Audit Programme to a wider audience of clinicians
The Clinical Directors for all care groups have agreed on the cohorts of patients to be included in the review process based on the NQB recommendations.
The group will include

1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
2. All patients with a learning disability
3. All patients with a mental health illness
4. All maternal deaths
5. All children and young people up to 19 years of age
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work
7. All 0-1 day LOS who are not receiving specialist palliative care
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care
9. All elective surgical patients,
10. All none elective surgical patients
11. All patients readmitted within 30 days of discharge
12. All patients with more than 4 admissions within the previous 12 months
13. All unexpected deaths/ coroner reported
14. Deaths in critical care
15. A random selection of 20% of others not in the cohorts above
16. 20 patients per month to be reviewed by the palliative care team to review EOL care

Subsequently it is anticipated that not all deaths will require review but is proposed that 100% of the selected cohort will be reviewed. The revised process was implemented for deaths occurring in June 2017.

Triggers identified per month are demonstrated in the table below

Flags Applied	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017
1. All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision	3	5	4	5	7	11	3
2. All patients with a learning disability	0	0	0	0	1	1	1
3. All patients with a mental health illness	0	0	0	0	0	0	0
4. All maternal deaths	0	0	0	0	0	0	0
5. All children and young people up to 19 years of age	0	1	2	0	0	0	0
6. All deaths where an alarm has been raised with the provider through SHMI, CQC, audit work	0	0	0	0	0	0	0
7. All 0-1 day LOS who are not receiving specialist palliative care	11	13	12	8	21	13	23
8. All patients admitted out of hours who die within 5 days, excluding those receiving specialist palliative care	46	14	20	14	23	15	34
9. All elective surgical patients	0	1	0	2	0	2	0
10. All none elective surgical patients	10	13	11	3	8	10	11
11. All unexpected deaths/ coroner reported	-	-	-	-	5	19	TBC
12. Deaths in critical care	8	5	5	6	15	10	8
13. A random selection of 20% of those other than listed above	6	8	8	6	10	7	6
14. 20 patients per month to be reviewed by the palliative care team to review EOL care	20	20	20	20	20	20	20
15. All deaths were an internal indicator is flagged readmissions within 30days	9	7	10	8	12	7	12
16. All deaths were an internal indicator is flagged readmissions >4 in 12 months	13	10	10	5	6	14	66

The number of deaths and subsequent reviews required based on the cohorts identified from the triggers is demonstrated below.

June 2017	
Total Number of Deaths	80
Total Number to be Reviewed	62
July 2017	
Total Number of Deaths	81
Total Number to be Reviewed	62
August 2017	
Total Number of Deaths	88
Total Number to be Reviewed	52
September 2017	
Total Number of Deaths	62

Total Number to be Reviewed	35
October 2017	
Total Number of Deaths	86
Total Number to be Reviewed	68
November 2017	
Total Number of Deaths	80
Total Number to be Reviewed	51
December 2017	
Total Number of Deaths	133
Total Number to be Reviewed	102

Since the implementation of the national guidance the performance for reviewing deaths within the care groups is demonstrated in the table below.

Performance against the 100% review of all cohort patients continues to be poor. This has resulted in insufficient to be indicative of meaningful trends relating to the quality of care and processes to inform lessons learnt and associate actions and review of practice.

The clinical lead for Mortality is to raise a concern with the MD in relation to dedicated time for clinicians to undertake the mortality reviews.

Specialities	**June 2017**			
	Number of Deaths	**Number with at least 1 Flag**	**Number Returned**	**Return Rate**
Elderly Care	27	23	15	69%
Long Term Conditions	19	10	9	90%
Emergency Medicine	11	8	5	63%
Cardiology	2	2	2	100%
Gastroenterology	5	3	3	100%
MSK	3	3	3	100%
General Surgery	5	5	4	80%
Head and Neck	0	0		-
Urology	0	0		-
ITU	8	8	7	87.5%
Total Figures	**80**	**62**	**49**	**79%**

Secondary Review Required	Number Returned	Return Rate
2	2	100%
Number Requiring Reporting on Safeguard (< 3)	Number determined as SI	Number Requiring RCA
0	0	0

Specialities	July 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	23	11	11	100%
Long Term Conditions	20	7	7	100%
Emergency Medicine	16	13	12	92%
Cardiology	4	4	4	100%
Gastroenterology	1	1	1	100%
MSK	4	4	4	100%
General Surgery	7	7	8	100%
Head and Neck	0	-	-	-
Urology	0	-	-	-
ITU	5	5	4	80%
Paediatrics	1	1	1	100%
Total Figures	**81**	**53**	**52**	**96%**

Secondary Review Identified as scoring ≤ 3	Number Requiring Secondary Review	Return Rate
7	4	3
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA
0	0	0

Specialities	August 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	22	8	8	100%
Long Term Conditions	20	9	8	89%
Emergency Medicine	17	15	13	87%
Cardiology	3	2	1	50%
Gastroenterology	7	0	-	0%
MSK	3	3	3	100%
General Surgery	8	7	7	100%
ITU	5	5	4	80%
Womens	1	1	1	100%
Paediatrics	2	2	2	100%
Total Figures	**88**	**53**	**47**	**88%**

Secondary Review Required	Number Returned	Return Rate
1	1	1
Number Requiring Reporting on Safeguard (< 3)	Number determined as SI	Number Requiring RCA
0	0	0

Specialities	September 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	15	8	6	75%
Long Term Conditions	13	2	2	100%
Emergency Medicine	16	11	1	9%
Cardiology	3	1	1	100%
Gastroenterology	4	2	0	0%
MSK	1	1	1	100%
General Surgery	3	3	3	100%
Urology	1	1	0	0%
ITU	6	6	2	33%
Womens	0	-	-	-
Paediatrics	0	-	-	-
Total Figures	**61**	**35**	**16**	**45%**

Secondary Review Required	Number Returned	Return Rate
1	1	1
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

Specialities	October 2017			
	Number of Deaths	Number with at least 1 Flag	Number Returned	Return Rate
Elderly Care	19	13	4	36%
Long Term Conditions	13	9	7	78%
Emergency Medicine	13	9	1	11%
Cardiology	4	4	4	100%
Gastroenterology	11	8	5	62.5%
MSK	6	6	6	100%
General Surgery	4	4	4	100%
Urology	0			
ITU	15	15	9	60%
Womens	0			-
Paediatrics	0			-
Total Figures	**86**	**68**	**40**	**58%**

Secondary Review Required	Number Returned	Return Rate
3	3	In progress
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA
1		

Specialities	November 2017				
	Number of Deaths	Number with at least 1 Flag	Number Notes Delivered	Number Forms Returned	Return Rate
Elderly Care	13	4	3	1	25%
Long Term Conditions	17	8	5	0	0%
Emergency Medicine	19	15	13	0	0%
Cardiology	2	2	1	1	50%
Gastroenterology	6	2	2	0	0%
MSK	2	2	2	1	50%
General Surgery	6	6	6	3	50%
Urology	0	-	-	-	
ITU	12	12	9	6	50%
Womens	0	-	-	-	-
Paediatrics	0	-	-	-	-
Total Figures	**77***	**51**	**41**	**12**	**24%**

Secondary Review Identified As Scoring <3	Second Review Required as Identified by Mortality Lead	Second Review Completed
4		1
Number Requiring Reporting on Safeguard (< 4)	Number determined as SI	Number Requiring RCA

The Performance and Information Team have developed an extensive data tool to capture all patient demographics and data relating to the episode of care. The data tool when populated by the Clinical Audit Team will also provide information relating to the triggers and outcomes of reviews for tracking and reporting purposes. The Performance and Information Team will produce summary reports based upon the content of the data set. The operational teams will be able to utilise these reports for internal and external reporting.

All deaths reviewed will be assessed for overall quality of care with a score of 1-5. Any deaths scoring less than 3 will be subject to a second review by a senior clinician and the Trust Lead Clinician for mortality supported by appropriate members of the MDT. This review will determine as to whether the death was avoidable, if this is found to be the case the death will be recorded in safeguard to determine the appropriateness of SI status and invoke duty of candour and investigation processes as per the trust policy.

Since June, 13 reviews have been escalated for secondary review. 2 have been reported as an SI, duty of candour has been enacted an RCA has been undertaken for 1; action plan developed and has subsequently been reported to the coroner.

The action plan has incorporated recommendations from the coroner. Actions have been completed.

The second case was managed via the SI framework and subsequently down graded

All deaths determined as avoidable will be required to be reported nationally.

To assure the quality of reviews once the RCP training has been undertaken a random selection of 10% of reviews undertaken will be reviewed by the mortality lead for each specialty and presented at their care group quality forums on a quarterly basis.

A trust learning from death policy has been developed, ratified and is available internally and externally via the internet

As part of the process It is proposed that the reviews will be undertaken by the specialty leads for mortality, presented and discussed at Care Group Quality teams to develop action plans and determine lessons learnt and presented at the Mortality Group for shared learning and reported through TQE, CQR and Trust Board. Appendix 4

The Trust has been asked to support the CCG in developing a similar process for Learning from Deaths and sharing learning across the health economy for those patients that die out of hospital within 30 days of discharge.

The Division of paediatrics continue to follow national protocols for reviewing paediatric and neonatal deaths and participating in regional and national forums and quality reviews.
For all Oncology patients who die within 30 days of receiving chemotherapy reviews will be undertaken as per the national guidelines.

Acting on Learning

Areas of learning are identified using a number of indicators from internal and external performance metrics.
The areas of learning are manged through he Care Group and Divisional Quality Teams and presented at the Mortality Group
Recent areas of learning have been identified as follows

Care Group	Review	What Have We Learnt	What Action Are We Taking	What Progress Have We Made	Owner	Review Date
Elderly Care	Patients who died and were diagnosed with aspiration pneumonia saw a rise in 2016	SaLT assessments were not timely SaLT resources were limited Relative patient and carer information was limited	An LIA was undertaken involving all stakeholders.	An action plan has been devised and implemented. Appendix 4	Dr Senthil Matron Julie Corns	~~**January 2017**~~ **October 2017 completed**
Palliative Care	Patients who died who were known to have a learning disability, to be reviewed as part of revised national guidance to support in reducing premature death	National evidence suggests that patients with LD are more likely to die prematurely and involvement of specialist support and involvement of carers is not always optimal	Undertaking a review of patients who have died in a 12 month period who we were able to identify as having a LD	A review has been undertaken which did not identify any concerns in relation to gaps in clinical care. There were no negative issues identified in relation to equality and diversity There was evidence to suggest that there was limited involvement of specialist teams to support with the care of patients with LD The Trust does not use an electronic identifier to support in notifying specialist teams of attendance or admission into hospital of patients with LD. The Trust are not able to identify all patients who have	Dr Esther Waterhouse Diane Rhoden Senior Nurse Quality and Safeguarding Mrs J Adams Kirstie Macmillan Sharon Thomas	~~**April 2017**~~ ~~**Aug 2017**~~ **May 2018**

				died in the Trust who have a LD. The leads for safeguarding are working collaboratively with the Business Change team, CCG and CSU to develop a sharing of information protocol and process to process to enable identification of this group of patients to enable analysis of care needs and any gaps in the models of care delivered The trust leads for Data Protection are seeking advice in relation to the use of flags for this group of patients in light of revised Data Protection Act guidance. A meeting has been convened with the trust DP leads, LD and safeguarding teams. An interim process to identify and report LD deaths has been developed pending the GDPR guidelines in Mat 2018		
Emergency Medicine	During December and January a significant rise in 0-1 day LOS deaths was observed		The lead clinician for AMU is to review these deaths and identify any learning points to be presented at the MGM in May 2017 The Care Group Manage for Community Services will review	Initial information has identified that a significant proportion of the patients with a 0-1 day LOS were or had received DN intervention, DC to undertake further case review to determine if there were any intervention that could have been undertaken to reduce admissions. Dr Ali has reviewed 0 day LOS patients admitted to	Dr Saim Donna Chaloner	~~**May 2017**~~ ~~**July 2017**~~ **complete**

			this group of patients to determine whether there are any learning points in relation to the community engagement	AMU during December and January. 1 patient receiving shared care has been referred for secondary review. No other specific issues were identified. Community services have reviewed the 0day LOS patient admitted during December and January. The review found that 5 patients had a community DNAR in place. Key areas of learning were identified in relation to recognition of the deteriorating patient and the early management of sepsis. KG will be working with the teams to implement actions as per an action plan developed as a result of the review. Appendix 5		
Palliative Care	During December and January a rise in the numbers of patients receiving specialist palliative care with and without EOL pathways in place was observed	EW presented findings following the review of a group of patients. The review found limited evidence of involvement of the palliative care team, EOL pathway and communication with relatives and carers	A meeting is to be convened with the MD, DD , CD , Matron medical and nursing teams	A meeting has taken place with the palliative care and clinical leads to agree on communication strategies and support required for the ward areas to ensure palliative care involvement at the earliest opportunity	Dr Esther Waterhouse Matron Karen Rawlings	**May 2017 complete**
Critical Care	VC reviewed deaths in critical care	Limited evidence of cause of death documented in the patient record	The clinical coding department will include the coding record in the	To commence May 2017	Sharon Thornywork	**May 2017 complete**

			patients notes for information for the reviewing clinician			
Critical Care	VC reviewed deaths in critical care	Limited evidence of consent being obtained for procedures form patients or information to patients, relatives and carers regarding procedures and interventions	A consent document to be developed for patients to sign on admission to critical care and a document for relatives to sign to document that they have been given information in relation to planned or potential procedures or intervention that may be required and are in best interest	A consent document has been developed for use in critical care for appropriate patients	Viktorijia Cerniauskiene	**June 2017 complete**
Long Term conditions	Review of patients recorded as PE contributing to deaths and development of a revised PE protocol and clinical guideline	Patients diagnosed or suspected to have massive PE are not suitable to be managed within a general acute admissions ward	Dr Selveraj to develop a revised guideline and protocol by where all patients with massive PE will be cared for in a CCU or Critical Care environment	Protocol and clinical guideline has been developed, to be presented at DQTs , QS and launched. EE is leading on the launch and clinical sign off of the guideline The final guideline will be received at DQB September 2017 The guideline has been uploaded to the trust intranet and circulated to all clinical groups for information and action	Dr Selveraj, JA	~~**August 2017**~~ **September 2017 Complete**
Elderly Care	Further review of patients with aspiration related deaths	Dr Senthil undertook further review of this group	D Rhoden and Donna Chaloner to liaise with the	KW community lead has developed a care plan used for those patients at risk.	DR, DC DR/CG/KW	~~**July 2017**~~ **October 2017**

		of patients, the review identified that a number of the patients developed aspiration pneumonia in a care setting in the community	community team to develop a specific SaLT care plan for careers at home and nursing homes	Issue to be presented at the next nutritional steering group for wider participation and consideration for the management of patients who are discharged with a feed at risk status		
Elderly Care	Review of deaths in elderly care	Dr Senthil undertook a review of deaths occurring in elderly care	The review found that not all MCA were completed for patients with DNAR in place Patient not consented for NIV Anuria for 23 hours not escalated	This is to be reinforced at CG and Grand round meetings. Seminar CPR/DNAR/MCA 27 September 2017 Medical staff to attend consent LIA 5 September 2017 Escalated to Matrons to reinstate fluid balance audits. Monthly audits of Vitalpac. Deteriorating patients to be a standing agenda item on CG Quality meetings.	VS/JA NT/JA Patient Safety Teams, VS	**October 2017 Complete**
Critical Care	Review of a patient with a CVP line	A patient was admitted to ITU and subsequently died. Mortality review undertaken and recorded as a concern on the safeguard system in respect of the management of the CVP line	A second review was undertaken and a table top exercise was undertaken supported by the patient safety team	The lessons learnt and action plan has been developed Key points Lack of widespread training for all Nurses across the Trust and then ability to the competency of this training Unable to currently monitor the amount of CVP lines in the Trust due to no team co-ordinating this. Ward round standards need to be updated to include the monitoring of CVP lines and		**August 2017 complete**

				to document the review in the notes Messages from reviews to be shared widely through screen savers Safety messages of the week being created and shared in AMU Moderate harm recorded Appendix 6		
Patient attending ED with low Hb	Review of a patient with a history of raised INR and haemoptysis	A secondary review has been undertaken and this incident has been recorded as an SI	Duty of candour and the Safeguarding Framework has been enacted	STEIS number 2017/19133.Cause of death recorded as PE as per post mortem. Low Hb and raised INR did not contribute to the death.RJ developing concise review and propose a downgrade . Lessons learnt discussed at ED CGroup. Concise report appendix 5	RJ/DH	~~**September 2017**~~ **October 2017 Complete**
September 2017 Out of Hospital Deaths	A review of out of hospital deaths for the month of MAY 2017, contributing to 37% of all deaths	To agree a process at the CCG Mortality reduction Group September 22		A review is being undertaken of the group of patients by the community teams, findings will be presented at the next CCG Reducing Mortality meeting for potential further reviews. Report attached  Mortality Report.docx	KG/YH/NA/JA	**November 2017 Complete**
September 2017. Elderly Care Deaths	A review of a random selection of deaths occurring in Elderly Care during May and June			A review has been undertaken , issues identified, documentation, DNARCPR documentation and	VS	**November 2017 Complete**

	2017, a continued high prevalence has been seen for these 2 months			escalation of the deteriorating patient. To be discussed and action plans developed at the CG quality meeting in February. Documentation to be picked up as part of the CQC PCIP plan		
September 2017	A review of EOL care as part of the EOL working group	As part of the deteriorating patient work a group of patients have been identified as EOL care where resuscitation may have been futile due to underlying and critical comorbidities.		Appendix 6 Update required from RJ 12/01/2018	RJ	**November 2017 January Complete**
October 2017	Review of COPD deaths occurring in Q1. Expected against observed shows an increase			NA to meet with NP to identify a nominee to undertake the review. A cohort of patients has been identified focusing on cohort groups.	SN/VB/	**December 2017**
October 2017	Review of cross organisational policies and processes in relation to DNAR/CPR/MCA with the acute Trust and CCG			An initial task and finish group meeting has taken place and will reconvene in November to scope options of joint documentation and information flow for patients being admitted and discharged	NA	**December 2017**
October 2017	Review of deaths with a fracture neck of femur	The T&O clinicians have reviewed all deaths since august.	A presentation delivered by GS identified an underlying theme of hospital acquired pneumonia.	A second multidisciplinary review of this group of patients will be undertaken to identify any changes in practice to support in reducing HAP	GS/LP/CG	**January 2018**

October 2017	Review of a shared care death	This death was recorded as an SI and managed via the SI framework. The death was subsequently reported to the coroner	An RCA has been completed, the coroner's report is complete	RCA action plan attached. Action plan completed and coroners recommendations addressed.  Remedial Action Plan 2017-14529.docx	SA	**November 2017 completed**
January 2018	Patient. SH. SI number 83455. Unit number 300440921	Medical patient died of a ruptured aneurysm during transfer to another provider		This has been recorded as an SI and an RCA is to be undertaken	JR	**February 2018**
January 2018	Patient BT SI number 83912. Unit number 300718440	Surgical patient. Deteriorating patient and escalation processes followed by the team are to be reviewed		This has been recorded as an SI and an RCA is to be undertaken	JR	**February 2018**
January 2018	Review of ED deaths	Review of all deaths occurring in ED between Oct-Dec 2017. Identified poor documentation	Issues relating to poor documentation to be taken to the ED quality group in February Further review of 2 patients to be undertaken to provide more detail relating to the timeline of care. 100052183 100096746	Further review to be presented	DC	**February 2019-8**
January 2018	Pt 300799748	Patient receiving chemotherapy , review to be undertaken			NA/NA	**February 2018**

Conclusion

Year to date HSMR has remained below 100. SHMI has moved to below 100 for 3 consecutive months
Primarily there are no Cusum risks or any specific SHMI risks.
The data for April and May does suggest a rise in elderly deaths and a rise in out of hospital deaths which have been reviewed as joint piece of work with the CCG and community teams.
Respiratory disease related deaths contribute significantly to the total deaths seen.
The revised process is supporting in identifying areas to review, lessons learnt and changes in practice.
Performance for undertaking reviews is below the expected. Review performance is not sufficient to be indicative for areas of concern in care or process. This results in an inability to determine lessons learnt
The quality of documentation is a common theme during reviews of patient's medical record.
The trust is required to report avoidable deaths. Improved governance will be required to be embedded to assure that those deaths reviewed and determined to demonstrate substandard elements of care or process are managed via the safeguard framework and determined as to whether any elements of care or process contributed to the death.

Recommendations

- Undertake a review of COPD deaths occurring in Q1
- Undertake a review of patients with fracture neck of femur developing hospital acquired pneumonia
- Escalate to DDs and CDs poor performance in reviewing deaths
- Review local data for deaths occurring in December to identify any themes and inform reviews required.
- Align the actions to address poor documentation to the CQC PCIP work relating to documentation

Progress has been made to deliver the recommendations within the NQB guidance.

- Going forward the Trust will align to the NQB Learning from death recommendations reviewing key cohorts of patients. This may not be 100% of the total deaths but the Trust will be working towards reviewing 100% of the selected cohort.
- From June 2017 the revised cohort of patients has been selected for review commenced
- A further revision of the cohorts selected will be applied for deaths occurring in August to incorporate multiple admissions in year and those readmitted within 30 days of a previous discharge.
- A nominated trust Lead for Mortality has been identified. The Trust is represented at the BCA Learning from Deaths forum.
- Specialty leads have been identified to lead on mortality

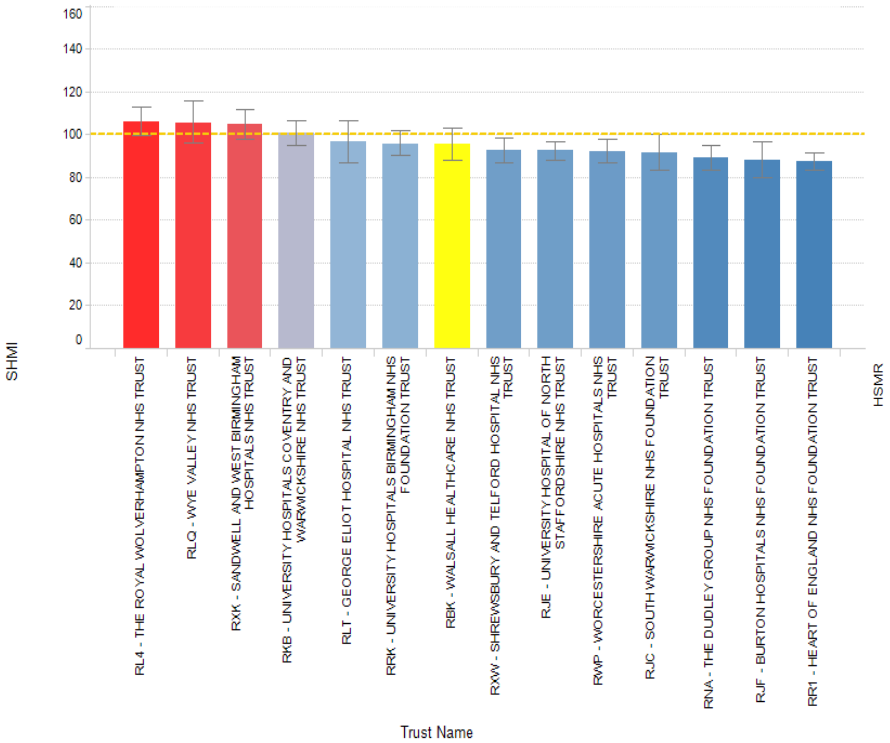
- Training provided by the RCP has been secured for October and November for 11 clinicians. Local RCP training has sourced for October trust audit day.
- Work has been completed on the development of a trust policy this has been circulated internally and externally to the trust appendix 3
- Robust governance will be implemented within specialties to ensure the clinical leads are taking ownership of learning from deaths and reviewing, identifying issues, developing action plans and sharing learning through the Mortality Surveillance Group.
- Collaborative work is being undertaken with the information services and performance team to develop robust reporting systems. A suite of reports has been developed to contribute to the monthly mortality paper and presentation to the Mortality Surveillance Group to communicate themes and performance to the clinical teams
- The Trust continues to develop and embed a robust process for monitoring and reporting deaths aligning to national recommendations including engagement with Dudley and Walsall Mental Health Trust
- Collaborative work is being undertaken with the CCG to share learning from mortality reviews to contribute to reducing deaths in hospital, support care closer to home, reduce inappropriate admissions and reduce LOS. The findings of reviews of deaths in hospital will be able to contribute to the commissioners' strategy of reducing death in Walsall.

Appendix 1

Month	Performance			HSMR					SHMI					
	Bed days	Hospital Inpatient Deaths	Per 1000 bed days	HSMR Spells (discharges)	Deaths HSMR Basket	Expected HSMR Deaths	Excess Deaths	HSMR	Deaths in hospital	Deaths 30 days discharge	Total deaths	SHMI Monthly	SHMI adjusted Palliative Care	HSMR Crude Mort
Jul-15	17685	65	3.68	1663	62	79.16	-17.16	78.32	63	38	101	86.09	73.79	3.73%
Aug-15	15254	45	2.95	1566	37	62.67	-25.67	59.03	42	41	83	82.81	73.32	2.36%
Sep-15	16789	85	5.06	1729	70	81.91	-11.91	85.46	83	38	121	101.40	86.63	4.05%
Oct-15	17663	99	5.6	1778	85	84.2	0.8	100.95	96	32	128	103.17	89.15	4.78%
Nov-15	17236	92	5.33	1796	86	91.83	-5.83	93.65	91	51	142	114.10	99.12	4.79%
Dec-15	18155	110	6.06	1969	92	105.53	-13.53	87.18	108	46	154	109.60	95.77	4.67%
Jan-16	17524	114	6.5	1891	101	96.77	4.23	104.37	113	41	154	110.12	100.38	5.34%
Feb-16	17481	98	5.61	2042	89	97.61	-8.61	91.18	95	26	121	94.78	81.88	4.36%
Mar-16	17324	110	6.35	1911	92	96.06	-4.06	95.77	106	32	138	105.23	92.23	4.81%
Apr-16	17536	104	5.93	1992	90	87.98	2.02	102.3	102	49	151	120.23	105.47	4.52%
May-16	15519	73	4.7	2050	63	76.13	-13.13	82.75	70	33	103	95.42	83.13	3.07%
Jun-16	17807	79	4.43	2120	70	83.35	-13.35	83.98	76	36	112	92.83	78.27	3.30%
Jul-16	16733	84	5.02	2033	69	79.52	-10.52	86.77	82	33	115	94.24	82.12	3.39%
Aug-16	17065	83	4.86	2072	75	81.65	-6.65	91.85	83	36	119	96.57	83.85	3.62%
Sep-16	15761	69	4.37	2100	64	80.46	-16.46	79.54	65	36	101	83.21	77.66	3.00%
Oct-16	17014	95	5.5	2124	81	76.2	4.8	106.3	93	38	131	109.84	98.38	3.81%
Nov-16	16416	80	4.8	2371	66	82.18	-16.18	80.31	78	43	121	93.95	85.32	2.79%
Dec-16	18008	128	7.3	2249	116	99.37	16.63	116.74	130	49	179	127.45	114.77	5.06%
Jan-17	17177	133	8.2	2192	122	101.8	20.2	119.84	140	49	189	129.16	116.82	5.24%
Feb-17	16094	84	5.46	2060	77	82.8	-5.8	92.99	83	47	130	104.21	93.9	3.73%

Mar-17	17041	88	5.16	2381	87	107.95	-20.95	80.59						3.65%
16/17	-	-	-	25744	980	1039.4	-59.4	94.29	-	-	-	-	-	-
Apr-17	15924	90	5.65	1919	82	81.9	0.1	100.12	88	41	129	104.07	90.59	4.27%
May-17	13785	94	6.82	2258	82	84.31	-2.31	97.26	90	53	143	106.99	93.4	3.63%
Jun-17	17629	81	4.59	2144	76	86.6	-10.6	87.76	80	35	115	82.95	73.07	3.54%
Jul-17	15495	80	5.16	2090	73	73.51	-0.51	99.41	79	33	112	87.86	78.16	3.49%
Aug-17	16025	91	5.67	1901	77	79.73	-2.73	98.93	89	38	127	95.43	85.28	4.05%
Sep-17	14422	63	4.36	1711	58	74.1	-16.1	78.27						3.38%
Oct-17	14871	86	5.7											
Nov-17	15082	80	5.3											
Dec-17	16400	138	8.4											

Appendix 2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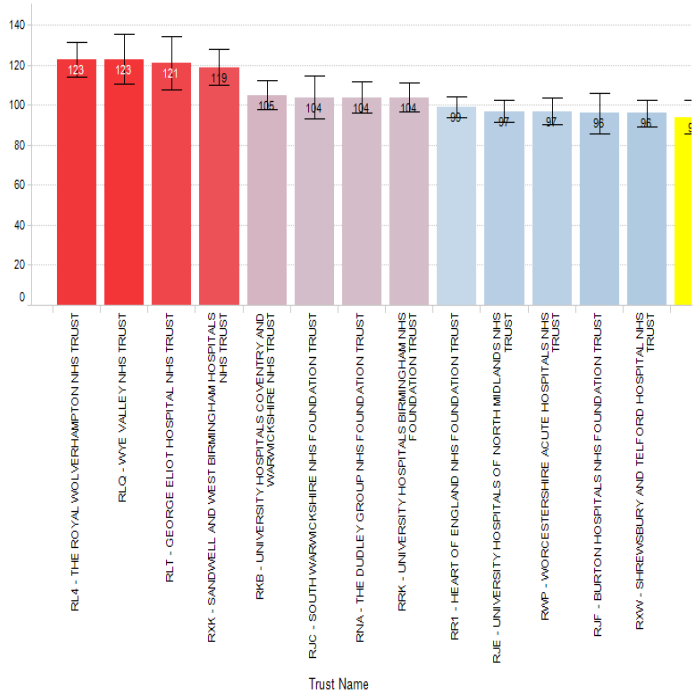
RXK - SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
RKB - UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
RLT - GEORGE ELIOT HOSPITAL NHS TRUST
RRK - UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
RBK - WALSALL HEALTHCARE NHS TRUST
RXW - SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
RJE - UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST
RWP - WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
RJC - SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
RNA - THE DUDLEY GROUP NHS FOUNDATION TRUST
RJF - BURTON HOSPITALS NHS FOUNDATION TRUST
RR1 - HEART OF ENGLAND NHS FOUNDATION TRUST
Trust Name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RJC - SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
RNA - THE DUDLEY GROUP NHS FOUNDATION TRUST
RRK - UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
RR1 - HEART OF ENGLAND NHS FOUNDATION TRUST
RJE - UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
RWP - WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
RJF - BURTON HOSPITALS NHS FOUNDATION TRUST
RXW - SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
Trust Name

Appendix 3
Learning from Deaths Policy

Learning from Deaths Policy V18.do

Appendix 4
Community report and action plan

Mortality Report.docx

Action Plan - Mortality Review.odt

Appendix 4.1

Mortality Report.docx

Appendix 5

Mortality Screening Review.pdf

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 1st February 2018**
Report Title	Quality & Safety Committee Highlight Report			**Agenda Item: 13** **Enclosure No: 11**
Lead Director to Present Report	Chair of Quality & Safety Committee, Non-Executive Director, Russell Beale			
Report Author(s)	Kara Blackwell, Deputy Director of Nursing			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Quality & Safety Committee meeting held on 25th January 2018 together with the confirmed minutes of the meeting held on 21st December 2017 (appendix 1) and the 30th November 2017 (appendix 2). Key items discussed at the meeting were: • VTE performance at the requirements to achieve the 95% performance target by March 2018 • The PCIP following the recent CQC report publication • The Safer Staffing Nursing Report and associated work-plan • Update on Never Event Final Action Plan Meetings held on November 2017, December 2017 and January 2018 were quorate and chaired by Professor Beale.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Not Relevant</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Not Relevant</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Not Relevant</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Embed the quality, performance experience improvements that we have begun in 2016/17</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☐</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☐</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Link to Board Assurance Framework Risk Statement No.1 ‘That the quality and safety of care we provide across the Trust does not improve in line with our commitment in the Patient Care Improvement Plan’</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Quality & Safety Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Quality & Safety Committee meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the Quality & Safety Committee meeting held on 25th January 2018 will be submitted to the Board at its meeting on 8th March 2018 at which the Board will also receive a highlight report from the Quality & Safety Committee meeting held on 22nd February 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

QUALITY & SAFETY COMMITTEE HIGHLIGHT REPORT
TRUST BOARD – 25th JANUARY 2018

1. INTRODUCTION

The Quality & Safety Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Quality & Safety Committee meeting and a highlight report on the key issues raised at the most recent meeting.

2. KEY ISSUES FROM MEETING HELD ON 25th JANUARY 2018

The Committee was quorate and discussed numerous items including a presentation from the Division of Surgery. Minutes will come to the Trust Board in March. The highlights for the Trust Board to be aware of are as follows:

3. PERFORMANCE AND QUALITY REPORT

The report was presented and discussed by the Committee. An update was provided with a focus on:

- VTE, The trajectory, although improved in December 2017 still did not meet the 95% target. VTE assessment was also a Regulatory breach in the recent CQC report and the Trust has provided an action plan to the CQC to achieve the performance target by March 2018. These actions included the multi-disciplinary team working together to ensure this safety measure was undertaken for every patient.
  Additional work with the Divisional teams of three supported by the Medical and Nurse Director needed to be undertaken to understand what, in addition, could be done to ensure we are consistently undertaking this assessment.
- An increase in the number of C. Diff cases bringing us close to our threshold target for 2017-2018
- Recent increase in Flu cases admitted to the Trust

The Committee discussed the impact of winter on ED, it was recognised that there were increased pressures but there had been no 12 hour trolley wait breaches and no major incidents due to this increased and prolonged pressure.

4. MATERNITY AND NEONATAL TASK FORCE UPDATE

An update of the on-going work being undertaken by the Maternity and Neonatal task force was presented.

The progress against the four areas for improvement in the Section 29A Warning Notice was reviewed. In both CTG monitoring and safeguarding training the standards were fully met. CTG monitoring had met compliance for 4 weeks consecutively. Continued work on a new model of Enhanced Maternity Care as part of addressing the HDU care issue was noted with plans to implement in February 2018 following ratification of the guideline in January 2018.

The acuity paper was presented which detailed the current acuity levels for December 2017 and it was noted that positive acuity was achieved on 85% of occasions which is in line with Royal College of Midwives recommendations. Ensuring staff were engaged in this was discussed, the senior leadership team in maternity are undertaking regular walk arounds to discuss this with staff and there are plans for the non-execs responsible for maternity to undertake some walkabouts also discuss with staff. The Midwifery Led-Unit was discussed and the decision that this would remain closed and reviewed again in 3 months via the Taskforce.

There was a slight increase in C-Section rates in December but actions were in place to address this and ensure that the daily morning review meetings took place consistently.

The Committee acknowledged the positive work and progress the team in maternity were making.

5. PATIENT CARE IMPROVEMENT PROGRAMME

The Patient Care Improvement Programme was presented. The regulatory breaches and actions to address these were reported back to the CQC on Monday 22nd January 2018.

The next steps in relation to the PCIP were outlined, this work follows on from the “first cut” of the action plan in relation to the “must” and “should” do actions and includes aligning these individual actions into themes, and linking these to the Trust Objectives and Quality Commitment. This work is currently being undertaken supported by the Improvement Director. Following this workshops are being arranged for March to further support the Divisions and Care Groups to embed these required changes and continue the improvement work which will enable services rated as requires improvement to progress to good, those good services to progress to outstanding, and those services rated as outstanding to continue to achieve this status.

6. SAFER STAFFING REPORT AND MONTHLY NURSE STAFFING

The Safer Staffing paper was discussed; it set out the nursing safer staffing, quality, patient safety, and operational accountability and assurance in relation to the nurse staffing skill mix/ratios on the medical and surgical inpatient wards. Benchmarking against peer organisations, and the NICE Guidance showed that the RN to Patient ratio on days exceeded the recommended 1:8 ratio. The report also outlined actions in relation to safe staffing and nursing workforce being undertaken over the coming months.

The Committee agreed that there needed to be a focus on reducing the current number of vacancies and functioning within the funded bed-base, as the additional capacity further stretches the existing workforce. An update on the current recruitment status including the recent successes with the Skype interviews for overseas nurses who already have the IELTS was discussed; it was acknowledged that the Trust has commenced further work on recruitment and retention and these should be discussed further at the next committee.

7. REPORT ON SEVEN DAY SERVICES

The report which outlines the standards relating to the 7 day service was presented by the Medical Director. Leads for the actions and timescales need to be defined.

8. CAPITAL EQUIPMENT REPLACEMENT PROGRAMME

The report outlined the equipment for replacement, this now needed to be prioritised, and discussions were taking place with the Divisional teams about this. It was agreed that the prioritised summary would be presented at a future Q&S Committee.

9. SAFER BUNDLE INTERNAL AUDIT REPORT

The report outlined the results from the Safer Bundle audit which were undertaken last summer and pre-date actions and systems subsequently put in place. The current analysis undertaken by ECIP and their report of recommendations was discussed and it was agreed that this report and the actions to address the recommendations from this should come to the next Committee.

10. NEVER EVENT REPORT AND ACTION PLAN

The recent never event and the actions taken following this were discussed. The swab and needle checks are now being audited daily to ensure that these are consistently being undertaken. A paper version for recording these checks is currently being used whilst a solution for this on Badger net to make these checks a mandatory field is developed.

Alongside the actions from this never event, the work on LocSIPPS and NatSIPPS which needs to be undertaken was discussed. There is now a lead in place and an update on this work needs to be provided to the Committee.

11. PRESENTATION FROM THE DIVISION OF SURGERY

The presentation from the Division of Surgery was presented. The key points identified were:

- An overview of the CQC report in relation to the Division of Surgery and the on-going work required for Surgery to progress from “requires Improvement” to “Good”.
- Work being undertaken to address improvements required in Critical Care and the team working with neighbouring Trusts who have been rated as “Good” by CQC
- The work that needs to be undertaken to improve the response and care of deteriorating patients.
- An update on the Theatre work-stream, including the work being undertaken to improve utilisation.

The trajectory for theatre utilisation was discussed at the Division of Surgery's Quarterly Review, improvements to bookings which supported utilisation had been implemented.

12. ITEMS FOR ESCALATION TO THE TRUST BOARD

The committee resolve that the following items would be referred to the Trust Board at its meeting on the 25th January 2018:

- Progress in maternity
- VTE compliance
- Never Event Final Action Plan received
- Discussion about theatre utilisation

As there was no Board Meeting in January , the following items for escalation from the Quality and Safety Committee meeting which took place on the 21st December 2017 are included:

- VTE Compliance
- Results of the GMC National Trainee Survey 2017
- Final CQC Inspection report to be shared with the Trust Board

Walsall Healthcare NHS
NHS Trust

PUBLIC BOARD REPORT

Meeting	Trust Board			**Date: 1st February 2018**
Report Title	**Black Country Pathology Service – Full Business Case update**			**Agenda Item: 14 Enclosure No.: 12**
Lead Director to Present Report	Mr Amir Khan Medical Director			
Report Author(s)	LTS on behalf of the Black Country Pathology Service			
Executive Summary	Following the feedback from the trusts after board discussions early in December, work has continued: • With the finance teams, to further develop the Commercial Terms, as requested. • To develop the Output Based Specification for the single LIMs. The clinical teams have committed significant effort to complete the task. • To begin work on agreed change management principles to support the HR agenda and enable discussions with staff side representatives. • The specification for the legal support required to commence the formation of the Black Country Pathology Service as an Arms-Length Organisation has been drafted and published for procurement. The attached Business Case is the proposed final version to be presented to all boards at the February board cycle. **Summary:** • The target operating model costs consist of Pay, Non-Pay, IM&T, Corporate overhead, Transition Costs, Capital expenditure, Interest on debt and PDC charge. The total As-Is costs are £724 million • Savings equal the difference between the forecast As Is Costs and the Forecast Target Operating Model Costs. • Forecast As is Costs total £672 million. This consists of RWT £200 m; SWB £234 m; WH £97m; and DGFT £141 m • Forecast Savings are £52 million net of investment over 10 years, 7.5 of which are at steady state. • The Savings have been allocated to each partner using a cost sharing percentage, which is volume based.			
Purpose	**Approval** ☒	**Decision** ☒	**Discussion** ☒	**Note for Information** ☐

Recommendation	• Approve the business case for the Black Country Pathology Service and agree to progress to the transition phase including the initiation of the enabling HR plans immediately. • Participate on the basis of the governance and commercial terms, as set out in the business case. If there are any changes that are recommended during the transition and due diligence phases these will be taken to the Oversight Group for consideration and approval. Where the impact results in a change of the financial position, any proposed changes will be taken to the Oversight group and if approved there, will be recommended to Trust boards for approval. • Agree to set up the BCPS as a shared Arms-Length Organisation, hosted by RWT. • Commitment to fund the necessary enabling works, as contained in the FBC. Delegating the Oversight Group to manage the appropriate detail. The approved costs incurred to date, are detailed in a paper presented to the Oversight Group, and amount to a total of £794,909, which equates to £ £198,727 per trust, based on a 25% split. • Authorise continuation of design development. • Appoint the substantive Clinical Director and Operational Manager.

	Work Closely with Partners in Walsall and Surrounding Areas	**With local partners change models of care to keep hospital activity at no more than 2016/17 outturn**
	Value our Colleagues so they recommend us as a place to work	**Embed an engaged, empowered and clinically led organisational culture**
	Use resources well to ensure we are Sustainable	**Tackle our financial position so that our deficit reduces**
Care Quality Commission Key Lines of Enquiry Supported by this Report	**The report supports the following Key Lines of Enquiry:**	
Board Assurance Framework/ Corporate Risk Register Links		
Resource Implications		
Other Regulatory /Legal Implications		

Safe	☐	**Effective**	☐
Caring	☐	**Responsive**	☒
Well-Led	☒		

Report History	This paper is the update to the Full Business Case to follow on from the Outline Business Case for the Black Country Pathology Service that was received by the Board in August 2017, the update paper that was received in November 2017 and the Full Business Case received in December 2017.
Next Steps	
Freedom of Information Status	**The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee**

BCPS – Full Business Case Update

Report Update into the development of a consolidated Black Country Pathology Service (January 2018)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Walsall Healthcare NHS
NHS Trust

The Dudley Group NHS
NHS Foundation Trust

The Royal Wolverhampton NHS
NHS Trust

Foreword

Following the Outline Business Case for Black Country Pathology submitted in July 2017, an updated report was issued in October 2017 for review. Comments and feedback from the Oversight Group & Trust Boards were received and are incorporated in this November 2017 update. This includes the sufficient detail and due-diligence to make an informed decision on the consolidation of pathology services across the four trusts. Operational and Clinical detail, including risks, have been reviewed with all departments and mitigation plans have been developed.

Staffing figures have been updated to incorporate detailed feedback from departments, reviewing proposed rotas to operate the proposed service.

Finance detail updated, description of Capex, Revenue and Funding included.

IT figures have been updated following a due-diligence assessment of the required LIMS to cater for a consolidated service.

Logistics detail covered to increase the required routes and optimised routes to sustain existing quality of the pathology service.

Governance updated.

Operational delivery description updated, to operate Hub & 3 ESLs, in addition to a variance of the Specialist Biochemistry Testing.

Estates reviewed in parallel with the operational workstreams. Including details of required refurbishment.

Risk indicated as main risks to run the service.

Timeline and Implementation of the proposed pathology service has been included with regards to IT, Estates, Transition of Equipment, Extension build and the impact of MMH build to SWB Microbiology and Histology.

Content

EXECUTIVE SUMMARY

Key Figures

- £52m total savings net of investment over 10 years (of which 7.5 years are steady state)
- £7.5m saving per year in Steady State
- £9.3m total transition capital investment
- £0.4m other transition costs (legal and expert support)
- £0.3m contingency for capital
- £0.4m per annum on additional contingency costs

Executive Summary

The conditional approval by the Trust boards of the OBC, highlighted the need to carry out detailed due diligence in a number of areas to provide reassurance that key risks were being managed and key cost drivers were accurate. The key requirements from the boards were:

1. Detailed analysis of staffing profiles in the TOM to reduce the risk to the delivery of the service;
2. Detailed analysis on IT and logistics costs to understand the extent of the investment required, IT infrastructure requirements, logistics routes, logistics costs and ability to improve quality and TATs;
3. Detailed analysis of capital investment required for the extension of the Hub and refurbishment of the ESLs;
4. Assessment on implementation timeline and key milestones for the construction and critical path to meet the needs of SWBH, including analysis of the impact of keeping SWBH specialist chemistry out of the partnership; and
5. Evaluation of key clinical and operational risks to ensure that these are addressed by the TOM.

While detailed work was being carried out in these areas, in early September 2017, **NHS Improvement** released a letter to all CEOs and Medical Directors in England highlighting the need to consolidate their pathology services into networks and through collaboration. The Trusts in the BCPS partnership were given a joint **savings target of £5.1m per year** to achieved by 2020.

The following document provides evidence on all of the areas above that the **TOM for the BCPS** would be able to **exceed the savings required**. It is predicted that the new **TOM can deliver** approximately **£52m savings over the project duration** including investment required, creating a sustainable service.

This report provides a summary of the due diligence exercise carried out on all of the above areas to provide a high level of certainty and confidence that the savings can be realised. The key findings from the due diligence are:

1. **Strategic Context:** the BCPS partnership will be able to exceed its required pathology service saving of £5.1m per year set by NHSI; Current TOM achieves NHSI target savings. The current TOM provides an annual saving in steady state of £7.5m per year
2. **Staffing:** the due diligence work with operational teams has increased the number of staff in the TOM by a total of 24, with a financial impact of £14m over ten years . The new TOM total staff numbers are now believed to be a very conservative estimate and BCPS should therefore be able to achieve further savings during the life of the partnership.
    - Whilst we recognise that in moving to the new BCP model there will be an overall reduction in staffing numbers, the aim will be to maintain security of employment, as far as possible. Given the duration of the project and taking account of natural turnover, it is hoped that any redundancies will be kept to an absolute minimum.

Executive Summary

3. **IT LIMS:** detailed work has been carried out with suppliers and an internal workstream with representatives from all Trusts. The new proposed IT architecture provides a system that can be implemented in the timeframe required to meet the needs of all the Trusts, especially those under pressure to move their facilities, and will deliver the required functionality and access to results across sites.. IT investment required is £1.7m

4. **Logistics:** to fully understand travel time and ensure that BCPS is able to maintain and improve quality and TATs, the team proceeded to the mapping of all collection points from primary an secondary care. The average calculated time from any GP surgery to the Hub is 2h 36min with a 98.9% of samples being in transit for less than 3.5 hours. In addition, the model allows for hourly collections from each hospital and transport to the Hub. The total cost of logistics has increased by £3m over 10 years.

5. **Capital costs:** detailed work with architects and laboratory design has been performed to ensure that the extension to the Hub provides all the space required for consultant offices and additional activity. The cost capital investment required is a total of £7.6m.

6. **Implementation timeline and project risks:** a detailed timeline for the construction of the Hub, implementation of IT and transfer of services has been developed. This timeline has given priority, as a critical path, to the transfer of services from SWBH to enable their Midland Met hospital development. There is a high degree of confidence that the timeline can be achieved and milestones met.

7. **Clinical risks:** the newly appointed interim clinical director for BCPS has been working with the operations director and clinical teams across the Trusts to ensure that the key clinical risks are documented and addressed by the TOM. The team has now created a live risk register that mitigates clinical risks and will be used as a live guiding document during transition phase.

8. **Impact of specialist chemistry being out of the partnership:** the consolidation of SWBH specialist services was never considered to provide any savings Due to the highly skilled and specialised nature of the staff. Only expected savings were meant to be derived from lower investment costs as a result of a smaller extension of the Hub. However, the need for additional capacity at the Hub to incorporate Shrewsbury hospital as per the NHSI letter means that the extension of the Hub wold still remain as planned and therefore no savings derived from it. The Net impact is approximately an additional cost of £4m to the partnership because of a small element of duplication, reducing savings to £48m.

Strategic Context and Introduction

1

Introduction

1.1 Background

The conditional approval of the initial OBC by the Black Country Trust Boards required the creation of a number of workstreams to provide a higher level of reassurance on a number of key costs and areas. These areas, over the last 2 months, have been subjected to a high level of scrutiny to provide an accurate level of savings that the creation of the Black Country Pathology Service partnership would generate. These areas are:

- **Staffing levels:** detailed analysis of the proposed staffing levels for the target operating model in collaboration with Trust pathology teams to validate and approve figures;
- **Financing:** identification of sources of finance for the capital requirement of the project and its treatment within the financial model;
- **IT:** detailed infrastructure architecture and links to ensure a fully costed and functional IT system that enables consolidation;
- **Logistics:** detailed costing and mapping of all logistics routes for primary and secondary care, including trunk routes between the Hub and hospital sites, to ensure TATs;
- **Governance:** Updated governance structure for the partnership;
- **Operational delivery;** detailed identification of key operational delivery risks, description of the operating model and how this model minimises clinical risks for the Trusts;
- Estates: design and layout for the extension of the current Hub facility, including detailed calculation of build costs and refurbishment of ESLs;
- **Risks:** creation of a detailed clinical and operational risk register with mitigation measures;
- **Timeline for implementation:** development of a detailed transition timeline for the implementation of the target operating model; and
- **Financial reconciliation:** to compare the variation in savings from the original OBC to the FBC figures based on the changes described above.

All of these areas are covered in the next sections of this report.

1.2 Strategic Context

Since agreed way forward from the OBC, the national pathology programme led by NHS Improvement, has been making progress in defining the direction for pathology services in England. The NHSI pathology team is currently in the process of collecting from all Trusts the pathology outturn financial positions for 2016/2017. Meanwhile, on the 7th of September 2017, the NHSI Pathology team issued a letter to all the CEOs and Medical Directors in England to notify them of the policy for the provision of pathology services in England. The key policy points described by NHSI and relevant to the BCPS network are:

- The clear and explicit commitment from Trust boards to the implementation of a consolidated model for pathology across the recommended networks;
- To postpone the signature of any managed services agreement that prevent the consolidation effort across the network;
- To reach an agreement on a partnership or outsourcing model for the delivery of pathology services across the network;
- For the Black Country Pathology Network to include the four current Trusts plus Shrewsbury and Telford NHS Trust, network called Midlands and East 1;

Introduction

1.2 Strategic Context continued

- To provide NHSI with a clear governance structure and timetable for the implementation of changes and realisation of savings;
- For the Midlands and East 1 Network to contribute with £5.1m of real savings to the national £200m savings target; and
- For the network to realise savings by 2020.

The requirements above focus on the need to collaborate across Trust to support the realisation of savings across networks. The definition of the networks is not mandatory if Trusts had already initiated the development of plans with other Trusts or were in the process of outsourcing the service as a whole STP.

It should be noted that discussions with NHSI have indicated that initiatives that prevent Trusts from joining a network and the realisation of savings by the Network as a whole will not be looked favourably by the national pathology team and will require further scrutiny and approvals.

The BCPS is in a unique position to deliver on the targets and national aims as highlighted by the NHSI letter and has already developed plans that would allow it to meet the targets set.

The details of these plans are described in the OBC and key areas of the OBC updated in this document

1.3 Work carried out from OBC to FBC

During the last two months the pathology team, including the Interim Operations Director and Clinical Director, supported by LTS have performed the following tasks:

- Development of a detailed reconciliation of current staff in post, staff declared by finance teams (to identify vacancies) and proposed staff in the future operating model;
- Workshops with all pathology operational teams across all Trusts to validate and agree staffing levels for ESLs and Hub; it should be noted that staffing levels have been increased significantly in certain areas to ensure a higher quality of service, which results to savings on staffing levels to be highly conservative. It is proposed that the levels of staffing are continuously reviewed and optimised throughout all stages of the project;
- Detailed mapping and development of IT infrastructure requirements to calculate detailed implementation and ongoing costs;
- Detailed mapping of all logistics routes to calculate mileage, TATs, collection points, frequency of collections and resources required to deliver a service that ensures sample stability and TATs;
- Identification of clinical and operational risks and development of a target operating model that addresses risks and minimises any potential disruption to the service;
- Definition of a target operating model that creates a service that increases quality and is responsive to the needs of patients and clinical users of the service; and
- Development of a detailed transition and implementation plan.

An updated report was issued in October 2017 to the Oversight Group and Trust Boards. Following feedback and comments, further work has been undertaken by the BCP and the discipline specific working groups to include the required detail in this November 2017 update.

STAFFING

2

Staffing – Workshops

2.1 Discipline Specific Workshops

Discipline workshops were set up with clinical leads and nominated operational staff from each of the trusts to ensure that the processes that had been outlined in the OBC were further developed and the Clinical and Laboratory Models, based on the single Hub plus three spoke ESL sites with Microbiology and Cellular Pathology at the Hub site are agreed by the four partner trusts.

The Black County Cytology service is already operational, so no planned operational changes are required.

The individual specialty workshops covered:

- Cellular Pathology
- Chemistry
- Haematology
- Immunology
- Microbiology (Bacteriology / Serology / Molecular)
- Specialist testing
- Transfusion

2.2 The objectives of the workshops were to scope:

- The current content of MSCs.
- Potential equipment migration.
- Test standardisation mapping.
- The validation of current state workforce.
- The validation and mitigation of the clinical risk register.
- The required clinical input at the ESL site hospitals, including the detailed current models of clinical input, including for MDTs, infection control, clinical consults, ward rounds, post-grad and undergrad teaching, research commitment, including 100K genome project, input into cancer & other national targets monitoring processes, input into specialised / regional services e.g. haemoglobinopathy, level 3 bone marrow transplant, integrated haematopathology, toxicology.
- Consensus agreement on the best model of delivery of clinical care which maintains quality and continuity of patient care, which is affordable and sustainable.
- Alignment of current & proposed working models including the transitional arrangements if necessary
- The use of technology (e.g. digital pathology, videoconferencing facility) to facilitate the delivery and for the provision of optimal service.
- Consensus agreement on the required laboratory input by medial consultants with the predominant clinical / hospital based activity (e.g. haematologists, microbiologists) and the optimum balance

2.3 Outcome of the workshops

Each of the disciplines ran their initial meetings in a way that they considered most appropriate for them, so for example, in Chemistry, the clinical and operational strands met together, in others the initial meeting was separate. The groups worked against a checklist of areas in which consensus was required. The focus was to concentrate on areas that would have a fundamental impact on the TOM, and so the FBC.

Staffing

2.12 Summary

Staffing numbers have increased in the target operating model from the original OBC proposed figure of 422.8 FTE for laboratory operational staff (Bands 2 to 8) to the new proposed steady state total of 440.1 FTE with some skill mix changes. This has an impact on the level of savings originally calculated in the OBC and shown in the financial summary. These changes are the result re-allocation of specific staff and of ESLs moving from the initially conservative number of 28 FTE to the new 31 FTE and the Hub moving from an original 338.8 FTE to the new 348.4.

The increases in the hub staffing figures are from Histology and Microbiology. For Histology, an operational change of processing volumes in the laboratory from Monday to Sunday on extended days as compared to the OBC reviewed processing of Monday to Friday during core hours has a significant increase on quality, reflected in improved TAT for tissue processing. As for microbiology, the FBC level increase is resulted from implementing a 24 hour – 7 day a week microbiology service. This ensures that the majority of the samples are processed more efficiently as compared to the OBC, but also results in increased costs.

The FBC proposed figures should be continuously improved whilst the project progresses and processes become standardised. This allows for further improvement towards the initial numbers of 422.8, which are closer to a realistic staff compliment and are supported by evidence from laboratories in the UK that have already consolidated their services and achieved similar efficiencies to those proposed in the OBC. As an example Wigan operate with 24 FTEs for the ESLs, NW London 22 FTEs for ESLs and Madrid centralised laboratories 16 FTEs.

Whilst we recognise that in moving to the new BCP model there will be an overall reduction in staffing numbers, the aim will be to maintain security of employment, as far as possible. Given the duration of the project and taking account of natural turnover, it is hoped that any redundancies will be kept to an absolute minimum.

FINANCE

3

Finance – Introduction and Assumptions

3.1 Finance Introduction

A financial model has been developed that provides detailed Income and Expenditure accounts for the partnership and a summary of savings and benefits for each Trust.

The charges to each Trust have been calculated on the basis of the following key assumptions: (a detailed table of assumptions is provided in the appendix)

1 – The total length of the partnership and financial model is 1 baseline year + 10 years of which 2.5 years are part of the transition period;

2 – The baseline for the model is actuals for 2016/2017 and an assumption of 3% CIPs for 2017/2018;

3 – Pay and non-pay costs have been uplifted year on year by the standard published NHS rates for pay and non-pay and by 2% from FY 2021/2022;

4 – Total activity and income growth has been assumed at a 2% activity growth (offset by 2% increase in staffing and reagents) and by a 2% growth in contract pricing;

5 – CIP savings of 3% are assumed for every year of the partnership;

6 – The model assumes that the start date for the Hub and ESLs is October 2019 which indicates the period during which the staff savings and on-pay savings will commence.

7 – Current corporate overheads have been excluded from the model as each Trust is retaining their revenue (see commercial terms) against which the corporate overheads can be allocated;

8 – Only incremental overheads for the Host as a result of the hosting arrangement, and infrastructure costs related ot the use of the space at the current laboratories and future ESLs have been incorporated into the model;

9 - Stranded costs have been fully identified and modelled on the basis of full allocation (100%) of costs to the partnership for the first 3 years and a tapering off arrangement of 75%, 50% and 25% of total for the following three years. This is aimed at ensuring that Trusts identify other income generating activity for the space vacated at each Trust.

Finance – Overview

3.3 BCPS total savings

As highlighted in the introduction, the recent NHSI letter indicated that the BCPS Trusts were required to achieve a total of approximately £5.1m savings per annum. The current Hub solution allows the Trusts to meet this requirement and exceed the savings required with a predicted total of £52m nominal and £51m real. This is a change of £40m from the original OBC that predicted £97m. There are two key drivers for this change which are explained in the reconciliation table. The table below provides an overview of the predicted savings by Trust and the impact of the different scenarios modelled.

Project Life Savings : TOM forecast versus As Is forecast (£m)

£m	Total	RWH	SWBH	WH	DGH
As Is Cost Forecast	724	215	249	107	152
TOM Cost Forecast	673	200	234	98	141
Project Savings	52	15	16	9	11
Member Share %		29.4%	30.1%	18.4%	22.2%

IT - LIMS

4

IT – Laboratory Information Management System (LIMS)

The IT workstream included representatives of all trusts to collectively agree on the proposed way forward. Consensus has been achieved with all CIOs with the proposed IT plan. Also, the workshops are on-going for the IT work group for continuous engagement.

3.1 IT Solution for Black Country Pathology Services Using Hub a single Laboratory Information Management System

The objective is to achieve an end state for the Black Country Pathology Service, (BCPS), to be in place and operational by December 2019 with a phase 1 deployment of Sandwell specific services by end June 2019.

The following table outlines the current pathology, order comms and patient administration systems in use across the Partners:

	Laboratory Information Management System (LIMS)	GP Order Comms	Patient Administration System (PAS)
Sandwell and West Birmingham Hospitals NHS Trust	CSC iSoft Telepath	Sunquest ICE	Cerner
Walsall Healthcare NHS Trust	CliniSys Winpath	Sunquest ICE	Lorenzo
The Dudley Group NHS Foundation Trust	CliniSys LabCentre	TQuest	Allscripts
The Royal Wolverhampton NHS Trust	TechniData (TD) NexLabs	Sunquest ICE	Silverlink

IT – Laboratory Information Management System (LIMS)

In order to incorporate the Essential Services Laboratories (ESL) activity into a single process the clinical view is that a single LIMS would be a pre-requisite of achieving this in a robust and safe manner. The procurement and implementation of a new LIMS is estimated to require a period of 14 to 24 months, which is within the operational tolerance for the requirement as currently presented.

The proposed centralised LIMS and associated systems will support the establishment of a hub and spoke model for the BCP Service. The solution comprises (as per figures 1 and 2 in the following slides) a number of elements including a the centralised LIMS HUB model, existing GP order comms systems feeding into and out of the HUB. Additional systems required would include an Integration layer and a Patient layer that are to be included in the solution of the LIMS supplier once selected.

The single LIMS solution will contribute towards the development and use of the hub LIMS for all diagnostic activity, if it is decided to pursue this option. The planned programme of work will contribute to the deployment of the hub LIMS to the spoke sites.

The current implementation plan (both operational and technical) will enable approximately 60% of diagnostic activity to be consolidated onto the hub LIMS, utilising the single LIMS solution by June 2019.

A procurement process can be initiated once the BCP Service receives the authority to procure the systems, technology and services required.

IT – Laboratory Information Management System (LIMS)

3.2 The Approach

The proposed approach is to utilise a single LIMS in order to meet the requirements of the BCP Service in providing a safe and reliable platform for Pathology service.

A supplier will be selected that has the proven capabilities and experience in providing a multi-site LIMS that can meet the BCP Service current needs and be flexible in having the ability to support growth in volumes of tests and increase in sites.

It is proposed that no data will be migrated from existing primary Trust LIMS although it is proposed that the blood transfusion data will be migrated when those services are migrated (Year 19/20). It will not be possible to meet the delivery timescales if data migration from the primary Trust LIMS has to be included. Incumbent systems with the respective Trusts will need to make provision for the access of legacy data (if appropriate) local to themselves.

By taking this approach work at spoke sites should be limited to connecting analytical platforms to the hub LIMS; providing network access to the hub LIMS from the spokes; conversion training for staff; adjusting sample numbering schema and testing. This approach is supported by the overall strategy to connect spoke pathology systems to the central LIMS hosted externally. Figure 1 shows a composite diagram of how the LIMS would work with a data centre model and support the activity of the 4 Trusts' pathology.

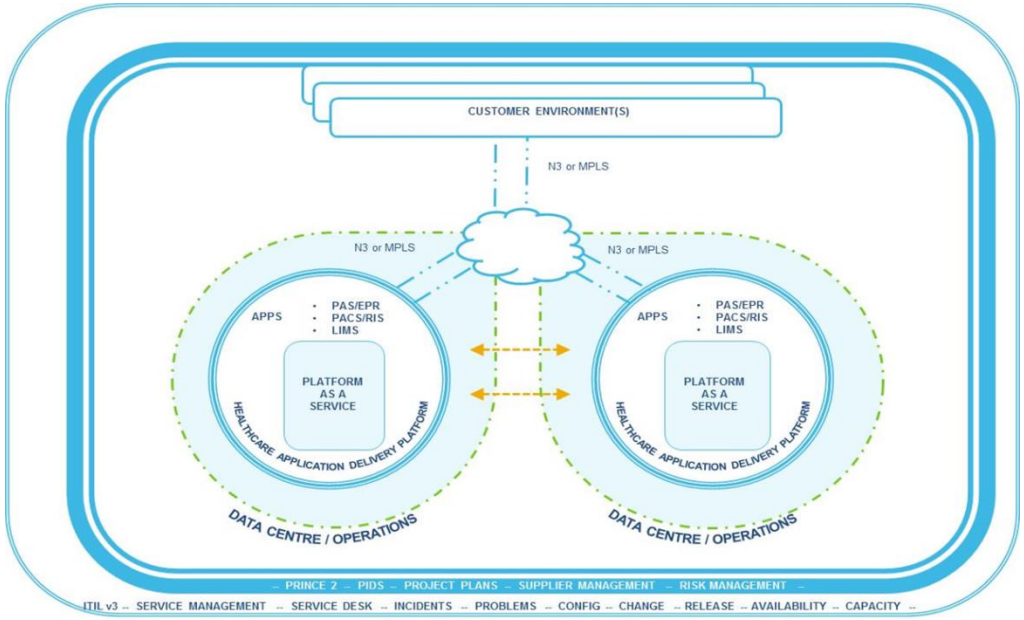


Figure 1.

IT – Laboratory Information Management System (LIMS)

3.2 The Approach (continued)

Figure 2 shows the flow of data and messages across the solution. All order comms systems will remain the same. Orders are processed through each Trust and then forwarded onto the HUB via a central Integration Layer. Disparate patient numbers originating in each system will be handled through the Patient Layer in the LIMS to ensure correct patient identification.

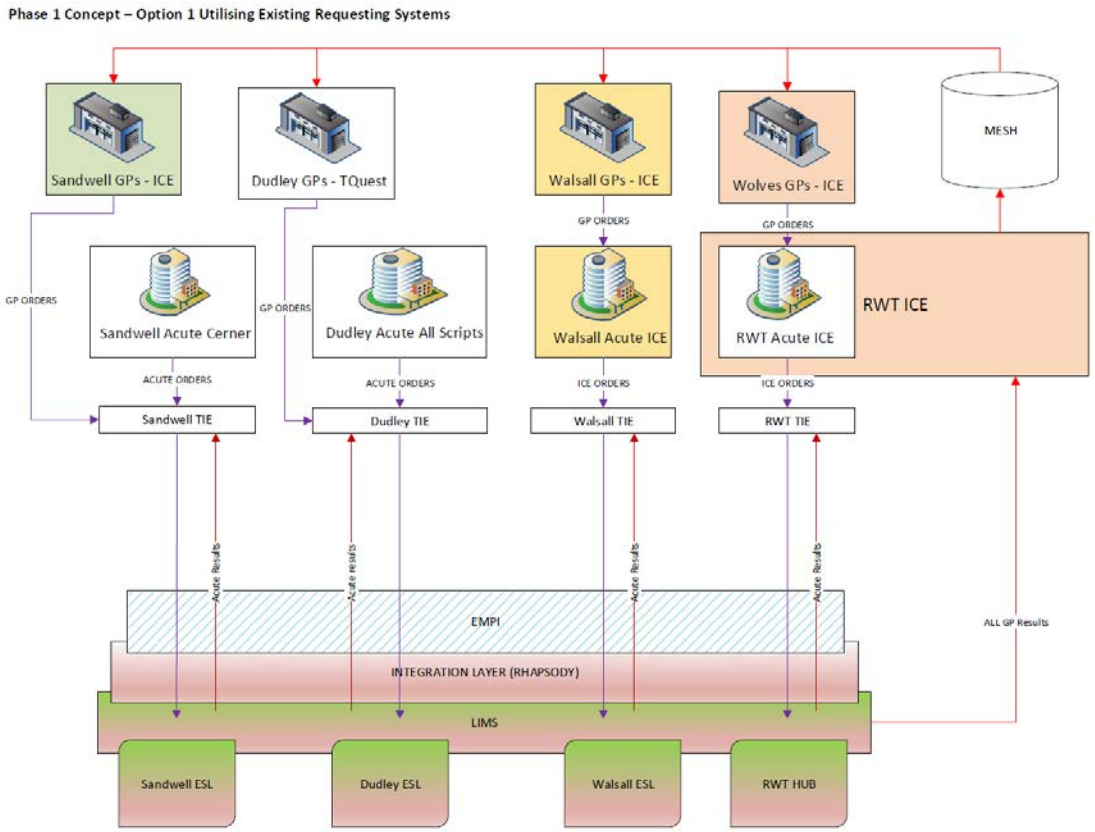


Figure 2.

IT – Laboratory Information Management System (LIMS)

3.3 Product Suitability & Capacity

The IT workstream would need further due diligence with a selected supplier awarded from the tender exercise to ensure any proposed system has the capability of managing all the current and proposed growth, which needs to be measured over the next 5-10 years for diagnostic activity of BCPS.

3.4 Supplier capacity to support implementation

The awarded supplier would need to confirm this as initial metrics will be inclusive within the output based specification used for the tender exercise. Indicative costs for a single LIMs system with provision of the solution within a Managed Service utilising data centre technology is incorporated into the costing table below. These costs are indicative and will be established further as part of the procurement tender.

3.5 Business Continuity

Suppliers bidding for the tender will need to present BC options – preferably dual / multiple data centre resilience with multiple servers in a clustered environment to ensure high availability.

A wide range of information management features will be required from any potential LIMs system and this will be detailed as a Hub requirement within the procurement output based specification document.

Robust KPIs and response times will be detailed within the output based specification document and is part of expected high end availability of the solution via any managed service.

The supplier will detail and cost all aspects of the LIMs infrastructure platform within their bid for the hub LIMs system. This could include but not restricted to Web servers, Database servers, Application Servers, MI Reporting tools, Back-up and resilience under data centre set-up.

IT – Laboratory Information Management System (LIMS)

3.6 Robustness of the solution

This typical architecture should be adaptable, with the various components installed on separate servers and resilience / multiple data centre resources, as per the BCP proposal.
Multiple architectures can be chosen, depending on performance, IT requirements or budget limitations, to optimise IT resources and leverage performances. Virtualisation of servers brings flexibility to adapt architecture over the years. Virtualisation platforms can be built with VMware or Microsoft Hyper-V technologies but this will be detailed within the supplier offerings.

Each main component hosted either on Physical or VMs needs to be high availability with robust backup strategies.

In the case of a hardware or software failure or operating system maintenance operations, this will comply within the KPIs agreed under any managed service agreement.

3.7 Timescales

Initial planning with a proposed single LIMS programme is estimated to be delivered and operational by June 2019 with the provision of SWBH service by that time, with Walsall and Dudley to follow by December 2019.

3.8 Proposed Project Timescales

Appendix A3 shows the proposed timelines based on what is currently understood about time periods needed for development and implementation. As such, they are indicative and subject to change as the refinement of the solution begins to coalesce. Although the project can learn from similar deployments such as that in South West London or Bristol, there are areas which may give rise to issues yet to be identified and with unknown or unrecognised solutions. The project timescales have been shared across the various teams and organisations but it is recognised that defined workstreams need to be generated from this.

LOGISTICS

5

Logistics

4.1 The Model Today:

The transport of GP direct access samples across the Black Country region is currently provided by 4 disparate transport systems, covering approximately 400 GP surgeries, clinics and district hospitals. For this document we will refer to these as Collection Centres.

There are over 550 regular daily collections, in addition to this some sites receive collections every other day or twice weekly.

Some collection centres operate all-day or continuous phlebotomy clinics, these centres have the potential to become “collection centre spokes”, we will cover their purpose as potential transport hubs later in the document.

Transport services are a mix of in-house NHS Trust transport and third-party provision;

- Russell’s Hall Hospital, provided by Interserve, www.interserve.com
- Walsall Manor Hospital, provided by ISS, www.uk.issworld.com
- Sandwell and West Birmingham, in-house NHS Trust Transport
- New Cross Hospital, in-house NHS Trust Transport

The current transport model is inefficient. There are clear areas of duplication, and routes with frequent dead-mileage are apparent, many of these can be reduced by combing and optimising routes.

The supplied information for analysis suggests that pathology collection routes are “fitted-in” to suit exiting route schedules transporting items such as patient notes, linen and pharmacy. Because of this, pathology collections are not always synchronised with phlebotomy clinics, meaning samples once bled can be on the road for long periods of time, in some instances samples will be in transit for longer than 4 hours to reach the lab, in some cases transport timings suggest samples are in transit for between 6 to 8 hours.

Sandwell and New Cross Hospitals have worked to optimise routes, they can demonstrate excellent use of the NHS transport service and in most cases, have accommodated the 4-hour collection turnaround times required by pathology.

By combining the best elements of each of the transport services into one optimised solution and adding an hourly intra hospital shuttle between the ESL sites and the Hub at New Cross, BCPS will have in place a highly efficient transport system ensuring all samples are received from collection centre to hub in under 3 hours and 30 minutes; a service that would set the benchmark within the UK pathology sector.

The following pages provide a summary of actions that would transform the current model, into an efficient, agile and dynamic In-House NHS Transport service.

Logistics

4.2 Optimising the routes – efficient and agile

The pathology requirement was for direct access GP samples to be received from surgery sites and accessioned onto the system within 4 hours. To model the routes, we requested all available collection details and current collection times from each of the Trusts, this data was then combined into one master file and optimised.

The modelling generated a transport solution covering 551 daily collections, from c380 collection centres, with 98.9% of all collections transported from the collection centre to the hub in less than 3 hours and 30 minutes, the average total transit time was 2 hours and 38 minutes.

The model, used 26 drivers, working 8-hour shifts, covering 1466 miles daily. A 10% traffic tolerance was built into the model to allow for congestion. Additional down time has been built into the routing to allow for additional ad-hoc or single runs to be carried out using the existing 26 drivers. This should ensure that the use of taxis is kept to a minimum.

To support collection routing, an intra-ESL shuttle service has been added. This model covers an hourly collection from each the ESL sites back to the Hub at New Cross. For the moment the shuttle service only covers ESL sites, we intend to add in a selection of the larger sites GP collection sites during any implementation phase. This may include sites such as Linkway Medical Practice or Rowley Regis Hospital.

The shuttle requires a total of 13 drivers, working a mix of 8-hour and 4-hour shifts, providing cover 24 hours a day, seven days a week. The shuttle service operates from all ESL sites to Hub Lab as follows:

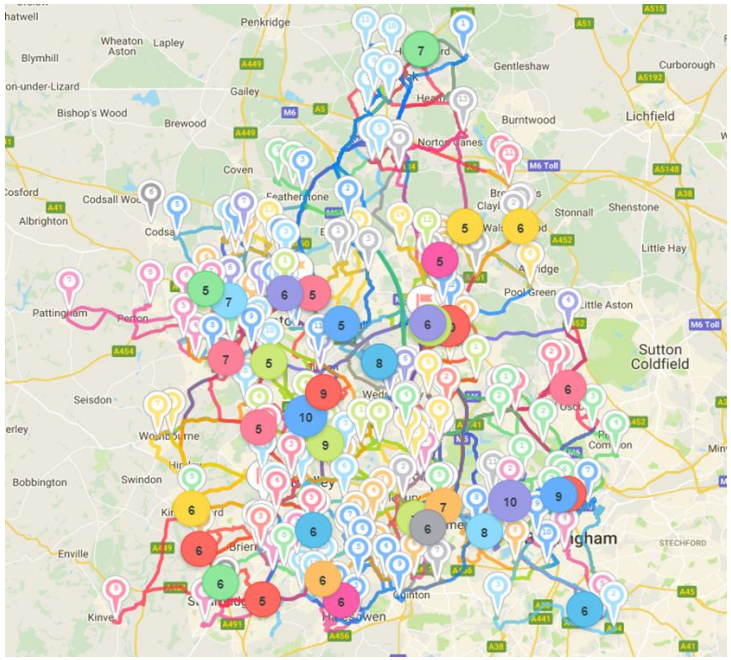
- 08:00 to 20:00, on the hour every hour, Monday to Friday (10 drivers)
- 08:00 to 16:00, collections to be confirmed, Saturday and Sunday (1 driver)
- 22:00 to 07:00, collections at 00:00 and 04:00, Monday to Sunday (2 drivers)

Notes:

- Data from RHH and WMH data was initially provided as a mixture of hand written and paper based run sheets rather than qualified electronic data, as such the data is only as accurate as the original information provided and is subject to adjustment and change, it is therefore not the final solution.
- A further fine-tuning exercise will take place prior to any implementation with the logistics teams from each of the sites to ensure the model is fully optimised. This is critical as local “real world” knowledge cannot be mapped within automated optimisation tool. It is therefore critical to apply relevant manual interventions to the model where appropriate.
- As part of the implementation process it is highly important to engage with each of the collection centres and carry out a fact-finding programme to ensure the transport model also works for each site, this will include verbally confirming the collection times are synchronised with their current phlebotomy sessions. This is also a good opportunity to engage with your clients to understand their views on the service, what could be improved, what already works well.

Logistics

The image below shows the BCPS optimised routing map, pins are an individual collection centre location, the larger circles containing numbers represent the number of collection centres within that area.



The tables below show optimised routes, they include the new arrival times, transit times to spoke and hub, the current arrival times and the hospital the collection site is currently aligned to.

Driver Name	Stop Num	Visit Name	Zip code	Time window start	Time window end	Arrive at	Start at	Finish by	Arrival @Spoke	Time to Spoke	Time to Hub	Current Arrival	SITE ID	Hospital
SWBH1	0	SWBH				09:00	09:00							
SWBH1	1	Malling Health Gt. Bridge	B70 0EN	09:45	10:15	09:05	09:45	09:50	11:33	01:48	03:03	10:00:00	126	CH
SWBH1	2	Dartmouth Medical Centre	B70 9JL	10:20	10:50	09:52	10:20	10:25	11:33	01:13	02:28	10:35:00	136	CH
SWBH1	3	GBPH Cordley St Surgery	B70 9NQ	10:15	10:45	10:26	10:26	10:31	11:33	01:07	02:22	10:30:00	138	CH
SWBH1	4	Malling Health Sandwell	B71 4DL	10:10	10:40	10:34	10:34	10:39	11:33	00:59	02:14	10:25:00	142	CH
SWBH1	5	Village Medical Centre	WS10 0EB	11:15	11:45	10:45	11:15	11:20	11:33	00:18	01:33	11:30:00	217	CH
SWBH1	6	Crankhall Lane MC	WS10 0EQ	11:20	11:50	11:20	11:20	11:25	11:33	00:13	01:28	11:35:00	218	CH
SWBH1	999	SWBH				11:33	11:33							
SWBH2	0					09:00	09:00							
SWBH2	1	Linkway Medical Practice	B70 7AW	09:15	09:45	09:06	09:15	09:20	11:24	02:09	03:24	09:30:00	131	CH
SWBH2	2	Lodge Road Surgery Smeth.	B67 7LU	09:25	09:55	09:25	09:25	09:30	11:24	01:59	03:14	09:40:00	112	CH
SWBH2	3	Hill Top MC 15 (Hanna)	B68 9DU	09:15	09:45	09:38	09:38	09:43	11:24	01:46	03:01	09:30:00	116	CH
SWBH2	4	Warley Medical Centre	B68 0RT	09:35	10:05	09:47	09:47	09:52	11:24	01:37	02:52	09:50:00	114	CH
SWBH2	5	Linkway Medical Practice	B70 7AW	09:45	10:15	10:04	10:04	10:09	11:24	01:20	02:35	10:00:00	131	CH
SWBH2	6	1 Cambridge St.	B70 8HQ	10:25	10:55	10:09	10:25	10:30	11:24	00:59	02:14	10:40:00	135	CH
SWBH2	7	Carters Green Med. Centre	B70 9LB	10:30	11:00	10:32	10:32	10:37	11:24	00:52	02:07	10:45:00	137	CH
SWBH2	8	Jubilee HC	WS10 7AL	11:05	11:35	10:43	11:05	11:10	11:24	00:19	01:34	11:20:00	219	CH
SWBH2	9	Hill Top Surgery	B70 0PU	11:05	11:35	11:13	11:13	11:18	11:24	00:11	01:26	11:20:00	128	CH
SWBH2	999					11:24	11:24							

Table 1. SWB Routes

Driver Name	Stop Num	Visit Name	Zip code	Time window start	Time window end	Arrive at	Start at	Finish by	Arrival @Spoke	Time to Spoke	Time to Hub	Current Arrival	SITE ID	Hospital
WMH2	0	Walsall Manor Hospital				09:00	09:00							
WMH2	1	The Wharf Family Practice	WS2 9ES	08:47	09:17	09:01	09:01	09:06	11:22	02:21	03:36	09:02:00	373	WMH
WMH2	2	St Peters Surgery	WS2 8DA	08:55	09:25	09:10	09:10	09:15	11:22	02:12	03:27	09:10:00	359	WMH
WMH2	3	Khan's Medical Practice - Pin	WS3 3JP	09:03	09:33	09:19	09:19	09:24	11:22	02:03	03:18	09:18:00	328	WMH
WMH2	4	Spires Health Centre	WS10 7EH	09:15	09:45	09:38	09:38	09:43	11:22	01:44	02:59	09:30:00	221	CH
WMH2	5	Moxley Medical Centre	WS10 8TF	10:04	10:34	09:44	10:04	10:09	11:22	01:18	02:33	10:19:00	349	WMH
WMH2	6	The Surgery	WS10 9JS	10:12	10:42	10:12	10:12	10:17	11:22	01:10	02:25	10:27:00	383	WMH
WMH2	7	Darlaston Medical Centre	WS10 9JS	10:17	10:47	10:17	10:17	10:22	11:22	01:05	02:20	10:32:00	344	WMH
WMH2	8	Darlaston Health Centre	WS10 8SY	10:23	10:53	10:23	10:23	10:28	11:22	00:59	02:14	10:38:00	345	WMH
WMH2	9	Rough Hay Surgery	WS10 8NG	10:31	11:01	10:31	10:31	10:36	11:22	00:51	02:06	10:46:00	343	WMH
WMH2	10	Mayfields	WV1 2GZ	10:40	11:10	10:46	10:46	10:51	11:22	00:36	01:51	10:55:00	244	NX
WMH2	11	Bentley MC	WS2 0BA	10:42	11:12	11:01	11:01	11:06	11:22	00:21	01:36	10:57:00	321	WMH
WMH2	12	Saddlers Medical Centre	WS1 1YB	11:04	11:34	11:14	11:14	11:19	11:22	00:08	01:23	11:19:00	363	WMH
WMH2	999	Walsall Manor Hospital				11:22	11:22							

Table 2. WMH Routes

The model has been set up so that runs are shorter back to each spoke (Hub in the case for New Cross). For ESL spoke sites a travel time of 1hour and 15 minutes was used for all samples back to New Cross.

Table 2 shows a surgery highlighted in red, this denotes a transit time of more than 3-hours and 30-minutes from collection centre to ESL to Hub.

The pathology requirement was for the samples to be received from GP surgery and accessioned onto the system within 4 hours, so with this model we are getting around 98.9% of the samples back within these windows. The average transit time from collection site to ESL to Hub is 2 hours and 38 mins. This should support the target window of 4 hours from bleed to accessioning at the Hub.

Additional capacity has been built into the optimised model to ensure there is contingency to support additional collections, ad-hoc movements and as-directed requests. Contingency for instances such as road closures, back-to-back traffic cannot be guaranteed or supported without local real-time intervention at the time.

COMMERCIAL STRUCTURE & GOVERNANCE

This sets out the potential governance and management arrangements as described in the BCPS partnership agreement (PA)

Reserved Matters will be categorised by those which need: To be finalised and agreed during transition by the BCP Strategic Management Board

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
Admitting a new Owner into the new entity	Formally adopting the annual Business Plan for the new entity in respect of each Financial Year [Unanimous voting will be needed for the first 3 years of operation]
Altering the name of the new entity	Participating in any partnership or joint venture (whether incorporated or not)
Amending the Partnership Agreement or the Support Services Agreements	Entering into any contract or arrangement that is not on an arm's length basis or which is outside the ordinary course of business [Unanimous voting will be needed for the first 3 years of operation]
Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Reserved Matters will be categorised by those which need:

- Unanimous voting: all Owner Trusts will need to be in agreement; and
- Majority voting: by a mechanism agreed by the Owners.

Unanimous vote (all Owners)	Majority voting
Admitting a new Owner into the new entity	Formally adopting the annual Business Plan for the new entity in respect of each Financial Year [Unanimous voting will be needed for the first 3 years of operation]
Altering the name of the new entity	Participating in any partnership or joint venture (whether incorporated or not)
Amending the Partnership Agreement or the Support Services Agreements	Entering into any contract or arrangement that is not on an arm's length basis or which is outside the ordinary course of business [Unanimous voting will be needed for the first 3 years of operation]
Allowing the new entity to cease (or propose to cease) to carry on its business	Dismissing any director or senior employee [in circumstances in which the new entity incurs or agrees to bear redundancy or other costs in excess of £[ ] in total]
Materially amending the Business Plan, or taking any actions which either (a) are not in accordance with the Business Plan, and/or (b) will cause the Partnership to [materially] depart from the annual budget included within the Business Plan	Making any material changes to the new entity's "Investment Guidance" policy [it is assumed the JV will be required to adopt an Investment Guidance policy which is consistent with the Founders Trusts' own equivalent policies and that any material changes to this policy would require the approval of the Founders Trusts]
Acquiring the whole (or part) of any business (more than a certain value e.g. £[1]m pa) or undertaking of any other person	Change in the pricing policy will occur if prices need to be adjusted by inflation. [Unanimous voting will be needed if the price is to be set above inflation]

Unanimous vote (all Owners)	Majority voting
Changing the nature of the Partnership's business or commencing any new business which is not ancillary or incidental to the existing business. [NB The entities business can be defined in the Joint Venture Agreement, for example: "the provision of pathology services and activities which are ancillary or incidental thereto"]	Creating or granting any Encumbrance over the whole or any part of the business, undertaking or assets of the new entity
[incurring any indebtedness or borrowings with the Owners except in accordance with the Annual Business Plan]	Making or proposing to make any material changes to the terms of employment of any employee or group of employees of the new entity which either (i) does not comply with applicable NHS policies and guidelines (e.g. Agenda for Change) or (ii) will result in the new entity exceeding its agreed staff costs budget as set out in the annual budget included within the Business Plan
[selling any significant asset or group of similar assets except in accordance with the Business Plan]	Entering into any leases or other forms of long term commitment which are material in the context of the new entity's business [except in accordance with the Business Plan]
[incurring any capital expenditure on any one item, or series of related items, which either (i) exceeds the host Trust's delegated capital expenditure cap or (ii) is not in accordance with the Business Plan and the new entity "Investment Guidance"] policy	Giving notice of termination of any arrangements, contracts or transactions which are material in the context of the new entity's business, or materially varying any such arrangements, contracts or transactions [except in accordance with the Business Plan]

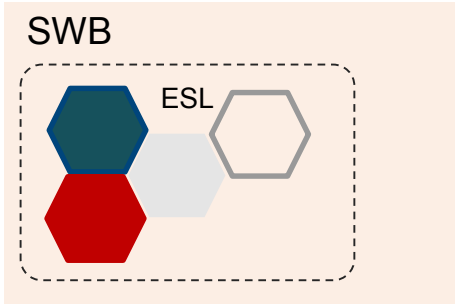
Unanimous vote (all Owners)	Majority voting
Appointing or dismissing the [Chair and Managing Director of the Joint Venture], or [materially] varying the terms of employment or engagement of any such person	Instituting, settling or compromising any material legal proceedings (other than debt recovery proceedings in the ordinary course of business) instituted or threatened against the new entity or submitting to arbitration or alternative dispute resolution any dispute involving the new entity [Voting will be dependent on the legal structure. If there is any shareholding liability unanimous voting will be needed]
Disposing of the whole (or part) of the business (more than a certain value e.g. £1m pa) of the Partnership to any person	Independent assurances over financial reporting and or/ appointment of auditors
Distributing any [trading profits / surpluses] to the parent Trusts except in accordance with the agreed distribution policy set out in Partnership Agreement, or making any change to the agreed distribution policy	Working Capital Investment Limits [limits are [£X]]
	Granting any rights (by licence or otherwise) in or over any intellectual property owned or used by the new entity [scale of intellectual property is needed [£X]]
Definition of Materiality Levels	
If liability/requirement has a value of 0-3% of new entity's revenues then it will be considered non-material and the decision will rest with the Management Board	
If liability/requirement has a value of greater than 3-9% then it will be a reserved matter requiring majority voting	
If liability/requirement has a value of greater than 9% then unanimous voting will be required	

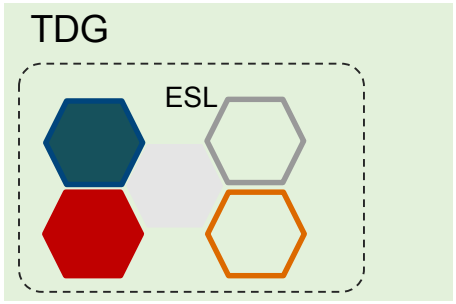
OPERATIONAL DELIVERY (HUB + 3 ESLs)

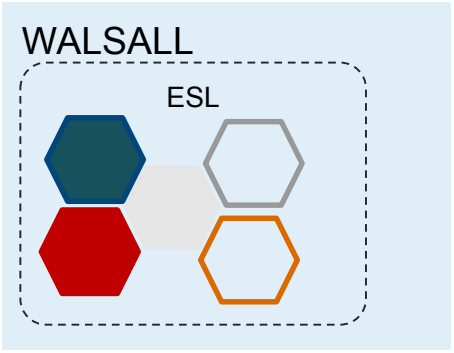
7

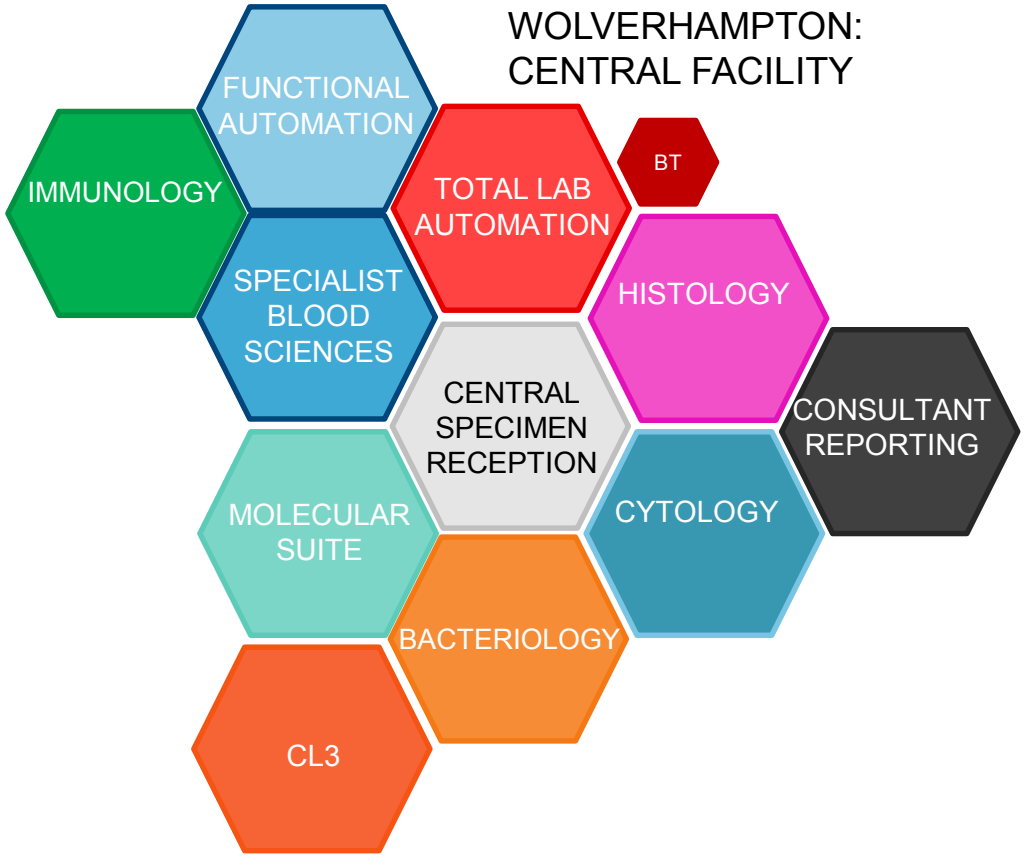
Operational Delivery (HUB + 3 ESLs)

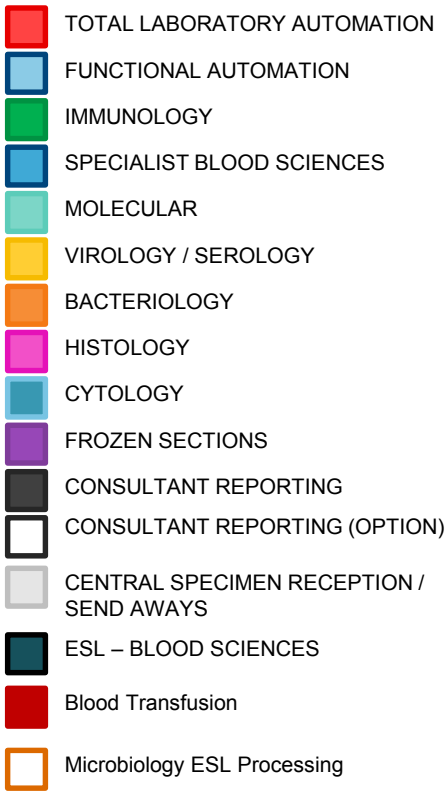
As stated in the OBC, the New Cross site is designed to be the Hub for the BCPS service. An ESL will be located at SWB, TDG and Walsall providing agreed essential services on-site.











Operational Delivery (HUB + 3 ESLs)

6.1 HUB

As described in the OBC, the target operating model for HUB and 3 ESLs indicates that all tests from all disciplines that have a TAT of greater than 4 hours can be moved to the central hub facility. There were clinical & operational risks highlighted within the workshops of the staffing groups in order to achieve this requirement, especially around logistics, laboratory space and sufficient staff at each site to process the required tests. As described in Logistics Section 4, the detailed review of route optimisation and increased resources has been applied to the FBC to ensure a quality service whilst proceeding with the implementation of the target operating model.

Cellular Pathology

As discussed within the staffing section, the proposed Histology service is designed to operate 7 days a week to ensure quality increases in the existing service. This allows for quicker processing of slides to be read by the consultants to achieve the 62 day cancer turn-around time targets.

Microbiology

Operating a fully automated bacteriology service over 24 hours ensures proposed operations enhance the current service with regards to quality. This allows work to be processed and read during the night in order to release results earlier to the clinical teams allowing for earlier patient management and intervention. This improves the patient pathway.

6.2 ESL

Additionally, the proposed Essential Services Laboratory (ESL) have been raised as a risk to adhere to the same quality of service as before target operating model implementation. This includes the timeline of transitioning all non-inpatient volumes to the Hub for processing, required resources and the appropriate skill mix on each site. The clinical teams have stated the requirement of a conservative transition period to transfer the outpatient volumes to mitigate the stated risks, hence there will be an interim transition period, during which the ESL's will process outpatient and inpatient volumes with a higher staff compliment as compared to the target operating model until October 2019. This allows for processes, logistics, staffing and equipment to be standardised prior to processing volumes across sites.

6.3 IT

IT system ensuring connectivity of the laboratories and Hospital Information System (HIS). The IT system is designed to have transparency and access to all requesting and results of BCPS tests across the trusts.

6.4 LOGISTICS

Detailed modelling of the logistics routes optimises the current routes of the four trusts to achieve an optimal service utilising economies of scale. GP routes bordering trusts are made more efficient to improve the arrival times of GPs into the site of processing. Additionally, extra routes for ESL to Hub shuttle services have been designed to align with the Hub operations to exceed the current turn-around times for specific departments.

Operational Delivery (HUB + 3 ESLs)

6.5 Summary

The detailed analysis and performed on the development of the Target Operating Model (TOM) was focused on being able to provide the boards reassurance that the new TOM would address the risks and issues in a number of areas. These are:

1. TATs: new model must provide improved TATs – the detailed operational analysis in terms of staffing levels at the Hub and ESLs and the mapping of detailed logistics routes has enabled the BCPS to increase their confidence that current TATs can be maintained and improved for all aspects of the service. A key feature will be achieving consistency on the performance of the service.
2. Improvement to GP service – the implementation of the IT solution and the new logistics solution would allow GPs to have an improved access to data and information. Patient results would be available across all sites and GP practices no matter where the test is performed. Electronic ordering would be a key feature for GPs together with improved logistics including sample tracking.
3. Consultant Pathologists travel time and attendance to MDTs: the solution proposed has allowed for the construction of consultant offices at the Hub to facilitate laboratory working and reporting. This combined with detailed job planning should allow consultants to have access to state of the art laboratory while still being able to perform their clinical duties at the hospitals.
4. Certainty on capital costs: the detailed design of the Hub facility has confirmed the initial estimated costs for the Hub. This is now an accurate figure that provides certainty on the delivery of the extension work.
5. Implementation timeline: the BCPS has developed a detailed implementation timeline that would allow to meet the requirements of SWBH in relation to their own hospital development and ensure service continuity for their routine and specialist services.
6. Hub capacity: the workforce, equipment and layout of the Hub has been designed with the possibility of adding additional capacity as required. Following the NHSI letter recommending that another Trust joins the partnership, the Hub would be able to accommodate the additional volumes of activity.

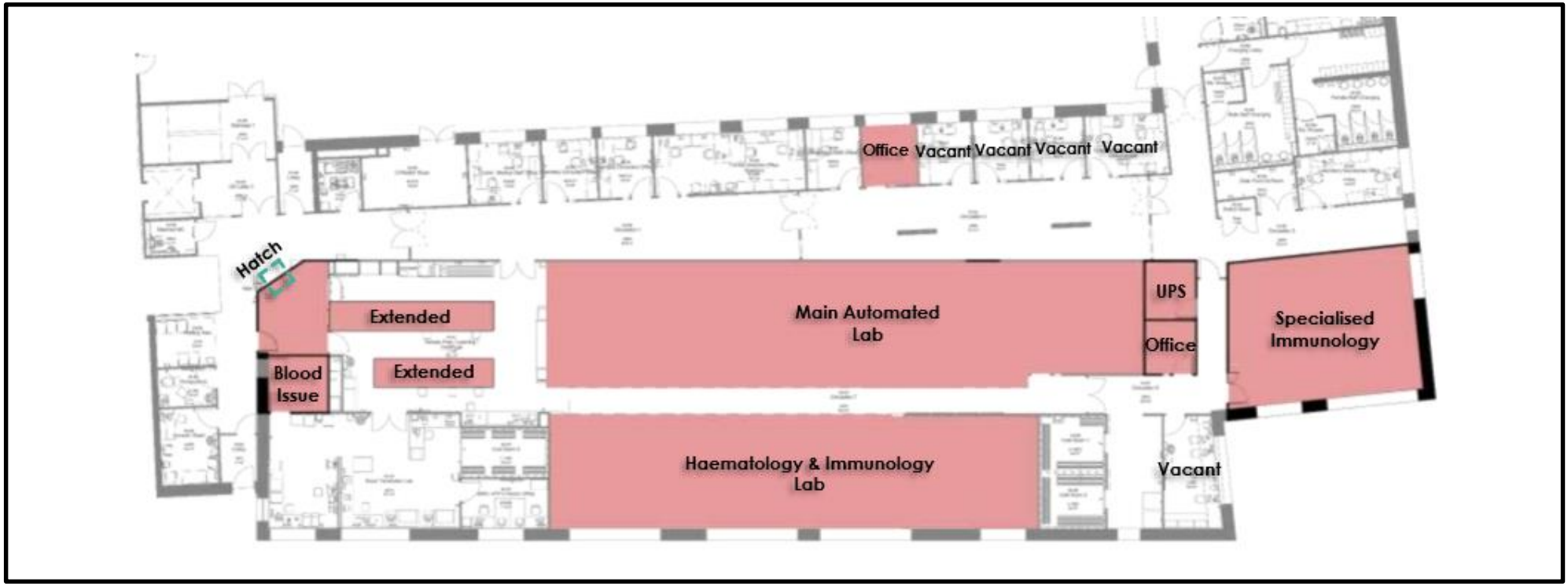
ESTATES (HUB + 3 ESLs)

Estates – Hub Refurbishment

7.1 Central Hub Facility – Proposed Reconfiguration of Existing Laboratory.

The existing Pathology Building was designed at the outset with potential expansion of services in mind and therefore reconfiguration for the additional equipment required to accommodate consolidation will be relatively straightforward.

On the Ground Floor, the Central Specimen Receiving area which links directly to automated tracks will be expanded to accommodate the necessary increase in the number of analysers for both clinical chemistry and haematology, the length of the open-plan automated laboratory space will be extended into rooms currently providing support functions with these then being relocated. The immunology laboratory will be relocated into an adjacent space and an additional immunology space in the ground floor has been allocated due to the increase of required space. This will increase the overall space for blood sciences, and immunology laboratory which was identified as a risk by the clinical leads.



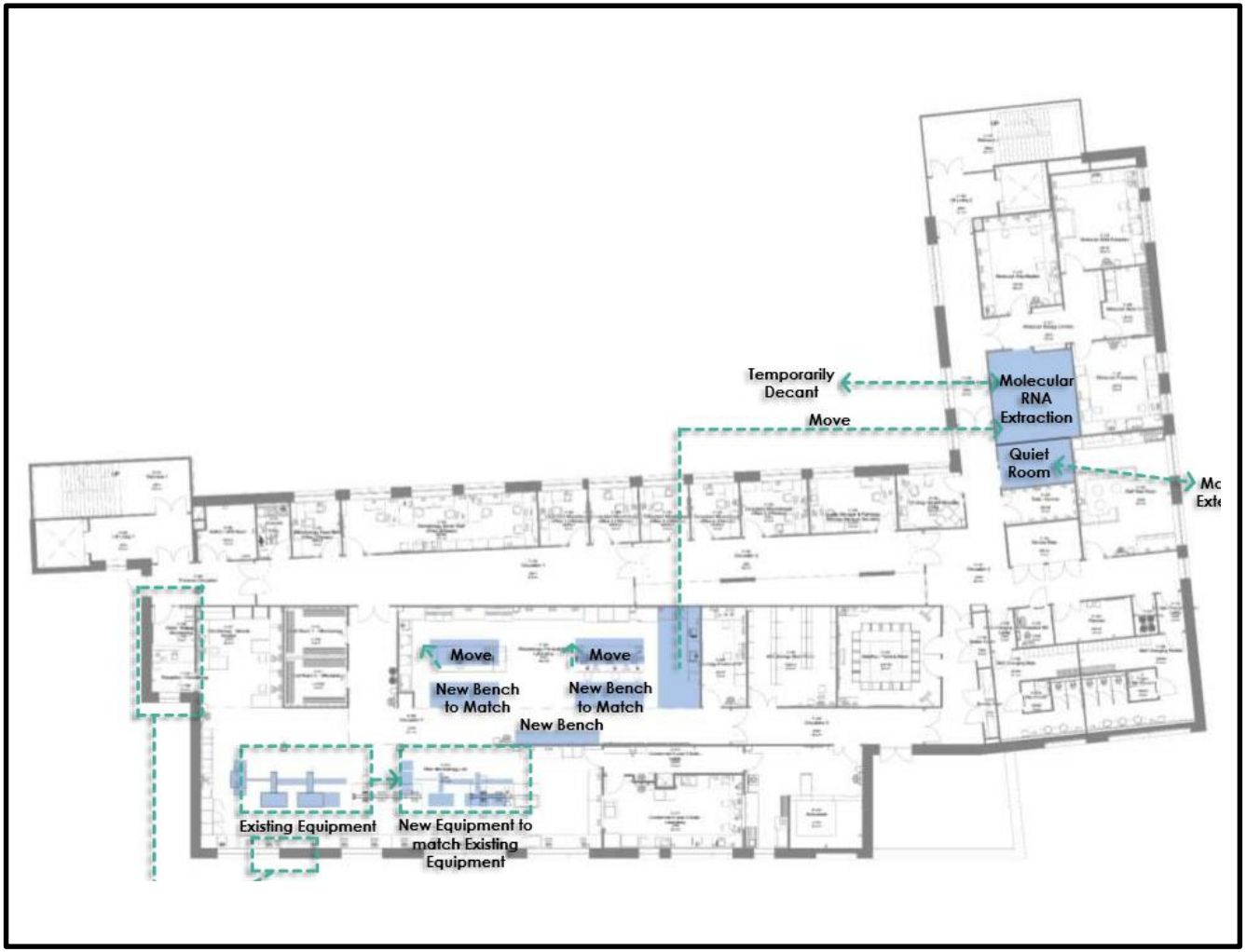
Ground Floor Layout Draft*

*On-going reviews with workshops for agreement

Estates – Hub Refurbishment

7.2 Central Hub Facility – Proposed Reconfiguration of Existing Laboratory.

The main laboratory space on the First Floor was originally configured to be readily adapted to accommodate future automation. The first WASPLab was installed just 12 months ago and now, by moving some freestanding benching, space will be created for installation of the second. The current Molecular Suite will be slightly reconfigured by reducing the size of Molecular Amplification in order to introduce a separate Clean Room.



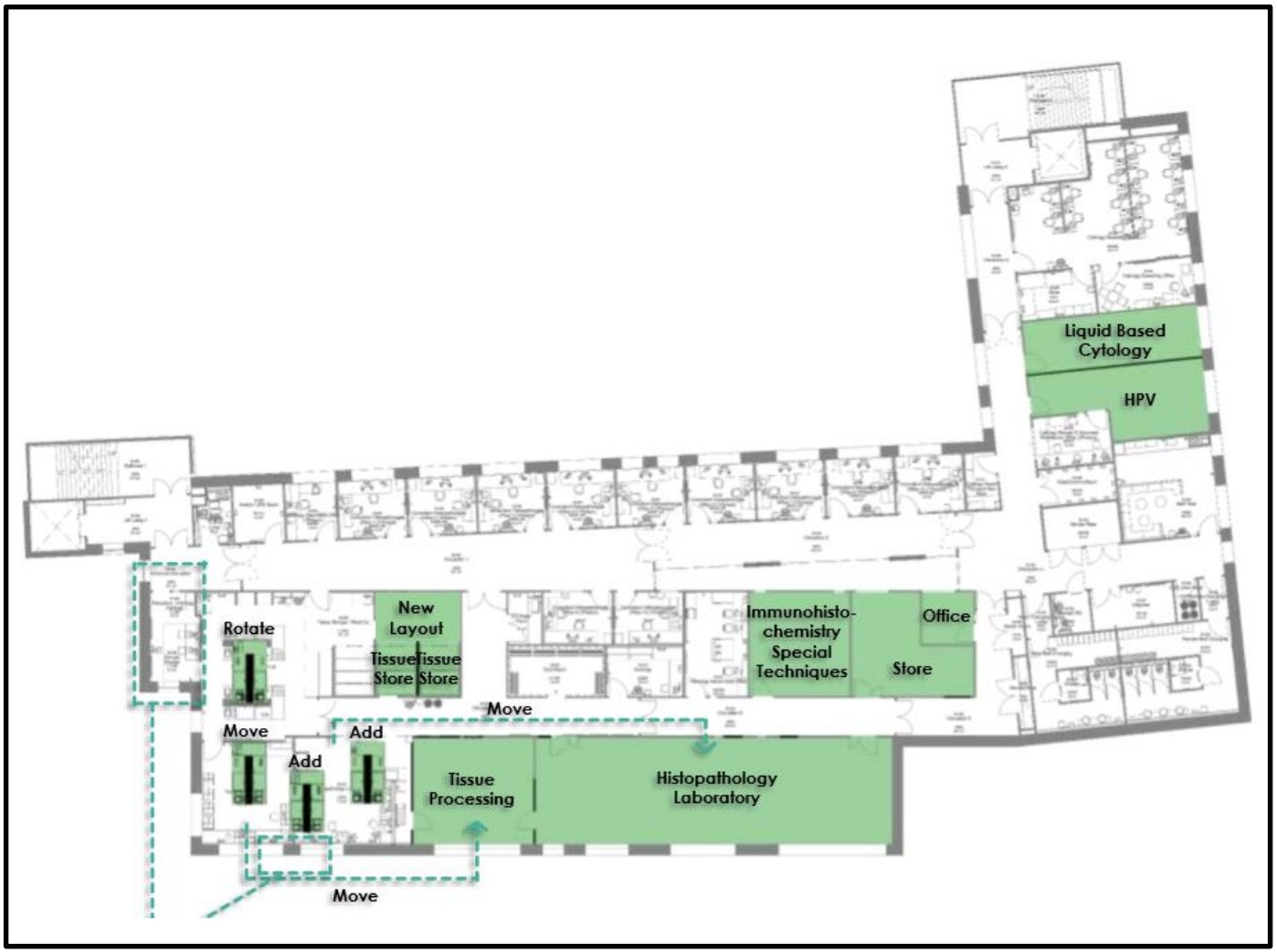
First Floor Layout Draft*

*On-going reviews with workshops for agreement

Estates – Hub Refurbishment

7.3 Central Hub Facility – Proposed Reconfiguration of Existing Laboratory.

A new space for the Histopathology Laboratory and for Immunohistochemistry Special Techniques will be provided on the Second Floor by relocating accommodation for non-laboratory areas to the extension. This will facilitate reconfiguration of the Reception, Cut-Up, Tissue Storage, Tissue Processing and Staining areas to accommodate the requirement for additional cut-up benches and storage.



Second Floor Layout Draft

*On-going reviews with workshops for agreement

Estates – Hub Extension

Introduction

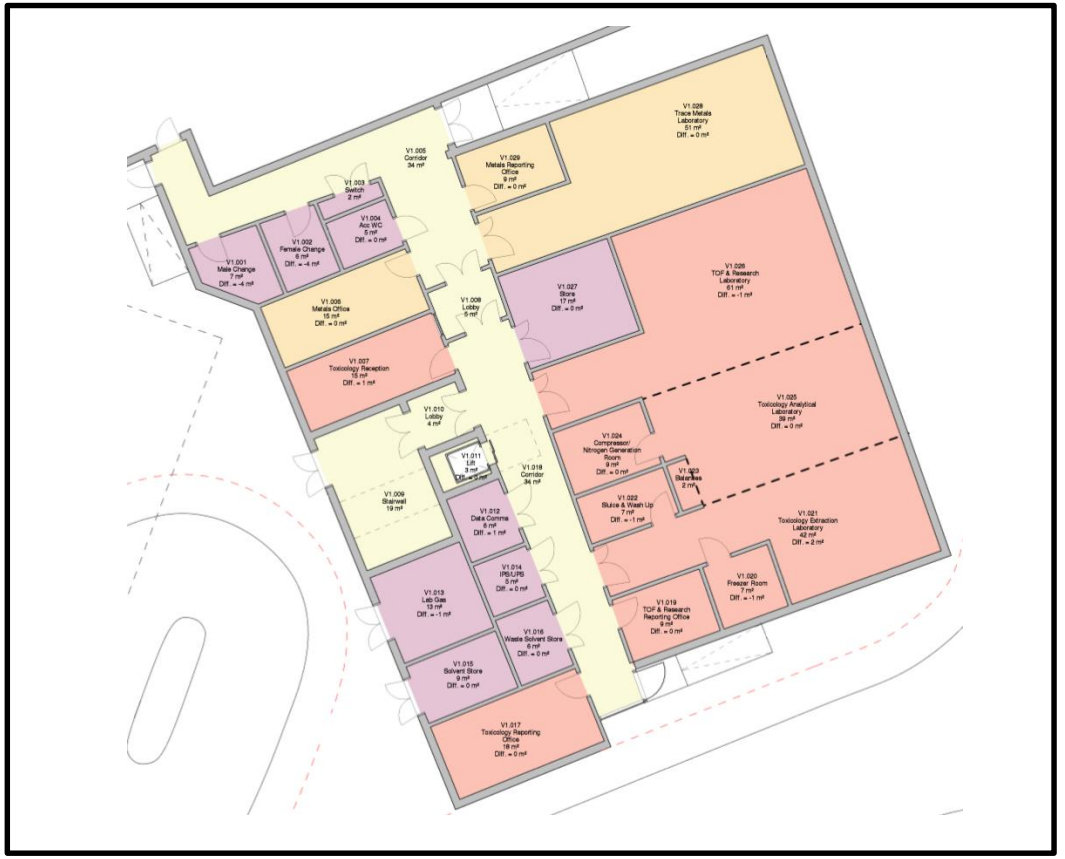
Following feedback from the operational and clinical leads, the first iterations of the extension was changed to accommodate a larger footprint for laboratory and administrative areas. The Hub extension section describes the detail of the change where the new proposed area accommodates additional space to address the feedback.

7.4 Central Hub Facility – Proposed Extension to the Existing Laboratory.

The proposed Extension is designed to fit into the empty space adjacent to building with a physical connection between the buildings.

The Extension, with an increased internal footprint, is designed over four floors of laboratory accommodation with a roof top plant room and additional office space located on the fourth floor. The extension can be accessed from the existing laboratory. The extension will have a secure lobby being provided at Ground Floor leading to the Laboratory. Within the building the circulation corridors are of the required width to facilitate escape in the event of an emergency and to readily accommodate delivery and movement of large equipment with matching wide-opening internal doors to laboratory and technical rooms.

The Trace Metals and Toxicology Laboratory will be housed on the Ground Floor with entry to the latter gained through a secure lobby controlled by a Receptionist in a room only accessed from within the secured perimeter. In addition to the Laboratory rooms, space will be provided for a Freezer Room, Solvent Stores, Offices and a sound attenuated Compressor / Nitrogen Generation Room.



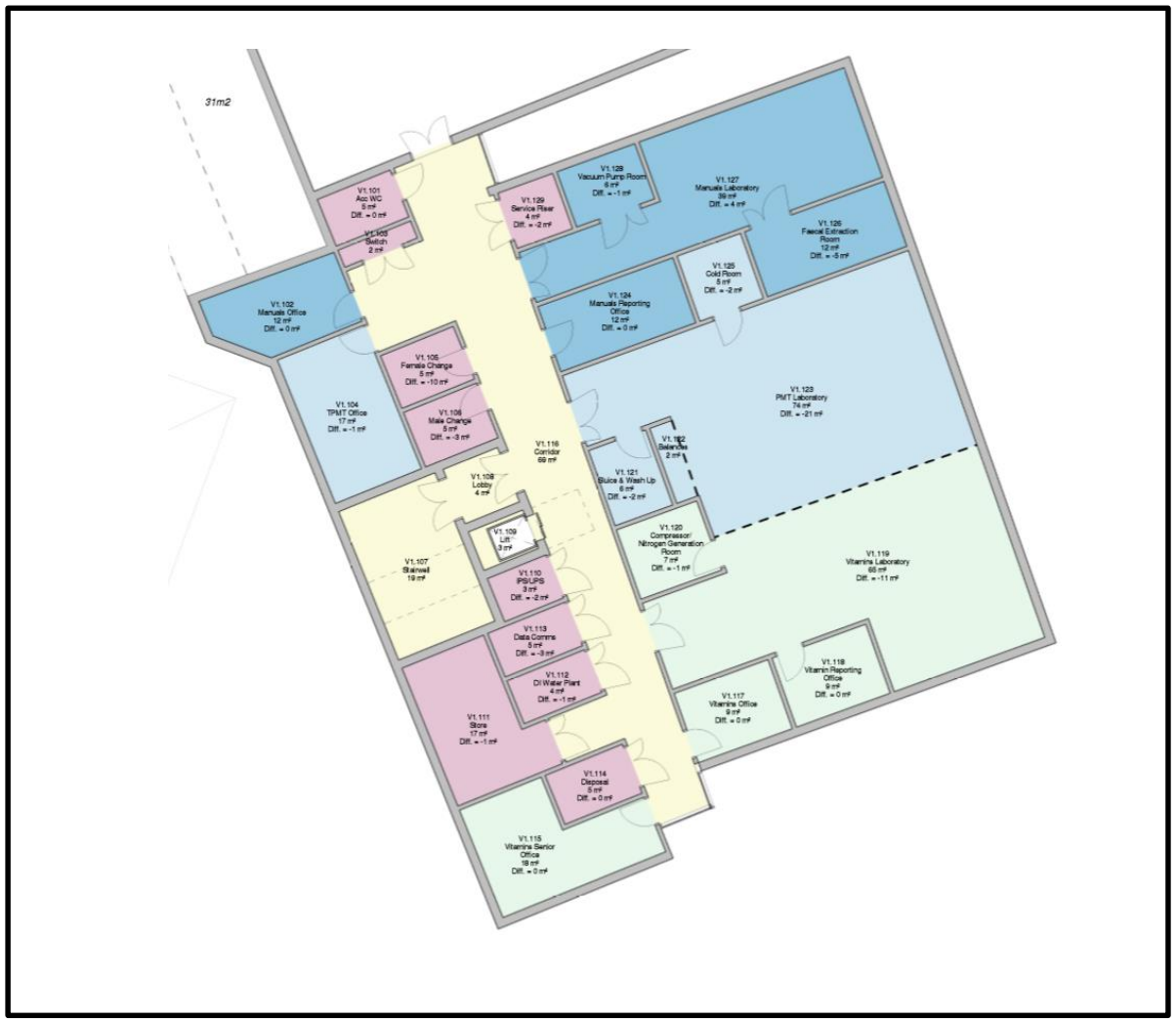
Ground Floor Extension Draft*

*On-going reviews with workshops for agreement

Estates – Hub Extension

7.5 Central Hub Facility – Proposed Extension to the Existing Laboratory.

Accommodation on the First Floor is similarly designed to accommodate Specialist Chemistry, with the layout again incorporating a dedicated Cold Room and Compressor / Nitrogen Generator Room and Offices. It will also accommodate associated offices.



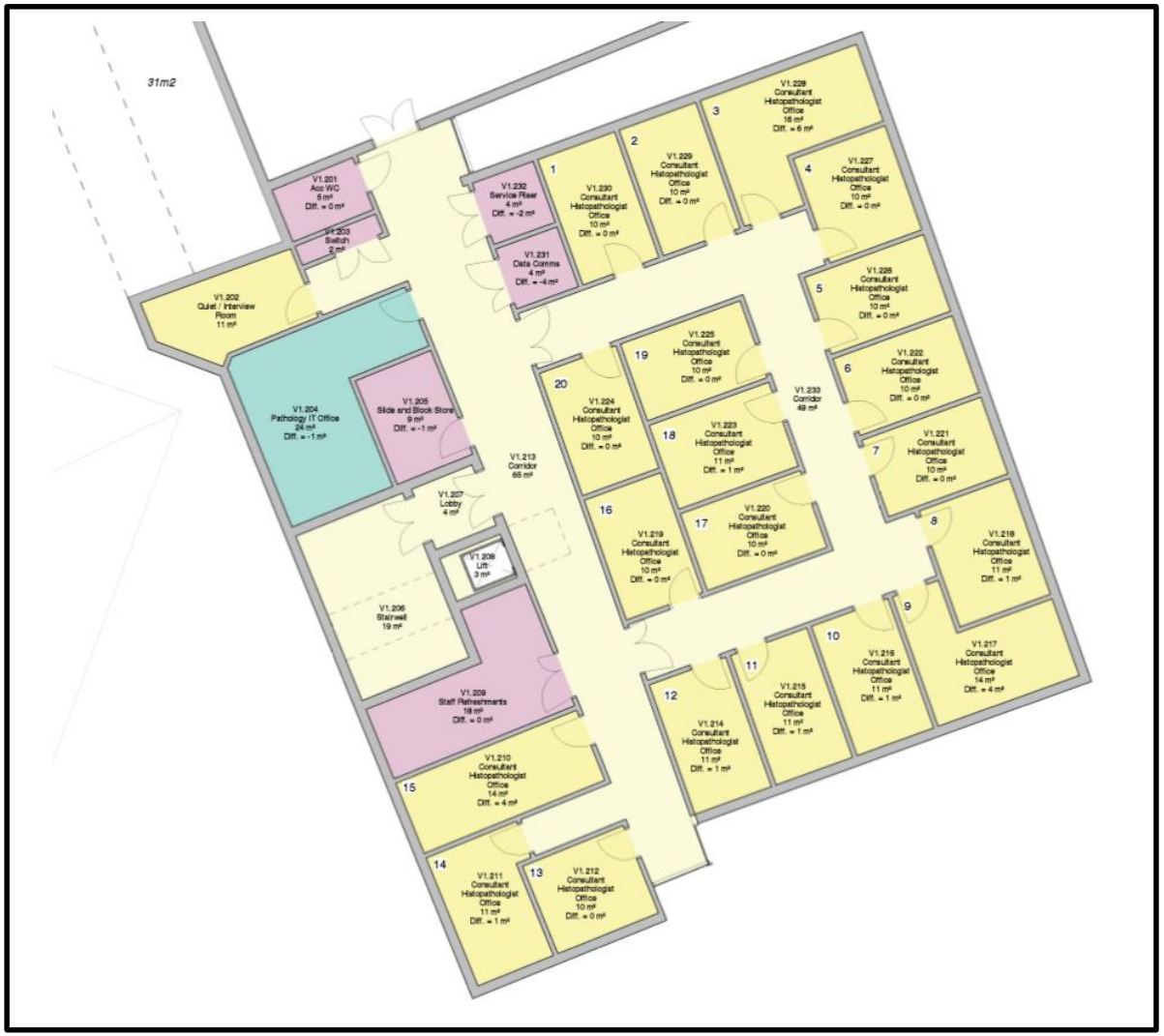
First Floor Extension Draft.*

*On-going reviews with workshops for agreement

Estates – Hub Extension

7.6 Central Hub Facility – Proposed Extension to the Existing Laboratory.

The second floor will accommodate an additional consultant Histopathologist offices, Pathology IT offices, slide/block store, and additional administrative space, along with supporting staff spaces.



Second Floor Extension Draft.*

*On-going reviews with workshops for agreement

7.7 Workshop Feedback

The discipline workshops identified a number of risks associated with the design of the hub. These included appropriate sized laboratory space for cellular pathology and immunology. The groups also expressed concern with the number of available offices for consultant Histopathologists and other senior scientists, as well as the need for larger spaces for storage, lockers and staff facilities.

All of these concerns were communicated to the architect and further changes to the schedule of accommodation have now been agreed and will be included as part of the second stage design process.

Ground Floor – Blood Sciences

As with the First and Second Floors, it continues to be the intention that the expanded and additional laboratory spaces will be provided by means of reconfiguring the existing spaces, in particular the additional Immunology and Haematology facilities.

It will however be necessary to alleviate pressures on existing staff lockers, WC's and general storage through the provision of facilities within the proposed BCP extension.

First Floor – Microbiology

Based on our current understanding of workflows and staff numbers, it is not intended to significantly amend the current proposal for the reconfiguration of the First Floor Microbiology accommodation, with the exception of the proposed creation of a Molecular Research Laboratory, which would preferably be accommodated within the area of the existing Molecular Suite if space permits.

Second Floor – Cellular Pathology

Whilst it is still proposed that the need for expanded Cellular Pathology laboratory spaces will be provided by reconfigured spaces within the existing Second Floor accommodation, there are a significant number of support spaces and the Cytology laboratory that will need to be provided within the BCP extension.

The existing Cellular Pathology Department is already experiencing a shortage of staff lockers, WC's and general storage space, which will further exacerbated by the increased number of staff, and as such the further accommodation to be added to the BCP proposal will seek to resolve these pressures.

Another existing pressure on space within the existing Cellular Pathology accommodation that is proposed to be resolved by the BCP extension is the need to store 8-12 months of current slides/blocks for reference, prior to be archived off site.

The requirement for additional Consultant Histopathologist offices has been identified to be 28, which is in addition to the 12 existing Consultant Histopathologist offices, this also includes potential future expansion.

Associated with the above increase in Consultant Histopathologist Offices is the requirement for a second MDT Room.

Directly associated with the above is the ongoing requirement for a Histopathology Secretaries Office for c.18 members of staff and a Junior Medical Staff (Trainee) Office for c.10 members of staff, both of which it is proposed to be accommodated within the BCP extension.

Estates – ESLs

7.9 ESL Refurbishment

Walsall: Given the current set-up of Walsall, the ESL can be designed into the existing Blood Transfusion and Blood Sciences laboratory. Agreed Office requirements, Microbiology and Histology areas would need to be accommodated within vicinity of the ESL as shown below in proposed ESL pathology areas. This can be achieved with no additional refurbishment to the existing space as indicated in Appendix 6 – Option B.

Released** pathology space, indicated in blue and retained space indicated in red and green, are identified in areas.

Note, there would be significant costs to develop the excess areas within Walsall* as per the indicated costs, hence these would require a separate business case.

*Note: Walsall indicated site development of Pathology as follows:

- Conversion to outpatients and offices - £9, 000,000
- Conversion to offices - £7,500,000
- Conversion to oncology and offices - £10,400,000

**Pending feedback from Estates teams to identify cost impact of decommissioning released areas

Walsall Pathology Areas

Estates – ESLs

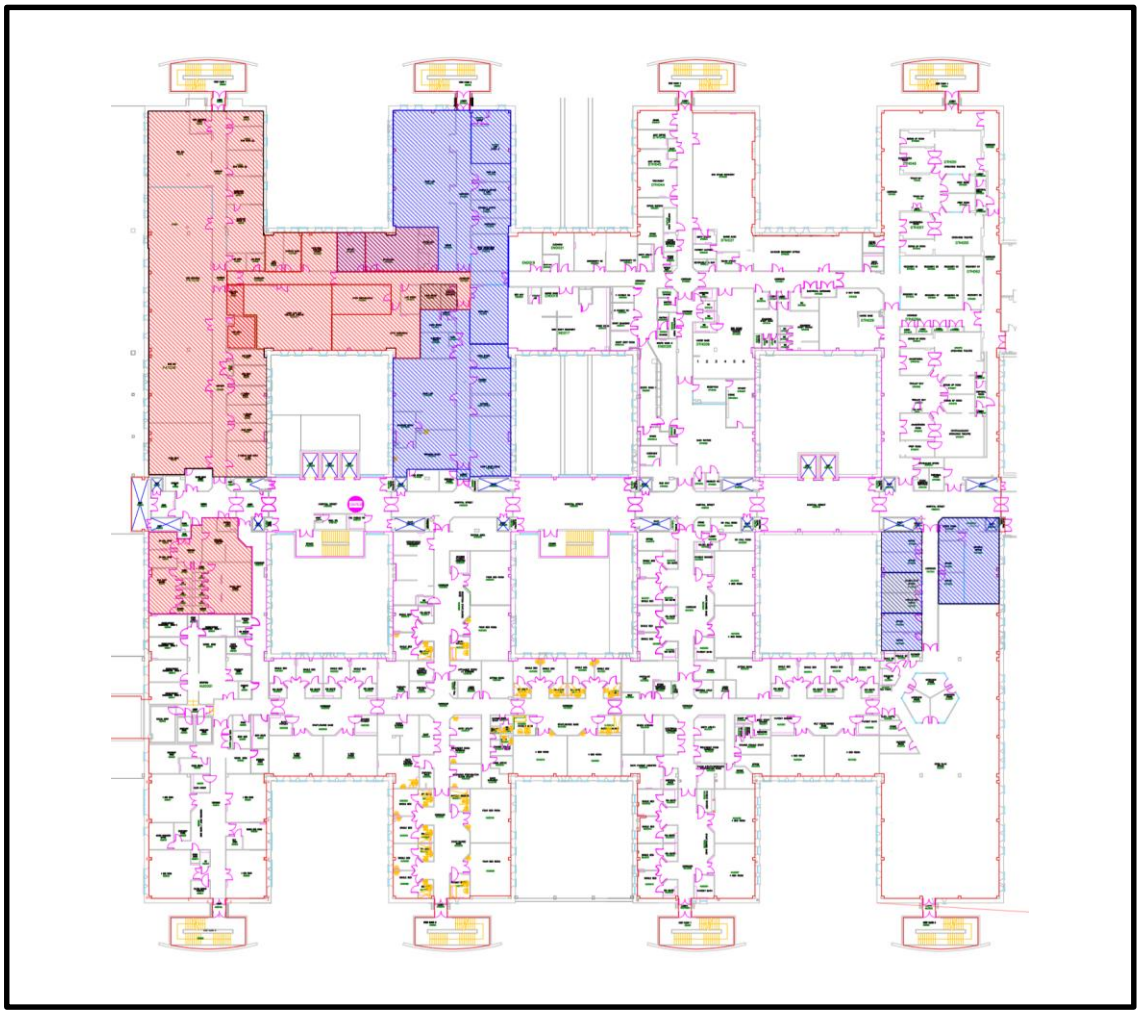
7.10 ESL Refurbishment

Russells Hall: Given the current set-up of Russells Hall, the ESL can be designed into the existing Blood Transfusion and Blood Sciences laboratory. Agreed Office requirements, Microbiology and Histology areas would need to be accommodated within vicinity of the ESL as shown below in proposed ESL pathology areas. This can be achieved with no additional refurbishment to the existing space as indicated in Appendix 6 – Option C.

Released* pathology space, indicated in blue and retained space indicated in red, are identified in current areas.

7.11 SWB - MMH: This is currently designed into the MMH by SWB to accommodate all required areas.

*Pending feedback from Estates teams to identify cost impact of decommissioning released areas



Russells Hall Pathology Areas

RISK

9

RISKS

Business Continuity

Following the NHSi letter and national direction for pathology services it will be essential to work in partnership with other local networks to ensure that a robust plan for continuity of service is developed for Midlands and East 1.

In a hub and ESL model, consideration must be taken to ensure a desired level of service in an event where the hub becomes compromised. An element of spare capacity and scope may be required to be built into an ESL for blood science samples should central specimens need to be tested there.

BCPS should engage in negotiations to set-up agreements outside of their immediate network, especially for testing samples for microbiology and cellular pathology due to any unperceived situation, which can occur from fire, IT and power failures or natural disasters, among others.

RISKS

The BCPS transition project team, through its interim clinical director, has engaged with all services across the Trusts to develop a comprehensive set of project and clinical risk registers. The development of the clinical risk registers involved engagement with all key scientific staff across all the services to ensure that all concerns with the target operating model were registered and addressed.

The clinical and operational risk register identified 172 risks as outputs from the initial group workshops, which was updated to 163 risks following the further work completed in November 2017. A summary is provided in the tables in the next slide. These risks were all rated and given a priority by the team. The mitigation measures associated with each risk are part of definition of the target operating model, as the new operating model has been thought through and developed to ensure that all critical risks are addressed and mitigated.

In summary, the key critical risks identified based on high consequences and likelihood are:

- Quality Blood Transfusion service
- Quality standards, UKAS, RCPath, MHRA Guidance & UK Law being addressed and achieved
- Adequate skill-mix and staff numbers in proposed service
- Timing to allow sign off of the FBC by boards: project has been moving at high speed and certain areas (like update of financial baseline) may have required additional work. To mitigate this issue, savings have been compared against the OBC baseline (updated for incorrect information) and shown in real terms without inflation and other indexes.
- IT LIMS implementation: this element is critical for the implementation of the BCPS. To minimise the implementation risk, an IT lead has been appointed and a detailed implementation plan with investment requirements has been developed.
- High staff turnover destabilises the service: staff may leave or recruitment may be difficult as a result of uncertainty. To minimise this risk it is important to have rapid decisions, good, frequent communication, consistent across all organisations. Communications plan. Workforce plan. Recruitment & Retention & career Pathways modelled. Early 4-way agreement to ensure mutual support in case of flight.
- Pathology coding: need to develop an integrated pathology coding system and nomenclature which would allow for the accurate ordering, reporting and counting of tests. This would also informed the shareholding discussions through common test counting and agreed pricing structure.
- Availability of resources: need to ensure key resources are identified for the implementation of the LIMS and IT links.

RISKS – Clinical & Operational

Detailed clinical & operational risks were collated from all discipline specific workshops and mitigation plans were provided. These were factored into the business case with regards to increased costs. Refer to Appendix A5 for detailed lists of all workshop submitted Clinical & Operational risks, including mitigation plans.

The first review of the risks, concerns and comments equated to 482, as shown below:

Department	Clinical Risk / Comment
Automated Biochem	1
Biochem	15
Biochem	2
Biochem - Transport	5
Biochem (General)	13
Biochem Support services	5
Blood Sciences	3
Chemistry	36
Special Biochem	3
Anticoagulation service	1
Blood Bank	2
Blood Transfusion	2
Transfusion	19
Haemathology	1
Haematology	59
Haematology	2
Haematology and Blood Transfusion	12
Immunology	72
Microbiology, Haematology & Transfusion	1
Cellular Pathology	20
Chemical Pathology	2
Histology	14
Mortuary	2
Mortuary	1
Pathology	1
Pathology wide	1
Phlebotomy	1
Unidentified Department	8
Microbiology	178
Total	482

Following the engagement of the BCPS project team and discipline specific workshops in September, October and November 2017 and January 2018, collective feedback per working group was received and this amounted to 168 risks, of which all were addressed with a mitigation plan and weighted scoring.

Discipline	**Total number of risks identified**	**Residual risk rating**			
		Red Scores 15 - 25	Dark Amber Scores 8 - 12	Light Amber Scores 4 - 6	Green Scores 1 - 3
Cell Path	29	0	7	9	13
Chemistry	29	4	19	5	1
Haematology	26	0	11	9	6
Immunology	31	1	28	2	0
Microbiology	25	3	16	4	2
Specialist Testing	13	4	9	0	0
Transfusion	15	0	7	8	0
Totals	**168**	**12**	**97**	**37**	**22**

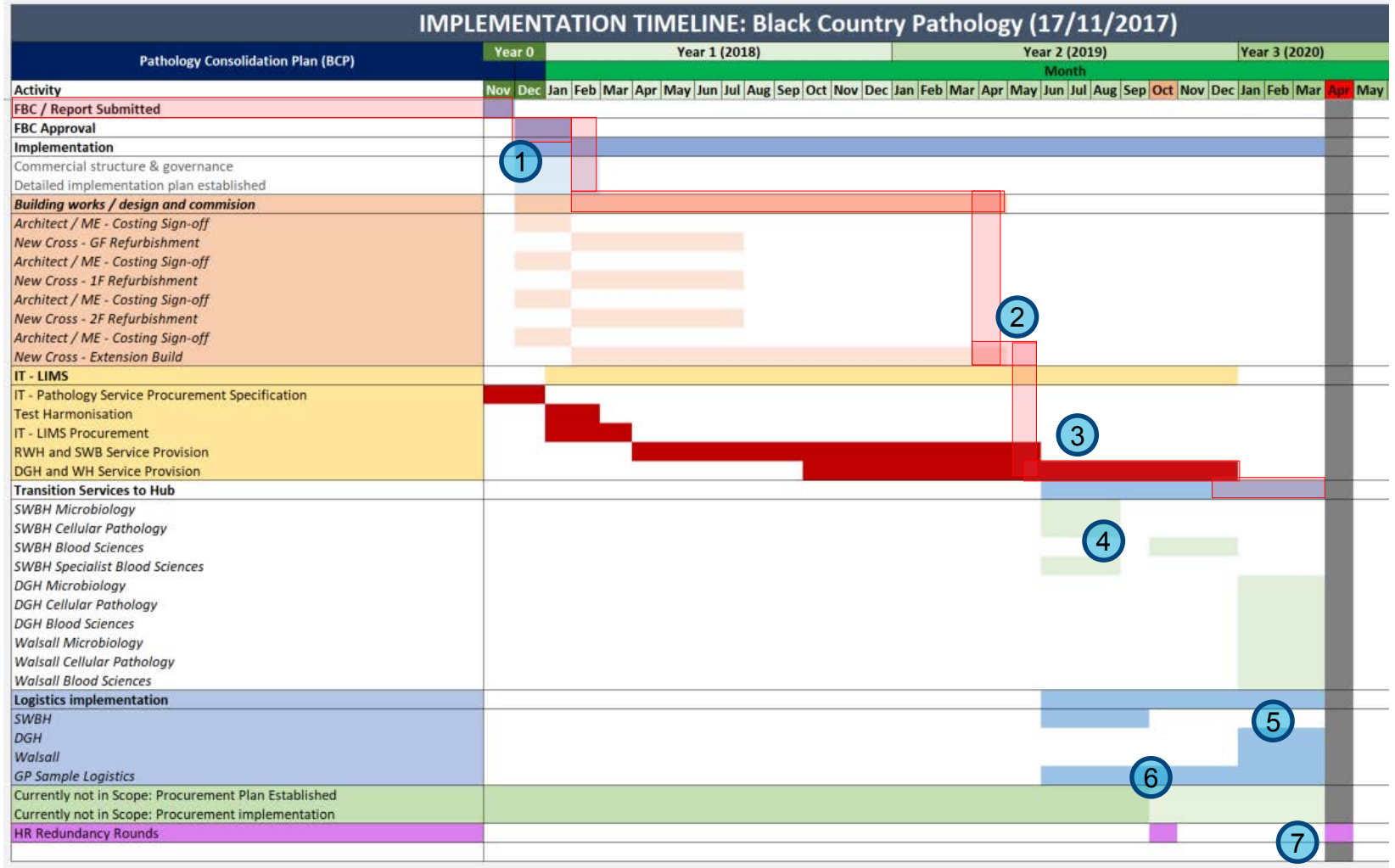
TIMELINE & IMPLEMENTATION PLAN

10

Timeline & Implementation Plan

The critical path indicates the constraints of the project and highlights what must be ensured to meet the timelines.

1. FBC review and approval and detailed implementation established.
2. Building works for refurbished and new build areas complete to accommodate volume growth into existing laboratory
3. IT system in place for all results to be appropriately dealt with within BCPS.
4. Transition of services an a phased plan, starting with SWB Microbiology and Cellular pathology allowing areas to be vacated before move to MMH.
5. Logistics in place before full transition of services for each trust, aligned with IT completion
6. Importantly: Completion of procurement for standardised blood sciences equipment and fully automated bacteriology to achieve 'go live' of TOM.
7. There are two rounds of HR discussions, which are in October 2019 and April 2020 to achieve the TOM figures.



Note: If procurement timelines are extended, then transferring OP work to the hub will be delayed.

Timeline & Implementation Plan

Year 0-1: Required sign-off and approval to proceed with project in order to meet the indicated timeline, especially related to building works and IT.

Year 1-2: IT, Building works and procurement need to start immediately to meet indicated timeline.

Year 3: Final go live date April 2020 of consolidated BCPS pathology service, when building works, IT, logistics and standardised analysers are in place.

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 1st February 2018
Report Title	People and Organisational Development Committee Highlight Report			**Agenda Item: 15** **Enclosure No.: 13**
Lead Director to Present Report	Non-executive Director and Committee Member, Mr Philip Gayle			
Report Author(s)	Trust Secretary, Linda Storey			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent People and Organisational Development Committee Meeting held on the 18th December 2017. The confirmed minutes of the meeting held on 20th November 2017 are included.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
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<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">BAF Risks:
No. 7 ‘That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff’.

No. 8 ‘That we are not successful in our work to establish a clinically-led, engaged and empowered culture.

11 ‘That our governance remains “inadequate” as assessed under the CQC Well Led standard’.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised within the report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Committee reports to the next Trust Board following its meeting at which the Board receives the approved minutes from the previous meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the meeting held on the 18th December 2017 will be submitted to the Trust Board in March 2018.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HIGHLIGHT REPORT

The meeting was quorate and approved the previous minutes and action log.

Key issues discussed were:

1. Health and Safety Quarterly Report

The Quarter 2 Health and Safety Quarterly Report was received. The key issues in report were

During Quarter 2 there were six RIDDOR reportable incidents. Four of the incidents resulted in over seven lost working days:

- 2x Slip, trip and fall – Theatres & Swift Discharge Suite
- Contact with moving object – A&E
- Impact with stationary object – Ward 11

One incident resulted in a specified injury, a bone fracture.

- Slip, trip and Fall – Member of the public

One incident release or escape of biological agents

- Needle stick from high risk source – Theatres.

There had been a total of 101 violence and aggression incidents from the 1st July – 30th September 2017. A high level of verbal abuse from patients to staff on surgical wards which was higher than in the Emergency Department was noted. Work would be undertaken to investigate the reasons for this.

The Committee emphasised the requirement for the Health and Safety Committee to meet regularly. Confirmation was given that the next meeting was scheduled for the following week and the meeting schedule would be reviewed.

2. Flu Update

The Committee was noted that the latest percentage for flu vaccination uptake stood at 55%. The meeting was advised that the divisional teams were receiving regular communications outlining their compliance and monthly targets. The measures to encourage uptake had been increased to include prizes and additional leave days. A key issue remained the number of peer vaccinators and the Deputy Director of Nursing was working with the teams to increase the numbers. The Committee was reminded that the national target was 70% compliance by the end of February 2018.

3. **Recruitment Final Audit Report**

In accordance with the Trust's governance framework the Committee received the finalised internal audit report on recruitment. The audit had been commissioned as part of the Trust's internal audit plan for 2017/18. The audit comprised of an evaluation of the recruitment, selection and vetting procedures to provide assurance as to whether procedures were followed in all instances and that only individuals with the appropriate skills, qualifications and experience were appointed. The outcome of the audit was one of substantial compliance.

The Committee noted that there was one high level recommendation to review the prescribed content of Job Descriptions to ensure the core requirements could be met; to then ensure the guidance was followed for Job Descriptions issued to applicants, especially the inclusion of the appropriate wording for Health and Safety, and the Duty of Candour.

4. Reflections Update from the Interim Director of Organisational Development and Human Resources

The Committee received an updated report from the Interim Director of Organisational Development and Human Resources which would be brought to the next Trust Board meeting.

5. Engagement Implementation

The Engagement Lead informed the Committee that following discussion and endorsement from the Trust Board earlier in the month, the engagement action plan would be implemented.

6. **Workforce KPI's**

November's sickness absence was 5.55%. Analysis indicated that the key reasons for absence were coughs, colds, gastroenterological and anxiety related conditions. It was noted that the biggest increase in sickness was due to long term conditions such as cancer.

A discussion was held about the correlation between sickness absence and working on bank following the increase in bank pay rates at the end of the summer. It was explained that analysis had been undertaken to ascertain whether there was increased sickness as a result of staff working additional hours on the bank. Further analysis was required but early indication showed some correlation. It was noted that further work would be required to identify whether policy could be implemented to address the issues.

Mandatory training compliance was at 79% and appraisal compliance at 76% in November.

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WALSALL HEALTHCARE NHS TRUST
MINUTES OF PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE
HELD ON MONDAY 20 NOVEMBER 2017 AT 10.00
IN SEMINAR ROOM ROUTE 121

Present:	Mr J Silverwood	Non-Executive Director ***(Chair)***
	Mr D Fradgley	Director of Strategy & Transformation
	Mr P Gayle	Associate Non-Executive Director
	Mrs V Harris	Non-Executive Director
	Mrs S Holden	Improvement Director
	Mr R Kirby	Chief Executive
	Mrs L Ludgrove	Interim Director of Human Resources & Organisational Development
	Mrs D Oum	Chair
Apologies:	Mrs B Beal	Interim Director of Nursing
	Mrs D Carrington	Non-Executive Director
	Mrs L Storey	Trust Secretary
In attendance:	Mrs M Belle	Workforce Lead
	Mrs D Davis	Head of Education Academy
	Mr S Johnson	Engagement Lead ***(In attendance for item 81/17)***
	Mrs B Petford	Organisational Development Practitioner
	Mrs L Pascall	Associate Director of Nursing
	Miss C White	Executive Assistant ***(Minutes)***

75/17 WELCOME AND APOLOGIES

The Committee Chair welcomed members to the meeting and apologies were noted.

76/17 MATTERS ARISING

No items were noted under matters arising from the Committee.

77/17 MINUTES OF THE LAST MEETING

Resolution

Minutes of the previous meeting held on Monday 23 October 2017 were received and approved as an accurate record.

78/17 ACTION LOG

Resolution

Members reviewed the live action log and asked the Interim Director of OD and HR to amend the deadline dates for actions ahead of the next meeting, with updates on outstanding actions.

79/17 WOMEN'S AND CHILDREN'S UPDATE

Members were advised that the Division had relayed late apologies the morning of the meeting and no presentation was available for circulation. The Chief Executive

agreed to discuss the none-attendance with the Division following the meeting.

The NHSI Improvement Director added that concerns had been raised at Maternity and Neonatal Taskforce with regards to how the Divisional Management team shared duties and recognised responsibilities.

Resolution

The Committee Chair acknowledged comments from the Improvement Director and asked that the concerns were addressed with the Division outside of the committee.

80/17 HEALTH AND SAFETY QUALITY AND SAFETY REPORT/LSMS REPORT

Resolution

Members noted that no report was available due to the Health and Safety meeting being cancelled. The Chief Executive confirmed that the Committee was up to date with regards to the report, as a detailed report was provided in October 2017. The Chief Executive added that Linda Storey, Trust Secretary was also the Executive Lead moving forward for Quality and Safety.

81/17 FOCUS GROUP FEEDBACK

The Trust Engagement Lead attended to provide a summary update regarding focus group feedback. The Engagement Lead confirmed that a full report would be presented at Trust Private Board in December 2017. It was added that feedback had been presented at the Executive Away Day and Trust Workforce Executive for information ahead of Trust Private Board. Members were advised that 19 focus groups were held with employees, including 1 BME focus group and additional feedback was provided outside of the focus groups by those wanting to anonymously comment.

The 5 key areas were listed as;

- Recognition
- Values
- Appraisals
- Bullying/Behaviour
- Change and improvements at work

The Engagement Lead explained that he had appointed 16 employees to become “Engagents”, who would communicate with employees across the Trust and be the link with engagement. It was added that the Engagement Lead’s aim was to appoint more Engagents to extend out across all Divisions, to ensure all employees are engaged. The Engagement Lead confirmed that he would be launching a new group of employees who would meet regularly to review the actions and implementation of actions, following the results of the focus group feedback. The group was to comprise of Executive Directors, Divisional Management teams, Engagents and the LiA Lead. It was added that there were 12 topics within the feedback where actions would be taken, which was detailed within the full Board report.

Members were informed that the Engagement Lead had a regular communication circulated to all employees called “In the loop”. The Engagement Lead added that

there would be a specific “In the loop” for feedback, to ensure that the employees received regular updates for assurance.

It was added that the Health and Wellbeing hub was holding a Winter Gala, week commencing Monday 27 November 2017 therefore the Engagement Lead was utilising a stall to promote engagement.

The Engagement Lead explained that it was key to address behaviours raised, throughout the focus groups as employees said “concerns had been raised previously but nothing happened before”. The Engagement Lead commented that it was key to begin making examples of individuals who had been named as “untouchable” with poor behaviour, to demonstrate that concerns were being addressed. It was added that if employees did not improve their behaviour after it being addressed then Managers should dismiss those behaving poorly, to improve the wider culture of the Trust.

The Chair asked what the bullying culture was. The Engagement Lead advised that employees were asked in the focus group, if they would tick on a survey that they felt they had experienced bullying and what examples they could provide. It was explained that this was to ensure the example was recent and genuine, not a Manager enforcing policies. The Engagement Lead added that the bullying culture was described using the following phrases; “face fits”, “favouritism”, “shouting”, “exclusion” and “humiliation”. Members were advised that the Executive team had been open to recognising issues, which was positive progress to move forward with making changes.

The Engagement Lead informed members that the Trust was 37th out of 37 in the Region for Staff Survey results, which was recognised as poor. It was added that the Staff Survey results evidenced the culture described at focus groups and confirmed the requirement for culture change.

Members discussed that the first steps for culture change were to change the Trust values, as most employees were not familiar or confident with the values. The Engagement Lead stated that it was important to engage employees in the decision making for new Trust values, therefore a suggestion was for a survey to be circulated to all employees for their opinions for new Trust values.

It was advised that the Engagents would support with; promoting the wellbeing hub and services, agreeing new Trust values and supporting the Appraisals LiA on Thursday 04 December 2017. The Engagents had also been included on the panels for staff award nominations, which received positive feedback.

The Engagement Lead provided an example of a positive story following a focus group, where many employees raised concerns regarding culture around Admin and Clerical and the lack of training and development opportunities. Following this Casey White was advised to launch an LiA for Admin and Clerical training and development. Within a week Casey had met with the LiA Lead and Engagement Lead and had a first event date confirmed. This was raised as a success story as there was a high level of engagement and clearly demonstrated how the Trust is moving forward with engagement and positive changes to support employees.

Questions/comments
The Committee Chair stated that he would have liked to see a paper presented to the Committee ahead of being presented at Trust Board, however was happy with the information provided and direction of progression. This was acknowledged by the Engagement Lead and Interim Director of OD and HR. The Interim Director of Organisational Development and HR commented that she had advised for the paper to not be submitted to the Committee as the feedback had been provided in other meetings and was being presented in full detail at Board. The Committee Chair thanked the Interim Director of OD and HR for comments received and asked that a paper was circulated to the committee for comments ahead of Trust Board.

The Director of Strategy and Transformation advised that the team needed to be open and transparent with employees regarding the work taking place. The Director of Strategy and Transformation stated that it was important for the Board report to reflect that the Trust is responding to challenges positively.

The Committee Chair commented that cross representation was required for the steering group and that the actions were to be taken in a timely manner, to demonstrate that the Executive team and Board recognised the importance of the feedback and were addressing concerns.

Mrs Victoria Harris commented that the progress made to date was very positive. Mrs Harris added that although culture change would take a long time. It was added that the Board had an opportunity with support from the Engagement Lead to make considerable improvements to the Trust, after a long period of recognising the concerns and issues raised through the Engagement Lead. Mrs Harris also added that it was key individuals were held to account for poor behaviour moving forward, to set expectations within the Trust.

The Interim Director of OD and HR advised that some employees had been named as “untouchable” within the Trust, throughout the focus groups and feedback to the Engagement Lead. Members were informed that these individuals would receive feedback on their behaviour following a review of results from staff surveys, exit questionnaires and pulse surveys. Members agreed that holding employees to account who are perceived as “untouchable” was important to progress with the required culture change.

The Chief Executive thanked the Engagement Lead for the positive work carried out and recognised that it was necessary to acknowledge the issues within the Trust, to be able to improve. The Chief Executive asked members to note that there was equally as much bullying up as well as bullying down. The Chief Executive asked that a timeline was produced ahead of Board including what actions were required, by who, for when, for the Committee to be able to monitor progress.

SJ

The Director of Strategy and Transformation advised that the Communications team was reviewing the way the Trust delivers communication, which could be supported by the Engagents. The Engagement Lead commented that although the Engagents were imperative to engaging employees and communicating information, it was felt members also needed to acknowledge that Managers were

accountable for communicating with their teams. It was added that Managers have a responsibility to ensure their teams are well informed, therefore although the Engagents would support with communications it was important that Managers were held to account if not efficiently communicating with their team.

The Engagement Lead added that the Engagent were a positive addition to the Trust, to empower the workforce and ensure engagement is a Trust focus. It was commented that Engagent were also able to support employees with discussion that they did not feel comfortable having with their Manager/Line Manager.

Mr Philip Gayle commented that the progress made to date was encouraging. The Engagement Lead advised that a separate focus group was held for BME colleagues, which would be summarised and shared at the Equality and Diversity Inclusion Committee (EDIC). Mr Gayle agreed to discuss BME focus group feedback with the Engagement Lead outside of the meeting, to add to the next EDIC agenda.

The NHSI Improvement Director raised that communication standards began at Executive and Board level, therefore good communications must commence from the most senior leaders within the Trust. It was added that good communication and accountability was demonstrated by the Interim Director of OD and HR, when informing members during the meeting that she had advised papers were not required for the meeting, to later be advised that they were.

The Engagement Lead advised that he would be launching an initiative called “a moment of truth”, which enables employees to confidentially provide feedback to colleagues on both positive and negative behaviour.

Resolution

The Interim Director of OD and HR agreed to ensure she had reviewed the Board papers by Friday 01 December 2017, for circulation to members for comments. Members agreed that positive actions had been taken however asked that the Board papers regarding focus group feedback was circulated to members for comments ahead of Board. **LL**

The Chief Executive confirmed that focus group feedback would be included in the December 2017 team brief.

The Chair asked that a summary was also prepared for Public Trust Board in January 2018. The Chief Executive advised that all papers for January 2018 Board were required before Christmas due to the timing of the meeting, which was noted by the Engagement Lead.

SJ

82/17 FLU UPDATE

The Interim Director of OD and HR advised that the CQUIN target for front line staff was to achieve 75% by Wednesday 28 February 2018. It was explained that at week ending Sunday 12 November 2017 the Trust had achieved 38.15% which was reported to NHSI, for front line staff. The Interim Director of OD and HR advised that the following actions were being taken to increase compliance;

- Week commencing Monday 20 November 2017 the team was to be publishing and promoting; the October annual leave winner (Joyce Bradley), November and December annual leave opportunities, articles from pier vaccinators and prizes available.

- During Winter Gala week (Monday 27 November 2017 until Friday 01 December 2017), the team aim to provide vaccinations each day at the Health and wellbeing hub via Pier Vaccinators.

- Information had been distributed via HR Managers to Divisions regarding their uptake by ward / team (as at Tuesday 31 October 2017) and bespoke sessions had been arranged for wards / teams.

- Flu clinics held every Tuesday and Friday at Costa was being promoted most days through the Daily Dose.

The Interim Director of OD and HR explained that the biggest risk was the capacity of the Occupational Health Team, to deliver vaccinations and the number of active Pier Vaccinators available.

Members were advised that the Trust was at the same point this year as last and the Trust achieved 75% by Saturday 31 December 2016.

Resolution

Members noted the update provided and the Committee Chair commented that positive progress had been made, with good actions in place moving forward. The Chief Executive asked the Interim Director of OD and HR to ensure all teams had been provided with their summary and support to improve compliance. **LL**

83/17 STAFF SURVEY UPDATE

The Interim Director of OD and HR advised that the current return rate for the Trust was 29%, which was a 3% increase in month. It was explained that if the Trust continued with the same pace of increase per week, the final return rate would be 39%. It was added that the national average last year was 40% and the Trusts return rate was 42%. Members were advised that an increase in returns was anticipated for the following week, due to the final surveys being handed to employees that week.

Members were informed that Matrons and Managers had been contacting the team asking for their team's surveys, so they could hand out surveys personally. It was added that Caroline Whyte, Divisional Director of Nursing and Paediatrics (WCCSS) had also asked her Clinical Managers to job swap with colleagues to enable the team to take time out to complete their survey. Members agreed that the example was good practice, to be replicated across the Trust. The Interim Director of OD and HR added that the Estates team were also undertaking great practice by delivering 'meet and complete' sessions, enabling colleagues to have protected time out to complete their surveys.

The Interim Director of OD and HR provided a summary of each Divisions compliance, which is noted below;

- Corporate: 54% (+3%)
- Medicine and Long Term Conditions (MLTC): 21% (+3%)
- Surgery: 21% (+3%)
- Estates and Facilities: 34% (+7%)
- Women's, Children's and Clinical Support Services (WCCSS): 31% (+0%)

Mr Philip Gayle asked if it was understood why there was reluctance to complete the survey. The Interim Director of OD and HR explained that she had received consistent feedback of employees feeling anxious that the survey was not anonymous, therefore they did not want to complete the survey due to the anticipation that their Manager would see their answers. The Interim Director of OD and HR assured members that the survey was anonymous and that no information would be shared relating to specific areas, if less than 8 responses were received. The Organisational Development Practitioner commented that compliance had increased to 30% as of the day of the meeting.

The Chief Executive queried if the Interim Director of OD and HR was aware of actions the Divisions were taking in response to their summaries. The Interim Director of OD and HR confirmed that Divisional actions were available for assurance.

Resolution
Members noted the updates provided.

84/17 WORKFORCE KPI'S

The report circulated ahead of the meeting was taken as read and members were asked for any comments or questions.

Sickness

The Committee chair raised concerns that there had been a 1.3% increase in sickness, in month. The Interim Director of OD and HR stated that the primary cause for sickness was due to home related mental health concerns, such as stress and depression. The Interim Director of OD and HR added that she was confident employees were receiving support for their mental health concerns, although it was felt that Managers should intercept earlier by speaking to employees when they notice a change to mitigate the risk of sickness. The Interim Director of OD and HR explained that due to the limited resources within Occupational Health, the team were looking to procure support from Sandwell and West Birmingham NHS Trust, along with looking at the Trusts establishment to support employees as much as possible. The Committee Chair added that the number of employees on sickness leave due to musculoskeletal was also concerning, to which the Interim Director of OD and HR advised the Physiotherapy support was available for employees. It was added that although Physiotherapy was provided for employees, there were funding concerns and not enough Physiotherapists to meet demand therefore the Interim Director of OD and HR was liaising with the Therapy Services Manager to address concerns.

The NHSI Improvement Director queried if the Trust utilised any online support

available such as CBT, or if the services provided were face to face only. The Interim Director of OD and HR advised that only face to face support was provided at present. The NHSI Improvement Director suggested that online self-management services would be beneficial and could be prescribed to employees. It was added that the service consisted of 6, 1 hour sessions. The Interim Director of OD and HR agreed that the suggestion was helpful and would be discussed with the Occupational Health team.

Mr Philip Gayle asked if all support for employees was facilitated through Occupational Health, to which the Interim Director of OD and HR confirmed it was. Mr Gayle advised that employees often felt that Occupational Health was a management tool, rather than employee support therefore an alternative such as social prescribing for online courses and utilising the Health and Wellbeing Hub may be more productive to support the reduction of sickness absence.

Mrs Victoria Harris added that Occupational Health also may not have the required expertise for mental health therefore external support would be beneficial for employees. Mrs Harris advised that she would liaise with a colleague of hers within the mental health sector to enquire what support is available, copying in the Interim Director of OD and HR to allow the Trust to have further information regarding external support available.

The Head of Education Academy commented that the Health and Wellbeing Hub was very successful and had received an award at the Trust Ball, which reflected the level of impact the team were having. The Head of Education Academy added that there was a range of services available through the Health and Wellbeing hub such as; Mindfulness classes, yoga, netball which had a high level of engagement. **LL**
It was stated that the hub was well attended by a variety of employees, although could be utilised more to address stress.

Members discussed that there were some inaccuracies and concerns from within the document provided to be amended for the next meeting. The Chief Executive asked that the report was amended ahead of Trust Board.

Mandatory training
The Chief Executive explained that during the winter period the Trust required as many clinical employees as possible to be patient facing. Due to this it was discussed that the priority for the Trust was performance, therefore it was agreed Divisions would be asked to sustain the current compliance until the end of the winter period. It was added that Children's Safeguarding compliance was still required.

Appraisals
The Head of Education Academy advised that more support and training was being provided and many employees complete e-learning over the Christmas period, while some areas were quieter, however due to an update of IBM the service was not anticipated to be available during the winter period for these employees. It was added that paper copies would be provided although it was likely less employees would want to complete their e-learning on paper.

Resolution

Members agreed the following to support the winter period, which was to be communicated to Divisions;

- **Mandatory training to maintain stable compliance.**
- **Children's safeguarding compliance required.**
- **Appraisal compliance was to increase at the end of the financial year.**

85/17 JOINT NEGOTIATING AND CONSULTATIVE COMMITTEE (JNCC) MINUTES

Minutes were circulated to members ahead of the meeting from JNCC held on Wednesday 18 October 2017 and were taken as read.

The Committee Chair raised that the apologies list from the Executive team was concerning and to be addressed. The Interim Director of OD and HR assured members that the lack of Executive attendance had been addressed and better attendance was present at the meeting in November 2017.

The Chief Executive added that Staff Side Leads were very concerned about the change to car parking charges, therefore an agreement had been made to review the quality of the carparks. The Interim Director of OD and HR added that the members of JNCC were very angry, as they felt sufficient communications were not shared with members ahead of changes being implemented, for their input and comments. It was added that the JNCC members felt they were disrespected by the way the change was implemented, to which the Executive team acknowledged that the change could have been coordinated with more consideration. The Interim Director of OD and HR stated that the Executive team had agreed with the Staff Side Leads that there would be a plan for increasing charges each year, produced with input from the Staff Side members.

Resolution

Members noted the updates provided.

86/17 LOCAL NEGOTIATING COMMITTEE (LNC) MINUTES

Minutes were circulated to members ahead of the meeting from LNC held on Friday 08 September 2017 and were taken as read.

The Chief Executive stated that there had been a lot of discussion at LNC meetings with regards to Clinical Excellent Awards (CEA) and it was agreed that the Trust had committed to historic rounds of CEAs, however members were now asking if the Trust would be holding 2017 to 2018 CEAs in 2018/19. The Interim Director of OD and HR advised that she had an update regarding CEAs, discussed with the Chief Executive outside of the meeting before feedback was provided.

Resolution

Members noted the update provided and The Committee Chair asked that the Interim Director of OD and HR and Chief Executive had the required discussions following the meeting, to feedback to the next meeting.

LL

87/17 MEDICAL EDUCATION MEETING

Resolution

Minutes were provided of the Medical Education meeting held on Tuesday 18

April 2017 and taken as read. No comments were received from members.

88/17 RISKS MONITORED BY THE COMMITTEE

The report provided by the Trust Secretary was taken as read and in the absence of the Trust Secretary the Committee Chair asked for any comments.

The NHSI Improvement Director commented that she felt there was a lack of assurance in the narrative provided and therefore more detail would have been beneficial. The NHSI Improvement Director added that the risks should triangulate where possible with the staff survey, exit questionnaires and pulse check, as they may affect the risks.

The Committee Chair queried if the consensus was that all current risks were recorded and that they were accurate. The Interim Director of OD and HR commented that she believed the current risks were being updates, however reviews were not taking place to see if any additions were to be made.

The Director of Strategy and Transformation advised that there had been a lot of work taken place regarding risks and all risks were on the Safeguard system. It was added that the Executive team were to take ownership of the risks and ensure they were updated regularly.

Resolution

The Committee Chair acknowledged comments from members and concerns were noted.

89/17 OBJECTIVES UPDATE

The Director of Strategy and Transformation circulated papers to members ahead of the meeting, which were taken as read. The Director of Strategy and Transformation advised that he had met with the Trust Secretary and Interim Director of OD and HR to review objectives, with evidence and core assurance for Corporate oversight and independent assurance. The Director of Strategy and Transformation added that good progress had been made, although it was recognised further work was required as some ratings were optimistic.

Resolution

The Committee Chair asked that members provided feedback via email to the Director of Transformation and Strategy following the meeting on the documents provided, ahead of Trust Board on Thursday 07 December 2017. All

90/17 ANY OTHER BUSINESS

WCCSS, workforce plan

The Associate Director of Nursing informed members that the WCCSS workforce plan was presented at Maternity and Neonatal Taskforce on Friday 17 November 2017, in draft format, not for circulation at present. Members were advised that the Division planned to change how Maternity care was delivered, in response to the pending CQC report and acknowledging their workforce Metrix, recognising that recent Serious Incidents (SI) are a concern along with supply and demand.

Members were informed that the Division were developing Maternity Support

Workers, who would always work with a Midwife on Delivery Suite however can work autonomously in areas such as Antenatal Clinic, Postnatal and Community to complement and enhance pathways. Marsha Belle, Workforce Lead was supporting the Division with their plans and looking to capitalise on Apprenticeship opportunities within Maternity.

Resolution

The Committee Chair commented that the Division were taking a sensible approach and members agreed that they looked forward to further information once available.

91/17 NEXT MEETING

Monday 18 December 2017, 15:00 in MLCC Room 10

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date: 1st February 2018**
Report Title	Update on OD & HR Reflections paper			**Agenda Item: 16 Enclosure No.: 14**
Lead Director to Present Report	Louise Ludgrove, Interim Director of OD & HR			
Report Author(s)	Louise Ludgrove			
Executive Summary	An update of progress against areas identified in July 2017 paper and timescales for completion on outstanding areas.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation				

Trust Objectives Supported by this	**Provide Safe High Quality Care Across all of Our Services**	**Embed the quality, performance and patient experience improvements**

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<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Submitted to People & Organisational Development Committee 18th December 2017.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2"></td></tr>
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Organisational Development & Human Resources
Update on Initial Reflections Agenda December 2017

1. Short term progress was made around integrating the services within the Directorate but the recent departure of a key manager has slowed that progress. Implementation of the draft Management of Change when a substantive Director has been appointed will enable a sustainable solution to this objective. This vacancy has also impacted on our ability to progress the Equality, Diversity and Inclusion agenda and will be resolved through the same solution. *Timescale for appointment: January 2018*

   Professional development within the HR team has been reintroduced and will be maintained.

2. The Directorate is working closely with colleagues in the engagement and transformation arenas across the range of issues covered within the team. This has been a successful approach and is embedded.

   The ability to develop services to become more agile and responsive to organisational need under strong leadership will be addressed by the draft Management of Change proposals. *Timescale: January 2018*

3. Leadership programmes delivered through the Kings Fund are almost complete. The Strategic Leadership programme saw 75 mid-level leaders from all disciplines and Departments attend a series of three workshops and additional summer workshops to progress some of the Learning in Action (LIA) big ticket items. Executive Directors participated in some of the workshops to ensure alignment of Trust strategy and leadership approach and initial feedback on the programme has been very positive and has indicated that participants found it valuable. Discussions are scheduled with Kings Fund to confirm final evaluation of the programme.

   A 360 degree assessment process has been designed for Divisional Directors and will commence in the New Year and we are planning to roll out this approach across the Trust. It is anticipated that 360 degree assessment will subsequently be extended to the Trust Executive and throughout the Trust.

   Trust financial pressures have curtailed some planned activities intended to conclude the Divisional Teams of Three programme, which was otherwise successful and again attended by Executive Directors.

   A successful service improvement and team development session was held with the Endoscopy Service and Gastro teams to support the embedding of the clinically led model. This formed the final session in a series of away afternoons that were initiated as part of the Consultant engagement work in early 2016.

As a result of a successful LIA event on Service Improvement, a leadership programme for developing leaders in Bands 6 and below is planned for early 2018 and later in 2018 we will be able to access the National Leadership Academy's "Seacole Local" programme at reduced rates. These programmes work to ensure a consistent approach to a clinically led, empowered and engaged workforce.

The Clinical Engagement work focused on SAS and Trust Grade doctors has now developed a CPD programme with input from the participants. The programme includes elements on consent, safeguarding, critical appraisal, leadership and revalidation and is facilitated by WHT staff, representatives from the GMC and NHS Elect. The programme is now live and is co-ordinated by the Medical Education Team.

4. The Trust has answered the Social Partnership Forum's "Collective Call to Action" to tackle bullying in the NHS by establishing a Steering Group. This Group has a wide membership including staff side, engagents, Freedom to Speak Up Guardians and OD/HR colleagues and is currently developing an action plan based on analysis of the 2016 Staff Survey, the outcomes of the Pulse Surveys and feedback from the engagement focus groups. The action plan will be aligned with the refreshed Trust values and behavioural framework. *Timescale for delivery: end of March 2018*

The latest Pulse check was carried out in July 2017 and showed an increase of positive responses from our staff of 13.9% across all questions. Further Pulse surveys will be run on an annual basis with the next one planned for summer 2018.

The Trust's Engagement Lead has completed the first stage of planned engagement through an extensive programme of focus groups for staff across the Trust. The feedback from this programme has now been gathered and analysed, considered in detail at Trust Board and shared through Divisional Teams. Recommendations in relation to themes emerging from these outcomes have been agreed and are now being taken forward.

One of the primary areas of concern arising from the feedback related to concerns raised by staff and a perception that the Trust had not historically addressed this issue. In response to these concerns the Engagement Lead has identified an approach whereby individuals named in this respect through feedback will be informed of the concerns that have been raised, to enable them to reflect on their behaviours through a developmental coaching approach. This feedback will be provided by a member of a small team of people skilled in providing sensitive feedback. Line managers will then be informed that a discussion has taken place and responsibility for managing any further issues will sit at local level. If further evidence emerges of a continuing problem, then formal Trust processes will be initiated.

This process is designed to address inappropriate behaviours directly with individuals, enable developmental opportunities for individuals to reflect upon and enhance their skills and to provide confidence to staff that the Trust will tackle problems directly. The long term goal is to develop a culture where individuals feel confident to provide feedback directly to an individual where they consider behaviour is inappropriate. *Timescale: January 2018 onwards*

Analysis of feedback from the focus groups has also identified that the current Trust "Promises" are not easily identified by staff. Therefore we are embarking on a programme of engaging with all staff to identify a simple and meaningful set of Trust Values, which are easy to remember and represent the culture of the Trust moving forward. Alongside the values we will identify a behavioural framework, linked to the values. This will enable everyone to recognise the appropriate behaviours demonstrating the improving culture of the Trust and modelled from Trust Board and throughout the organisation.
Timescale: May 2018

5. Trust Board approved the Trust Workforce Strategy in September 2017 and work is underway to populate a Workforce Plan. The Workforce Transformation Lead is working closely with clinical areas to take this work forward. *Timescale: March 2018*

BOARD/COMMITTEE REPORT

Meeting	Trust Board	**Date:** 01/02/18
Report Title	Month 9 Finance Report	**Agenda Item: 17** **Enclosure No.: 15**
Lead Director to Present Report	Mr R Caldicott, Director of Finance	
Report Author(s)	Mr T Kettle, Deputy Director of Finance Mr P Steventon, Head of Financial Management	
Executive Summary	1. The Trust has attained a £20.3m deficit against a deficit plan of £16.4m, giving an unfavourable variance of £3.9m for the period ended 31st December 2017 2. The 2017/18 contract agreement for acute services with Walsall CCG is on a cost & volume basis for elective care with the Trust paid for emergency activity that exceeds a cap of £1.9m. The contract agreed for community services remains a 'block' arrangement 3. The Trust risk to delivery of planned clinical income centres upon CQUIN, Sepsis, RTT and variance to forecast outturn on elective and outpatient activity. In addition, the Trust has reduced income from non-elective activity (births) in year, whilst emergency activity continues to overperform 4. Fines are capped at £1.0m and the CCG is committed to reinvesting £1.5m of Emergency Threshold deductions and CQUIN underperformance 5. The Divisional financial performance was: - • Clinical Divisions expenditure overall is £5.1m adverse to plan mainly due to temporary staffing costs and CIP underperformance • CIP delivery YTD is £6.6m. The annual target is £11m • Temporary staffing expenditure in December 2017 totals £1.9m 6. The Trust's full year targeted savings for 2017/18 are £11m. As at month 9 the Trust has delivered £6.6m against a phased plan of £8.1m 7. The Trust has achieved a £20.3m deficit to date with a targeted delivery of a £20.5m deficit for the year 8. The Trust must maintain a minimum £1.0m cash balance while in receipt of Loan funding to support the deficit position. The Trust's cash balance at the end of December is £1.5m. The Trust has access to additional borrowing to support the £20.5m deficit plan.	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☐	☐	☐	☒

<table>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td><u>Recommendation</u></td><td colspan="4">Trust Board is recommended to: NOTE THE REPORT AND ASSOCIATED RISKS</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td colspan="2">Provide Safe High Quality Care Across all of Our Services</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Care for Patients at Home Whenever we can</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Work Closely with Partners in Walsall and Surrounding Areas</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Value our Colleagues so they recommend us as a place to work</td><td colspan="2">Not Relevant</td></tr>
<tr><td colspan="2">Use resources well to ensure we are Sustainable</td><td colspan="2">Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="4">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="4">Attainment of the 2017/18 financial plan and sustainability for the future</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="4">The financial risks are identified in the key messages section of the report, attainment of the clinical income planned for the year, the delivery of CIP, maintaining a reduction in temporary worker expenditure and the delivery of targeted financial and performance recovery plans are the key risks for the Trust to financial year end.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="4">The Trust needs to demonstrate financial viability</td></tr>
<tr><td><u>Report History</u></td><td colspan="4"></td></tr>
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Walsall Healthcare NHS
NHS Trust

2017/18 Finance Report
December 2017 (Month 9)

Becoming your partners for first class integrated care

2017/18 Finance Report: April 2017 to December 2017 (Month 9)	Page
• Key Messages	3
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• Divisional Finances – Summary	6
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• Cost Improvement Target Achievement	9
• Capital Programme	10
• Statement of Financial Position	11
• Statement of Cash Flows	12

Key Messages

Financial Month 9 plan.	• The total financial position for the Trust at M09 is a deficit of £20,342k against the planned deficit of £16,351k, resulting in an unfavorable variance of £3,991k (£3,093k November) • The clinical income position is down against plan (obstetrics and outpatients below plan) and Clinical divisions are currently overspending on nursing and medical establishments, resulting in the increased deficit to plan • CIP delivery is behind plan (£6.6m delivered to date against a target of £8.1m) and 30% of the delivered CIP achieved non-recurrently. The utilisation of non-recurrent savings for CIP delivery places greater emphasis on areas to remain within budgets, as underspends are not available to off-set areas exceeding budgeted allocations • Temporary workforce remains high at £1.9m (previously the highest spending month this year was £1.8m)
Financial Risks	• Ability to deliver financial recovery given against increasing spending on temporary workforce and income risk • CIP delivery in the first half of the year has a high proportion of non recurrent savings (targeted recurrent) • Delivery of CQUIN targets and contractual activity to deliver clinical income
CIP	• The Trust's Cost Improvement Target for the year is £11m recurrent spend reduction with savings of £6.6m delivered YTD of which £2m is achieved non-recurrently.
Bank, Agency and Locum spend	• Temporary staffing costs increased in December by £54k to £1.94m (£1.88m in November). • Agency costs increased by £43k to £0.69m in December (£0.64m in November). • Bank Staffing costs increased by £67k to £0.61m in December (£0.54m in November). • Locum staffing costs reduced by £56k in December to £0.64m (£0.70m in November).

Summary Financial Performance to December 2017 (Month 9)

Financial Performance - Period ended 31st December 2017					
Description	**Annual Budget**	**Budget to Date**	**Actual to Date**		**Variance**
	£'000	£'000	£'000		£'000
Income					
NHS Activity Revenue	226,284	169,602	167,791		(1,811)
Non NHS Clinical Revenue (RTA Etc)	941	731	1,359		628
Education and Training Income	9,873	6,560	6,560		(0)
Other Operating Income (Incl Non Rec)	7,653	5,883	7,530		1,647
Total Income	**244,751**	**182,777**	**183,240**		**464**
Expenditure					
Employee Benefits Expense	(171,963)	(127,920)	(130,592)		(2,672)
Drug Expense	(15,660)	(14,318)	(14,622)		(304)
Clinical Supplies	(18,464)	(13,802)	(14,199)		(397)
Non Clinical Supplies	(15,661)	(11,718)	(12,213)		(495)
PFI Operating Expenses	(5,019)	(3,756)	(3,764)		(8)
Other Operating Expense	(23,186)	(15,947)	(16,341)		(395)
Sub - Total Operating Expenses	**(249,952)**	**(187,460)**	**(191,731)**		**(4,271)**
Earnings before Interest & Depreciation	**(5,201)**	**(4,683)**	**(8,490)**		**(3,807)**
Interest expense on Working Capital	51	38	14		(25)
Interest Expense on Loans and leases	(8,460)	(6,538)	(6,724)		(185)
Depreciation and Amortisation	(6,890)	(5,167)	(5,141)		26
PDC Dividend	0	0	0		0
Losses/Gains on Asset Disposals	0	0	0		0
Sub-Total Non Operating Exps	**(15,299)**	**(11,668)**	**(11,851)**		**(184)**
Total Expenses	**(265,251)**	**(199,127)**	**(203,582)**		**(4,455)**
RETAINED SURPLUS/(DEFICIT)	**(20,500)**	**(16,351)**	**(20,342)**		**(3,991)**
Impairments	0	0	0		0
ADJUSTED SURPLUS/(DEFICIT)	**(20,500)**	**(16,351)**	**(20,342)**		**(3,991)**

Division	YTD Budget £000's	YTD Actual £000's	Variance £000's	*Narrative*
MLTC	43,395	45,722	(2,327)	*MLTC is £2.3m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.5m) and Medical agency cover for ED and Gastro.(£1.0m).*
Surgery	40,293	42,112	(1,819)	*Surgery is £1.8m overspent due to overspends mainly within Nursing £0.4m (Gen Surg) and medics £0.4m (Anaesthetics) and Critical Care/Theatres (£0.4m).*
WC & CSS	50,877	51,882	(1,005)	*WCCSS is overspent by £1.0m driven by medical staffing overspends (£0.4m) mainly Paediatrics and non delivery of CIP (£0.4m).*
Estates & Facilities	11,429	11,821	(392)	*Off plan due to non delivery of CIP.*

Financial Performance

- The total financial position for the Trust at M09 is a deficit of £20,342k, which is only £158k short of the annual plan of £20.5m. The YTD deficit plan is £16,351k, which results in an unfavourable YTD variance of £3,991k.
- The contracted income position is down against plan (£1,811k), the underperformance largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income is over-performing largely as a consequence of winter STP funding and other one off income allocations such as Diabetes.
- The main area of overspending is pay (£2,672k) and is largely as a consequence of nursing expenditure on wards and on specialist nurses. There are also overspends within medical budgets.
- The YTD CIP delivery is £1,521k behind plan. If the planned CIP was phased in equal 12^{ths} the target would be £8,250k year to date (current plan £8,141k) and the Trust would be reporting an overspend to M09 of £4.1m.

CIP 2017/18 Delivery

- The Trust's Annual Cost Improvement Programme requirement is £11m.
- The CIP plan for M09 is £8,141k (74% of the target) and actual delivery is £6,620k, which is an under achievement of the savings target of £1,521k. In addition, of this total £1,998k was delivered non-recurrently, placing increased pressure on future financial sustainability.

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding is £1.5m, the increase in cash being the receipt of the winter funding allocation on the final working day of December.
- The Trust's agreed borrowing for 2017/18 is £20.5m, reflecting the deficit plan. The Trust has utilised earlier borrowing to ensure continued payment for goods and services because of overspending against plan.

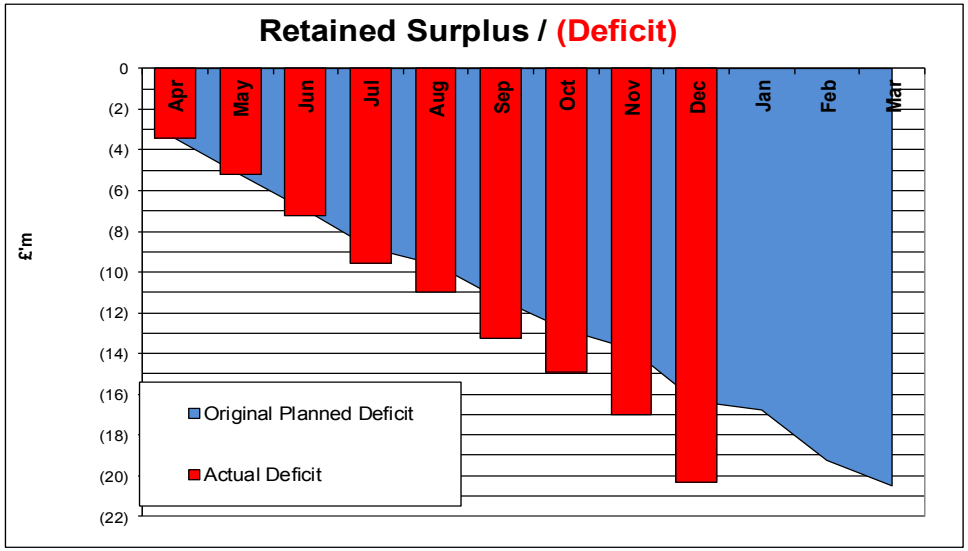
Capital

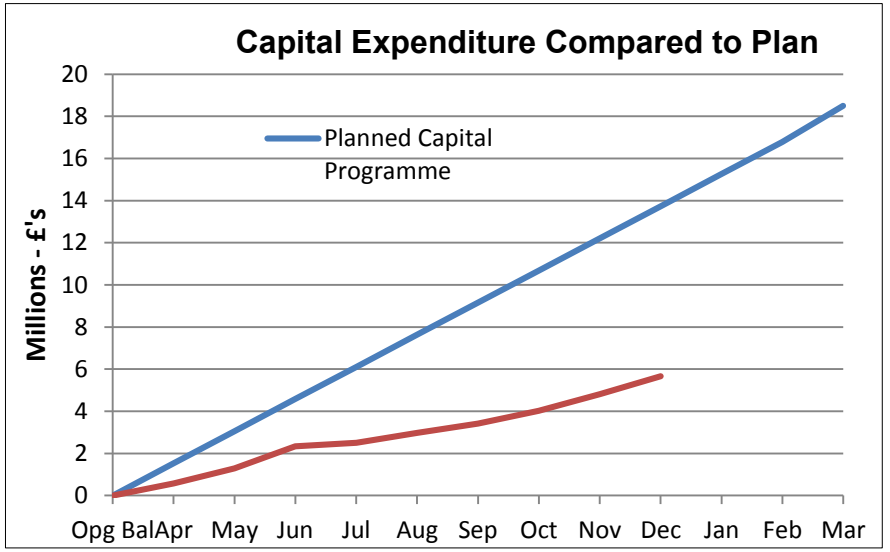
- The year to date capital expenditure is £5.66m, with the main spends relating to ICCU (£3.4m), Medical Equipment (£0.6m) and Community Mobile technology (£0.5m).

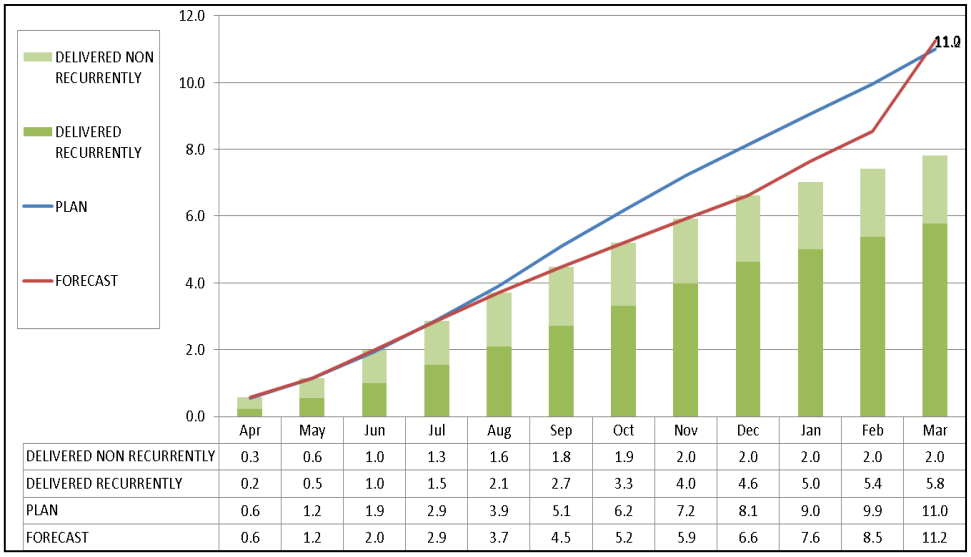
Temporary Workforce

- £1.935m December 2017 (£1.881m November 2017) a £54k increase in month and £568k increase over Aprils expenditure (£1.367m).

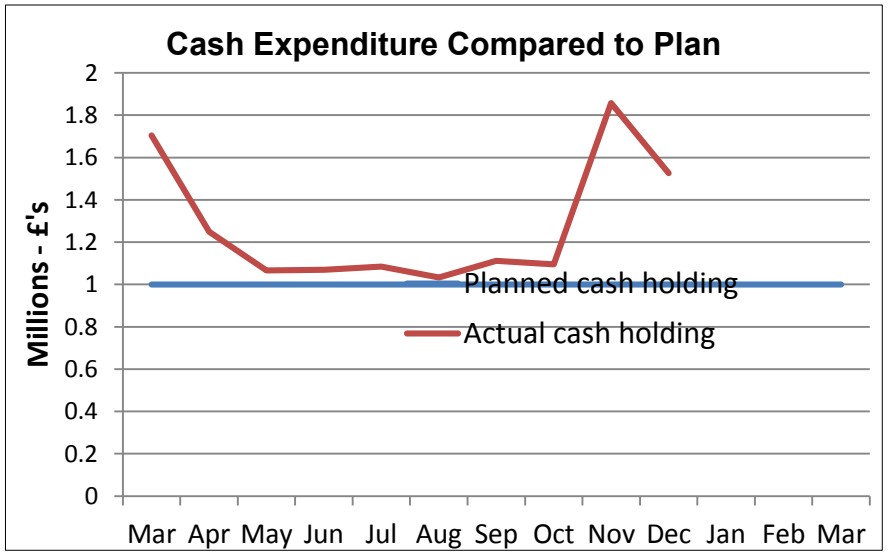
Overall Summary and RAG Assessment continued







	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.3	0.6	1.0	1.3	1.6	1.8	1.9	2.0	2.0	2.0	2.0	2.0
DELIVERED RECURRENTLY	0.2	0.5	1.0	1.5	2.1	2.7	3.3	4.0	4.6	5.0	5.4	5.8
PLAN	0.6	1.2	1.9	2.9	3.9	5.1	6.2	7.2	8.1	9.0	9.9	11.0
FORECAST	0.6	1.2	2.0	2.9	3.7	4.5	5.2	5.9	6.6	7.6	8.5	11.2



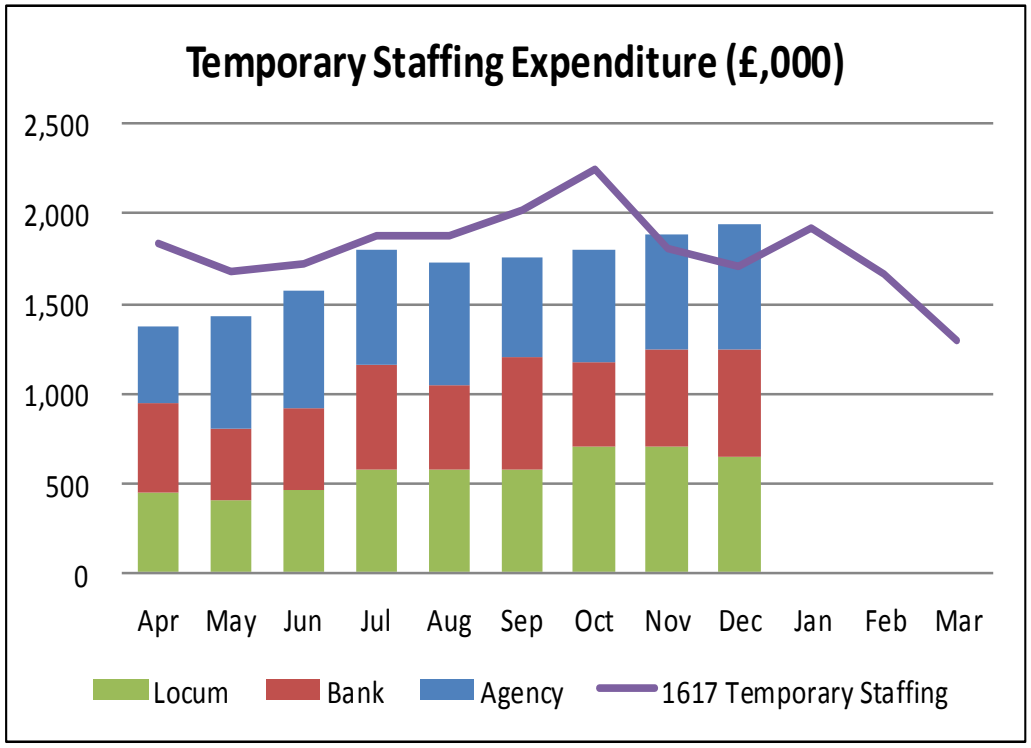
Divisional Income & Expenditure positions: April 2017 to December 2017 (Month 9)

DIVISIONAL POSITIONS	Healthcare Income				Expenditure Less Other Income				Net Divisional Position			
	Annual	Year to Date		Variance	Annual	Year to Date		Variance	Annual	Year to Date		Variance
	Budget	Budget	Actual	Over (-) / Under	Budget	Budget	Actual	Over (-) / Under	Budget	Budget	Actual	Over (-) / Under
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Divisions												
Medical & Long Term Conditions	79,961	58,472	61,428	2,956	(56,406)	(43,395)	(45,722)	(2,327)	23,555	15,077	15,707	630
Surgical	53,953	40,050	39,318	(732)	(51,985)	(40,293)	(42,112)	(1,819)	1,968	(243)	(2,794)	(2,551)
Women, Childrens & Diagnostics	67,547	50,397	46,229	(4,168)	(66,591)	(50,877)	(51,882)	(1,005)	956	(480)	(5,653)	(5,173)
Total Clinical Divisions	**201,461**	**148,919**	**146,975**	**(1,944)**	**(174,982)**	**(134,565)**	**(139,715)**	**(5,150)**	**26,479**	**14,354**	**7,260**	**(7,094)**
Estates & Facilities				0	(15,316)	(11,429)	(11,821)	(392)	(15,316)	(11,429)	(11,821)	(392)
Total Operational Services	**201,461**	**148,919**	**146,975**	**(1,944)**	**(190,298)**	**(145,994)**	**(151,536)**	**(5,542)**	**11,163**	**2,925**	**(4,561)**	**(7,486)**
Corporate Services												
Management Executive					(1,776)	(1,368)	(1,391)	(23)	(1,776)	(1,368)	(1,391)	(23)
Nurse Director					(5,661)	(4,203)	(3,978)	224	(5,661)	(4,203)	(3,978)	224
Chief Operating Officer					(262)	(209)	(207)	2	(262)	(209)	(207)	2
Medical					(1,344)	(1,099)	(1,164)	(64)	(1,344)	(1,099)	(1,164)	(64)
Finance					(1,512)	(1,098)	(475)	622	(1,512)	(1,098)	(475)	622
Informatics					(4,412)	(3,311)	(3,053)	258	(4,412)	(3,311)	(3,053)	258
Strategy & Partnership					(919)	(639)	(568)	71	(919)	(639)	(568)	71
Corporate Affairs					(520)	(408)	(451)	(42)	(520)	(408)	(451)	(42)
Human Resources					209	44	(76)	(120)	209	44	(76)	(120)
Medical Negligence / Emp Liability					(13,152)	(9,864)	(9,877)	(12)	(13,152)	(9,864)	(9,877)	(12)
PFI Charges					(4,889)	(3,667)	(3,738)	(71)	(4,889)	(3,667)	(3,738)	(71)
Total Corporate Services	**0**	**0**	**0**	**0**	**(34,239)**	**(25,821)**	**(24,977)**	**844**	**(34,239)**	**(25,821)**	**(24,977)**	**844**
TOTAL ALLOCATED BUDGETS	**201,461**	**148,919**	**146,975**	**(1,944)**	**(224,537)**	**(171,816)**	**(176,514)**	**(4,698)**	**(23,075)**	**(22,896)**	**(29,538)**	**(6,642)**
Profit/Loss on Disposal of Assets					0	0	0	0	0	0	0	0
Depreciation - Owned & Donated Assets					(6,790)	(5,092)	(4,893)	200	(6,790)	(5,092)	(4,893)	200
Depreciation - Impairments					**0**	0	0	0	**0**	0	0	0
Total Depreciation					**(6,790)**	**(5,092)**	**(4,893)**	**200**	**(6,790)**	**(5,092)**	**(4,893)**	**200**
Unitary Payment Interest					(7,687)	(5,765)	(5,832)	(67)	(7,687)	(5,765)	(5,832)	(67)
Interest Receivable					(722)	(735)	(875)	(140)	(722)	(735)	(875)	(140)
Reserves & Provisions					(6,048)	(1,802)	464	2,266	(6,048)	(1,802)	464	2,266
Health Care Income: Block Contracts	24,822	20,683	20,816	133	(1,000)	(493)	(942)	(449)	23,822	19,940	20,332	392
Total Reserves & Block Income	**24,822**	**20,683**	**20,816**	**133**	**(7,048)**	**(2,295)**	**(478)**	**1,817**	**17,774**	**18,138**	**20,796**	**2,658**
RETAINED SURPLUS/(DEFICIT)	**226,284**	**169,602**	**167,791**	**(1,811)**	**(246,784)**	**(185,703)**	**(188,591)**	**(2,888)**	**(20,500)**	**(16,351)**	**(20,342)**	**(3,991)**

Commentary

- The Trusts deficit is £20.3m year to date.
- MLTC is £2.3m overspent year to date as a result of nursing staffing cost overruns (Wards, capacity and specialist areas – £1.5m) and Medical agency cover for ED and Gastro.(£1.0m).
- Surgery is £1.8m overspent due to overspends mainly within Nursing £0.4m (Gen Surg) and medics £0.4m (Anaesthetics) and Critical Care/Theatres (£0.4m).
- WCCSS is overspent by £1.0m driven by medical staffing overspends (£0.4m) mainly Paediatrics and non delivery of CIP (£0.4m).
- Corporate divisions overall are underspent by £0.8m. The underspend mainly coming from Informatics is as a result of staff vacancies.
- Central Reserves shows a favourable variance. It should be noted that in arriving at the YTD position, £1.3m of RTT reserves is utilised leaving a balance of £0.3m remaining.
- The overall income position is down against plan, the underperformance largely a consequence of reduced Obstetric and outpatients activity.

Temporary staffing by Type: April 2017 to December 2017 (Month 9)

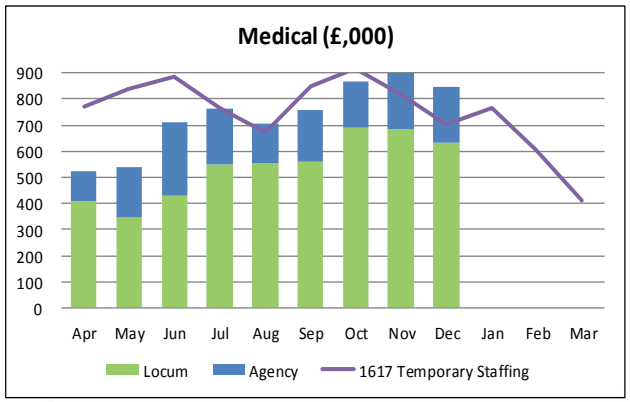


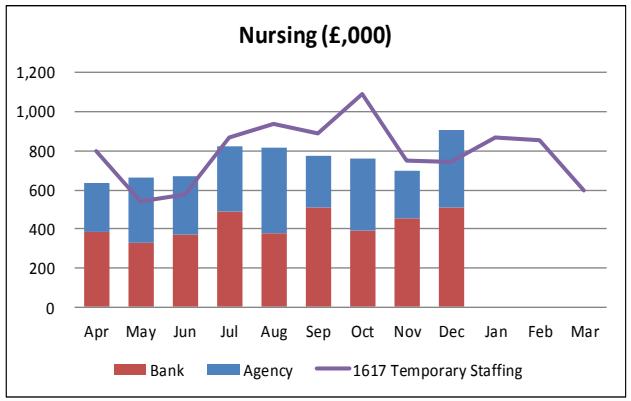
Commentary

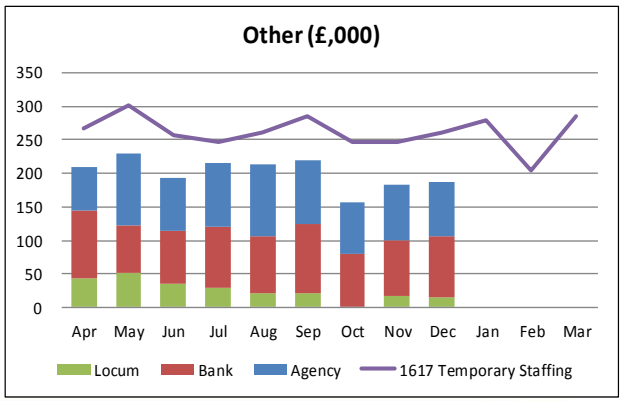
- Temporary staff costs totalled £1.935m in December 2017 (£1.710m December 2016), of which agency is £0.686m.
- NHS Improvement target for the Trust is to spend no more than £7.0m on agency in 2017/18. The Trust originally planned for agency spend to total £8.2m,
- The Table below shows an annual forecast using the agency target and extrapolating the balance of temporary worker spending:-

Description	2017/18		*2016/17*
	Dec YTD £000's	Annual £000's	*Annual £000's*
Temporary worker	15,266	22,484	*21,649*
Agency	5,544	8,670	*10,932*

- In 2017/18, NHSI has set the Trust a target to reduce Medical agency spend by £1.2m against the 2016/17 outturn of £4.85m (this does not affect our agency spend ceiling of £7.0m)







Temporary Staffing Expenditure: April 2017 to December 2017 (Month 9)

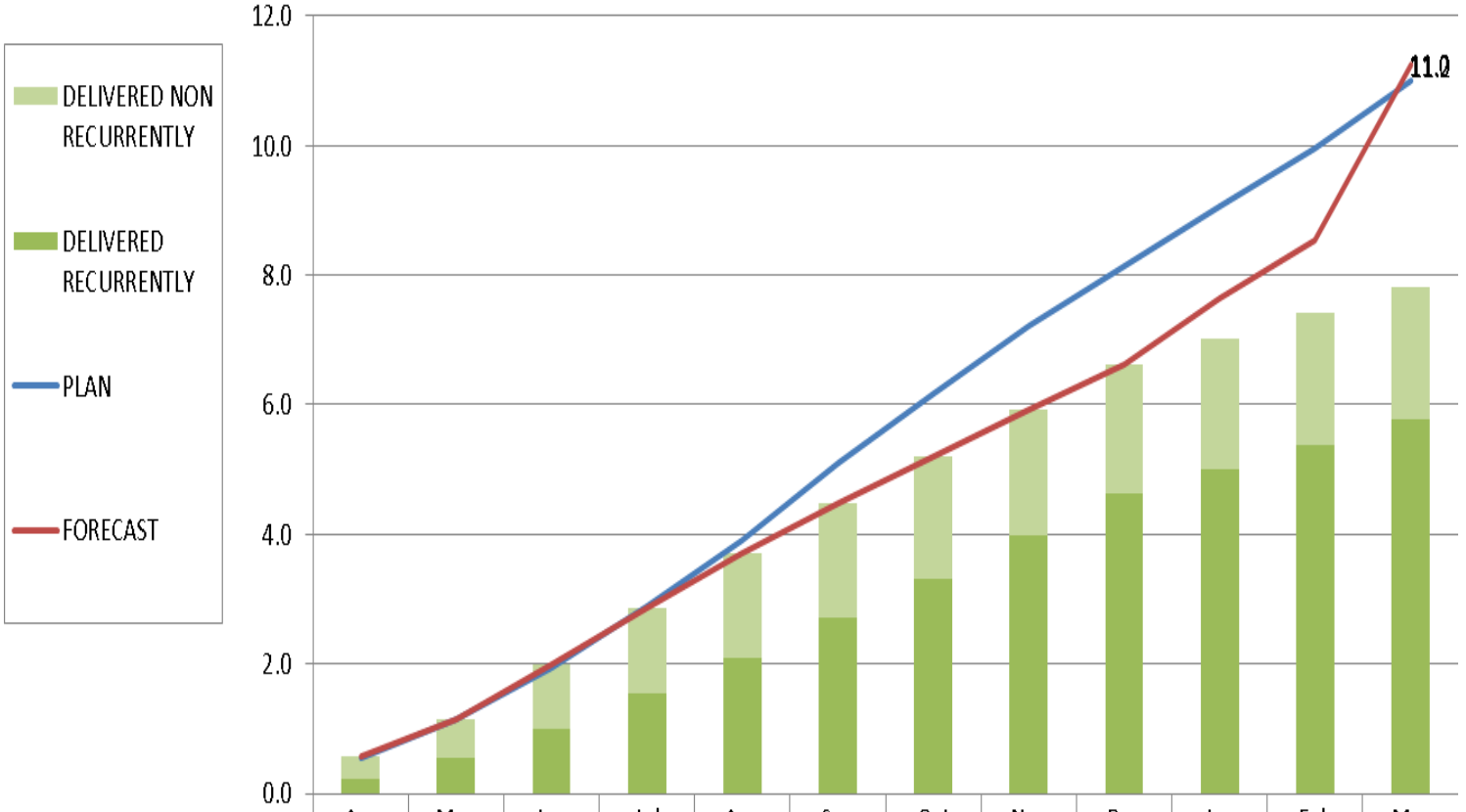
Agency	16/17					17/18									
	Dec	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	400	272	269	156	4,852	114	189	280	213	153	194	174	317	215	1,848
PTB	17	36	13	21	345	6	18	21	19	23	11	15	-6	1	108
Nursing & Midwifery	267	442	420	220	4,284	247	330	301	332	432	264	367	244	392	2,910
Other Staff Groups	135	133	83	152	1,452	59	87	59	77	84	83	62	89	78	678
Agency Total This Year	**820**	**883**	**784**	**548**	**10,932**	**426**	**625**	**660**	**641**	**692**	**553**	**618**	**644**	**686**	**5,544**
Monthly Movement	(10)	63	(98)	(236)		(123)	199	35	(19)	51	(139)	65	26	42	

Bank	16/17					17/18									
	Dec	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PTB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nursing & Midwifery	478	428	435	377	5,230	386	330	370	489	382	511	393	454	512	3,827
Other Staff Groups	84	73	71	80	970	101	72	79	91	85	104	79	83	93	787
Bank Total This Year	**562**	**501**	**506**	**458**	**6,200**	**487**	**402**	**449**	**580**	**466**	**616**	**473**	**537**	**605**	**4,614**
Monthly Movement	48	(61)	5	(48)		29	(85)	46	131	(114)	149	(143)	64	68	

Locum	16/17					17/18									
	Dec	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Staff Group	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Medical Staff	302	493	334	252	4,138	411	348	430	551	553	561	691	683	630	4,858
PTB	25	39	38	31	376	43	51	35	30	22	21	16	17	14	248
Nursing & Midwifery	0	0	0	0	0	0	0	0	0	0	0	0		0	0
Other Staff Groups	0	-0	0	1	3	0	0	0	0	0	0	0		0	1
Locum Total This Year	**328**	**532**	**372**	**285**	**4,517**	**454**	**399**	**465**	**581**	**575**	**582**	**707**	**700**	**644**	**5,108**
Monthly Movement	(140)	204	(159)	(88)		169	(55)	66	116	(6)	7	125	(7)	(56)	

Grand Total	**1,710**	**1,916**	**1,663**	**1,291**	**21,649**	**1,367**	**1,426**	**1,574**	**1,802**	**1,733**	**1,750**	**1,798**	**1,881**	**1,935**	**15,266**
Total Monthly Movement	(102)	206	(253)	(372)		76	60	147	228	(69)	17	47	83	54	

Cost Improvement Target Achievement: April 2017 to December 2017 (Month 9)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DELIVERED NON RECURRENTLY	0.3	0.6	1.0	1.3	1.6	1.8	1.9	2.0	2.0	2.0	2.0	2.0
DELIVERED RECURRENTLY	0.2	0.5	1.0	1.5	2.1	2.7	3.3	4.0	4.6	5.0	5.4	5.8
PLAN	0.6	1.2	1.9	2.9	3.9	5.1	6.2	7.2	8.1	9.0	9.9	11.0
FORECAST	0.6	1.2	2.0	2.9	3.7	4.5	5.2	5.9	6.6	7.6	8.5	11.2

Headlines & Commentary

Cost Improvement Programme Target for 2017/18 is £11m.

YTD Delivery

- Year to Date delivery at month 9 totalled £6.6m against a plan of £8.1m, giving an under-delivery of £1.5m
- Of the total savings achieved £2m is delivered non-recurrently

Full Year Plan

- The full year delivery forecast totals £11.2m with a number of schemes still remaining as medium to high risk.
- Work continues with the FIP(2) programme to support the delivery of future schemes.
- £7.8m has been delivered full year for 2017/18 of which £5.8m has been delivered recurrently.

Capital Programme

Capital Schemes	2017/18 Plan £'000	Actual Expenditure 2017/18 £'000	Remaining Balance £'000
Estate			
Life cycle – estate maintenance	2,006	921	1,085
Integrated Critical Care Unit	7,800	3,356	4,444
Maternity	5,200	74	5,126
Accident & Emergency	2,000	53	1,947
Pharmacy Retail Development	0	0	0
Treatment Rooms	0	0	0
Medical Equipment Replacement	800	175	625
Gamma Camera	300	416	(116)
Information Management & Technology			
Hardware & Software	400	131	269
Total Mobile	0	537	(537)
Contribution to SLR	0	0	0
Total Cost of Capital Schemes	**18,506**	**5,663**	**12,843**

Commentary

- The Trust's capital expenditure totals £5.7m as at the 31st December 2017. This is below plan mainly due to the delay in the commencement of the ICCU, A&E and Maternity schemes.
- The Gamma Camera is also part funded through a League of Friends donation and the Trust's Charitable Funds.
- The Outline Business Case for the A&E development has been submitted to NHS Improvement for review.
- A review of the programme will be completed to confirm the required capital resource limit with NHSI.

Statement of Financial Position

Statement of Financial Position	as at 31/03/17	as at 31/12/17	Movement
	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	133,168	133,853	685
Intangible Fixed Assets	1,010	1,097	87
Total Non-Current Assets	**134,178**	**134,950**	**772**
Current Assets			
Receivables less than one Year	14,603	24,208	9,605
Cash (Citi and Other)	1,705	1,526	(179)
Inventories	2,107	2,216	109
Total Current Assets	**18,415**	**27,950**	**9,535**
Current Liabilities			
NHS Payables less than one year	(6,561)	(3,813)	2,748
Payables less than one year	(22,896)	(33,980)	(11,084)
Borrowings less than one year	(31,183)	(54,188)	(23,005)
Provisions less than one year	(420)	(420)	-
Total Current Liabilities	**(61,060)**	**(92,401)**	**(31,341)**
Net Current Assets less Liabilities	**(42,645)**	**(64,451)**	**(21,806)**
Non-current Assets			
Receivables greater than one year	1,119	1,194	75
Non-current liabilities			
Borrowings greater than one year	(131,346)	(128,729)	2,617
Total Assets less Total Liabilities	**(38,694)**	**(57,036)**	**(18,342)**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	56,318	58,318	2,000
Revaluation	12,752	12,607	(145)
Income and Expenditure	(107,764)	(107,619)	145
In Year Income & Expenditure	0	(20,342)	(20,342)
Total TAXPAYERS' EQUITY	**(38,694)**	**(57,036)**	**(18,342)**

Commentary

Non Current Assets

- The movement year to date is due to the capital expenditure incurred.

Current Assets

- Receivables have increased by £9.54m since 31st March 2017. Invoiced debtors has increased by £0.6m net in month and primarily reflects monthly SLAs with the Trust's main commissioner, prior year reconciliation issues, invoicing for M8 drugs and M6 maternity pathways.
- Cash is £0.2m lower than the balance at 31st March 2017 as the Trust attempts to reduce the level outstanding creditor balances.

Current Liabilities

- Payables have increased by £8.3m net, and primarily reflects the delays in cash settlement of creditor invoices due to cumulative effect of continued overspending. The Trust has taken deficit loan support of £23.0m in year at the end of December.

Provisions

- The balance of provisions has remained unchanged in April and reflects the non-clinical provisions held by the NHSLA, and a fines provision.

Tax Payers' Equity

- Income & Expenditure reflects the current deficit of £20,342k and shows the brought forward balances on the revaluation reserve and Income & Expenditure Reserve.

Cash Flow Statement

	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	(13,635)
Depreciation and Amortisation	5,142
Donated Assets Received credited to revenue but non-cash	(248)
Fixed Asset Impairments	0
(Increase)/Decrease in Trade and Other Receivables	(9,682)
Increase/(Decrease) in Trade and Other Payables	9,027
Increase/(Decrease) in Stock	(109)
Increase/(Decrease) in Provisions	0
Interest Paid	(6,720)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	(16,225)
Cash Flows from Investing Activities	
Interest received	14
(Payments) for Property, Plant and Equipment	(6,356)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow)from Investing Activities	(6,342)
Net Cash Inflow/(Outflow) before Financing	(22,567)
Cash Flows from Financing Activities	22,388
Net Increase/(Decrease) in Cash	(179)
Cash at the Beginning of the Year 2016/17	1,705
Cash at the End of the Month	**1,526**

Commentary

Cash Flow

- The Trust made an adjusted operating deficit of £13,635k at the end of December and received cash of £5,142k in respect of depreciation and amortisation.
- Trade and Other Receivables increased over the period (a negative impact on cash).
- Trade and Other Payables increased over the period (a positive impact on cash).
- The Trust spent a total of £6,356k in relation to payments for outstanding capital projects from 2016/17 and current 2017/18 projects.
- The Trust has received a total of £23.0m against the temporary borrowing loan facility by the end of December to support working capital payments, and £2.0m in returned PDC.

BOARD/COMMITTEE REPORT

Meeting	**Trust Board**	**Date:** 1st February 2018
Report Title	Performance and Quality Report for December 2017	**Agenda Item: 18** **Enclosure No.: 16**
Lead Director to Present Report	Director of Finance & Performance, Russell Caldicott	
Report Author(s)	Head of Performance & Strategic Intelligence - Alison Phipps	
Executive Summary	The report format aligns all of the indicators to the organisational strategic objectives. **SUMMARY OF THE KEY POINTS:** Areas of note are:- 1. **A&E: Time Spent in A&E (within 4 hours): Target 95%:** Although performance improved to 83.38% compared to 82.03% in November it remained below the trajectory of 87%. 2. **Ambulance Handover:** The number of delayed ambulance handovers significantly increased in December to 281 compared to 130 in November, of these the number delayed by more than 1 hour also increased to 35 from 8. 3. **Cancer** – All national cancer metrics achieved in November. The 62 day consultant upgrade local target failed to achieve, reporting 87.84% against a 91% target. Unvalidated performance for December shows achievement of all metrics with the exception of 62 day consultant upgrade. 4. **18 Weeks Referral to Treatment Incomplete: Target 92%:** December's performance declined to 80.99%, the lowest reported since returning back to national submissions. There was 1 patient waiting more than 52 weeks in December on an incomplete pathway. 5. **Diagnostic waits:** This achieved the 99% target (99.05%). 6. **HSMR (HED) & SHMI** - September HSMR rate was 78.27. August SHMI changed to 95.43 from 87.86 in July. There were 137 deaths in December. 7. **Infection Control** – There were 4 reported cases of C Difficile and no MRSA. 8. **Pressure Ulcers – (category 2, 3 & 4's) – Avoidable per 1000 beddays** – The rate for October was 0.61. 9. **Falls** - The rate of falls per 1000 bed days declined to 5.79 from 5.50 in December but was within the target of 6.63. There was 1 fall resulting in serious injury. 10. **Open Contract Performance Notices** – Six remain open in December. 11. **CQUINS** – Work continues on schemes for 2017-19. A forecast summary is included.	

Purpose	**Approval**	**Decision**	**Discussion**	**Note for Information**
	☒	☐	☒	☐

<table>
<tr><td><u>Recommendation</u></td><td colspan="2">The Committee is asked to NOTE the content of the paper and DISCUSS any areas of concern.</td></tr>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>As above</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>As above</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>As above</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>As above</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table>
<tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr>
<tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr>
<tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr>
</table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Areas of significant underperformance are expected to be reported within Corporate/Divisional Risk registers.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Not applicable to this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Many of the metrics are defined within the national NHS contracts and contracts agreed with Commissioners.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">Trust Performance and Finance Executive – 16/01/2018
Trust Quality Executive – 19/01/2018
Quality and Safety Committee – 25/01/2018</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The Performance and Quality Report is shared with all Commissioners as part of a contractual requirement.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

Walsall Healthcare NHS
NHS Trust

Performance & Quality Report

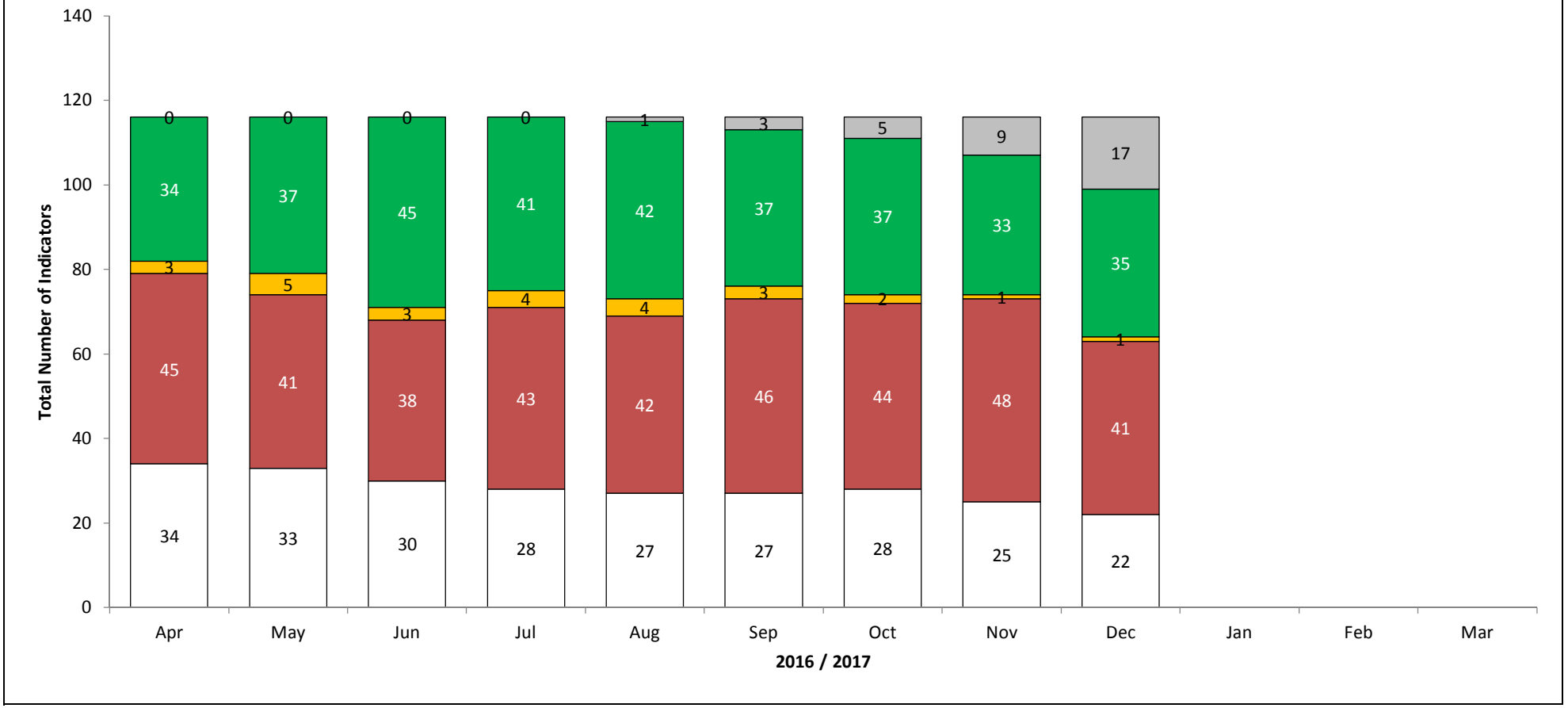
January 2018
(December 2017 Results)

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

Becoming your partners for first class integrated care

Contents

TRUST PERFORMANCE FRAMEWORK



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

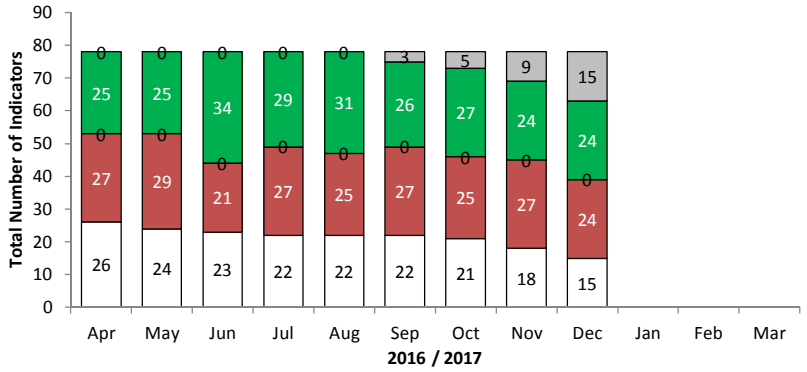
Minor Variance from Plan

Achieving Target or On Plan

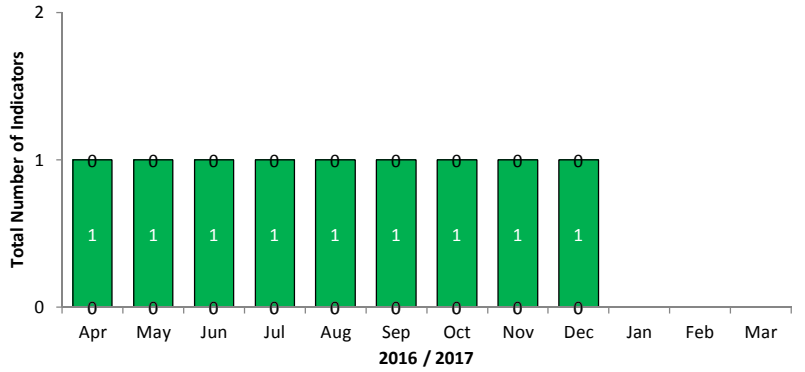
Indicators reported in Arrears or not yet available in Month

TRUST STRATEGIC VALUES FRAMEWORK

Provide Safe, High Quality Care Across All Our Services



Care For Patients at Home Whenever We Can



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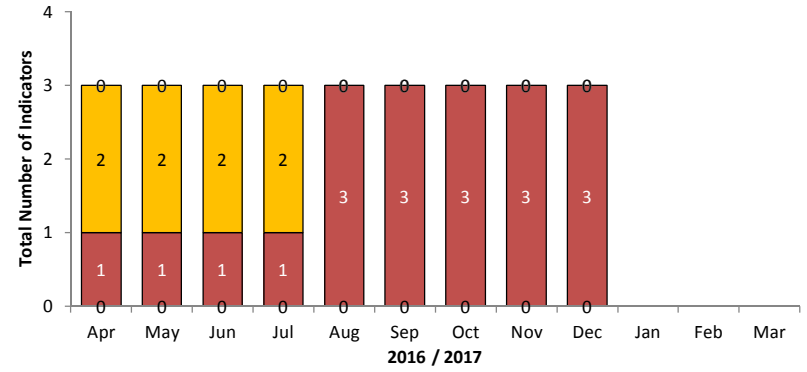
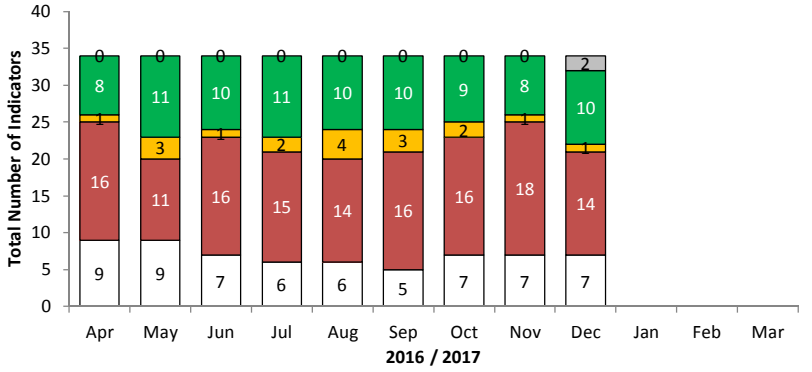


Use Resources Well to Ensure We Are Sustainable



Indicators with No Targets

Failing to meet Target or Major Variance from Plan

Minor Variance from Plan

Achieving Target or On Plan

Indicators reported in Arrears or not yet available in Month

Walsall Healthcare NHS
NHS Trust

Quality and Safety Committee

Becoming your partners for first class integrated care

Quality & Safety Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Quality & Safety Committee

PERFORMANCE ACHIEVED – OF NOTE: There was a significant reduction in the number of serious incidents (Hospital acquired) from 16 in November to 9 in December.

PERFORMANCE NOT ACHIEVED: There was a decline in the number of mixed sex accommodation breaches in December from 6 to 9 however this was within the monthly trajectory of 11. The number of cases reported for C Difficile increased to 4 in December. There were 9 avoidable category 3 and 4 pressure ulcers reported for October. The was one fall resulting in severe harm in December. VTE final validated position is due 25th January, although it is unlikely to achieve the 95% target it is anticipated to report a significant improvement. Although there was a decrease in the number of serious incidents (Community acquired) from 5 in November to 4 in December, this failed to achieve the monthly trajectory of 3. One to one care in established labour did not achieve the 100% target with performance of 98.91%. C-Section rates exceeded the 30% target in December at 32.86%. Emergency Readmissions within 30 days did not achieve in November with performance of 10.35%. EDS compliance failed to achieve however improved to 89.73%. Dementia screening declined significantly to 44.47%, against a target of 90%, however methodology to determine performance of this metric is still under review. 6 FFT areas failed to achieved. This is the same as last month.

TO NOTE:
The number of deaths significantly increased during December from 80 in November to 137. There remains one new metric which has been defined and reporting will commence from next month. The percentage of medication incidents resulting in harm has temporarily been removed from the dashboard, whilst a validation process is established to align the numbers reported between pharmacy and safe guarding. It is anticipated that this will be completed for Q4.

NONE APPLICABLE

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED – OF NOTE: Total births continue to be below the expected number.

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE

2017-2018

		JUL	AUG	SEP	OCT	NOV	DEC	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
no	Sleeping Accommodation Breaches	2	15	4	7	6	9	**53**	0	**105**	N
no..	HSMR (HED)	99.31	96.58	78.27				**93.69**	100.00		N
no..	SHMI (HED)	87.86	95.43						100.00		BP
no	Number of Deaths in Hospital	80	91	63	86	80	137	**802**		**1123**	BP
%..	% of patients who achieve their chosen place of death	47.62%	34.78%	58.82%	66.00%	73.81%	46.30%	**54.39%**			
no	MRSA - No. of Cases	0	0	0	0	0	0	**0**	0	**0**	N
no	Clostridium Difficile - No. of cases	2	0	2	1	0	4	**11**	18	**21**	N
%..	Percentage of patients screened for Sepsis (CQUIN audit - quarterly)	93.59%	93.59%	93.48%				**93.70%**	90.00%		
no..	Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	0.39	0.37	0.35	0.61						BP
no	Pressure Ulcers - No. of Avoidable (category 2, 3 & 4's) - Trust	6	6	5	9				0	**19**	BP
no	Pressure Ulcers - (category 2, 3 & 4's) - Hospital	11	7	5	14					**167**	
no	Pressure Ulcers - (category 2, 3 & 4's) - Community	19	19	12	16					**143**	
no	Falls - Total reported	84	89	98	96	83	95	**760**		**932**	BP
no..	Falls - Rate per 1000 Beddays	5.42	5.55	6.80	6.46	5.50	5.79		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	2	0	1	0	2	1	**7**	0	**22**	BP
no	Falls - Avoidable Falls resulting in severe harm or injury	0	0					**0**	0	**4**	BP
no	Falls - Unavoidable Falls resulting in severe harm or injury	0	0					**0**			BP
%..	VTE Risk Assessment	79.28%	88.30%	90.75%	90.45%	89.95%		**86.18%**	95.00%	**90.90%**	N
no	National Never Events	1	0	0	0	1	0	**2**	0		N
no	Local Avoidable Events	0	0	0	0	0	0	**0**	0		L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	10	6	6	7	16	9	**89**	102	**102**	L
no	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	10	7	5	4	5	4	**60**	50	**49**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	21	17	18	22	31	28	**198**		**218**	L
no	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	8	6	4	10	4	2	**61**		**55**	L
%..	% of incidents resulting in moderate, severe harm or death as a % of total incidents	2.83%	2.19%	2.29%	3.06%	3.27%	3.09%	**2.76%**		**2.41%**	L
%..	Deteriorating patients: Percentage of observations rechecked within time	90.67%	90.13%	89.80%	91.30%	90.16%	88.19%	**90.20%**	85.00%		
%..	Medication Storage Compliance			95.00%	95.00%	95.00%		**95.00%**			
%..	Controlled Drug Compliance (quarterly audit)			80.50%				**80.50%**			
%..	% of Pharmacy Interventions made based on charts reviewed				20.15%	20.00%	26.56%	**22.61%**			
no..	Midwife to Birth Ratio	1:27.9	1:29.2	1:28.1	1:25.7	1:25.4	1:25.4	**1:25.4**	1:28	**1:30.6**	N
%..	One to One Care in Established Labour	96.23%	93.62%	95.50%	99.07%	98.96%	98.91%		100.00%	**100.00%**	N
%..	C-Section Rates	25.62%	27.96%	26.84%	25.77%	28.62%	32.86%		30.00%		

Walsall Healthcare NHS Trust

QUALITY AND SAFETY COMMITTEE

2017-2018

		JUL	AUG	SEP	OCT	NOV	DEC	YTD Actual	17/18 Target	16/17 Outturn	Key
%..	Instrumental Delivery	8.43%	12.20%	12.83%	11.95%	11.47%	8.93%				
%..	Induction of Labour	29.94%	36.17%	33.89%	35.74%	33.33%	33.45%				
%..	NHS Safety Thermometer - Maternity - Women's Perception of Safety	80.80%	82.40%	100.00%	96.20%	64.30%	95.50%				
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital	9.27%	10.64%	11.43%	10.75%	10.35%		**10.41%**	10.00%		L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	87.76%	88.03%	87.35%	88.30%	85.38%	89.73%	**88.86%**	100.00%	**88.40%**	N/L
%..	Dementia Screening 75+ (Hospital)	53.03%	55.16%	49.07%	60.52%	44.47%		**56.86%**	90.00%	**87.24%**	N
no..	MCA Stage 2 Compliance Metric (New metric under development)										
no	Complaints - Total Received	23	33	23	22	15	13	**211**		**327**	BP
%..	Complaints - Percentage responded to within the agreed timescales	82.61%	100.00%	96.30%	100.00%	92.00%	100.00%	**82.40%**	70.00%	**47.75%**	BP
no	Clinical Claims (New claims received by Organisation)	15	10	8	13	9	10	**99**		**124**	L
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	**0**	0		N
%..	Number of RN staffing Vacancies Metric	10.90%	11.08%	10.94%	9.74%	8.85%	9.78%	**9.78%**			
%..	Friends and Family Test - Inpatient (% Recommended)	95.00%	97.00%	94.00%	95.00%	92.00%	91.00%	**95.00%**	96.00%		N
%..	Friends and Family Test - Outpatient (% Recommended)	91.00%	90.00%	91.00%	91.00%	90.00%	91.00%	**91.00%**	96.00%		N
%..	Friends and Family Test - ED (% Recommended)	76.00%	77.00%	75.00%	73.00%	76.00%	77.00%	**76.00%**	85.00%		N
%..	Friends and Family Test - Community (% Recommended)	97.00%	98.00%	97.00%	97.00%	99.00%	99.00%	**97.00%**	97.00%		N
%..	Friends and Family Test - Maternity - Antenatal (% Recommended)	82.00%	88.00%	88.00%	73.00%	82.00%	80.00%	**82.00%**	95.00%		N
%..	Friends and Family Test - Maternity - Birth (% Recommended)	95.00%	100.00%	88.00%	89.00%	94.00%	83.00%	**95.00%**	96.00%		N
%..	Friends and Family Test - Maternity - Postnatal (% Recommended)	65.00%	83.00%	92.00%	100.00%	79.00%	85.00%	**65.00%**	92.00%		N
%..	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	89.00%	71.00%	100.00%	87.00%	100.00%	100.00%	**89.00%**	97.00%		N
	RESOURCES										
no	Total Births	332	336	304	293	279	280	**2781**	4200	**4190**	L

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Becoming your partners for first class integrated care

Performance, Finance & Investment Committee – Key Messages

Please refer to dashboard and exception pages for further detail

Performance, Finance & Investment Committee

PERFORMANCE ACHIEVED – OF NOTE: All national Cancer measures (7) achieved in November.
PERFORMANCE NOT ACHIEVED: The ED 4 hour performance improved to 83.38%., it is worth noting that attendances at the WiC have been included with effect from the 1st December. ED median waiting time was slightly longer in December. The number of delayed ambulance handovers significantly increased in December to 281 compared to 130 in November, of these the number delayed by more than 1 hour also increased to 35 from 8. Cancer 62 day consultant upgrade failed to achieve the current local target in November and unvalidated performance for December also forecasts a fail. 18 weeks Incomplete RTT for December declined to 80.99%, this is the lowest reported performance since resuming national submissions in November 2016. There was 1 patient reported as waiting more than 52 weeks at the end of December. The percentage of stroke patients who spent 90% or more of their stay on a stroke unit failed to achieve for the third consecutive month. The number of open contract notices remained at 6.
TO NOTE: Applying the national cancer breach allocation guidance to the 62 day cancer targets for the validated November results would have resulted in a fail against the 62Day GP target of 85%. The national cancer breach allocation guidance aims to provide a fairer method of cancer breach allocation when treatment is delayed between referring and treating organisations involved in the cancer pathway. Initial unvalidated performance for December shows achievement of all national cancer measures.

NOTHING OF NOTE.

NONE APPLICABLE.

PERFORMANCE ACHIEVED – OF NOTE: Delayed transfers of care achieved the 2.5% target in December (2.16%).

PERFORMANCE NOT ACHIEVED: DNA Rates for Acute and Community did not achieve the monthly trajectory of 9.37% with performance of 14.36%, the highest rate recorded this financial year. Length of stay increased from 7.06 to 7.51 days.

FINANCE: Please refer to Finance report.

TO NOTE: Theatre Utilisation for December will be reported next month following the completion of a new monthly "touch utilisation" report.

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		JUL	AUG	SEP	OCT	NOV	DEC	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)	82.34%	80.72%	81.82%	82.75%	82.03%	83.38%	**82.86%**	95.00%	**84.10%**	N
no	Total time spent in ED - No. of Trolley waits over 12 hours	0	0	1	0	0	0	**3**	0	**2**	N
no	Median Waiting Time in ED Metric (average in mins)	174	177	179	177	171	179		120		
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	62.06%	60.21%	69.33%	62.19%	70.04%	58.42%	**65.39%**	100.00%	**65.44%**	BP
no	Ambulance Handover - No. of Handovers completed between 30-60mins	166	144	110	193	122	246	**1325**	0	**1765**	N
no	Ambulance Handover - No. of Handovers completed over 60mins	24	16	4	35	8	35	**169**	0	**249**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment	96.79%	93.82%	94.49%	97.13%	95.88%	97.64%	**95.04%**	93.00%	**96.12%**	N
%..	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	96.97%	93.65%	94.92%	97.14%	96.88%	100.00%	**96.14%**	93.00%	**96.15%**	N
%..	Cancer - 31 day second or subsequent treatment (surgery)	94.44%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.57%**	94.00%	**99.07%**	N
%..	Cancer - 31 day second or subsequent treatment (drug)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	98.00%	**100.00%**	N
%..	Cancer - 31 day diagnosis to treatment	99.05%	98.08%	100.00%	100.00%	100.00%	100.00%	**99.34%**	96.00%	**99.16%**	N
%..	Cancer - 62 day referral to treatment from screening	100.00%	95.65%	100.00%	100.00%	100.00%	100.00%	**97.48%**	90.00%	**96.20%**	N
%..	Cancer - 62 day referral to treatment of all cancers	87.18%	94.51%	86.05%	87.65%	85.51%	86.25%	**87.98%**	85.00%	**87.10%**	N
%..	Cancer - 62 day referral to treatment from consultant upgrade	88.68%	85.32%	85.53%	82.89%	87.84%	80.85%	**86.05%**	91.00%	**92.03%**	N
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	85.02%	84.74%	85.06%	84.75%	83.57%	80.99%		92.00%		N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	2	1	2	1	1	**12**	0	**97**	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Admitted	1	1	3	1	1	0	**8**	0	46	N
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Not Admitted	1	0	2	0	1	0	**8**	0	165	N
%..	Diagnostic Waits - % waiting under 6 weeks	99.78%	99.42%	99.05%	99.64%	99.53%	99.15%	**99.08%**	99.00%	**99.24%**	N
%..	Elective Cancellations - No. of last minute cancellations on day of operation or after patient admission	0.24%	0.37%	0.44%	0.73%	0.58%	0.51%	**0.49%**	0.75%	**0.65%**	N
no	Elective Cancellations - No. of last minute cancellations not rebooked within 28 days	0	0	0	0	0	0	**0**	0	**3**	N
no	No urgent op to be cancelled for a second time	0	0	0	0	0	0	**0**	0		N
%..	Stroke - % of Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	82.14%	86.67%	80.65%	77.27%	78.95%	74.29%	**82.87%**	80.00%	**89.42%**	BP/SS
no	Rapid Response Team - Avoidable admissions	175	180	176	206	237		**1478**			
no..	FES Avoided Admissions Metric (New metric under development)										
%..	Number of RN staffing Vacancies Metric	10.90%	11.08%	10.94%	9.74%	8.85%	9.78%	**9.78%**			
no	No. of Open Contract Performance Notices	7	9	9	6	6	6	**6**	0	**6**	L
	CARE AT HOME										
%..	ED Reattenders within 7 days	6.80%	6.68%	6.98%	6.89%	6.50%	7.00%	**6.80%**	7.00%	**7.03%**	BP
	RESOURCES										
%..	Clinic Utilisation Rate	88.75%	85.59%	87.07%	92.27%	92.15%	91.14%	**89.49%**	90.00%	**87.27%**	L
%..	Outpatient DNA Rate (Acute and Community)	12.43%	12.29%	11.98%	11.99%	11.77%	14.36%	**12.41%**			
no..	New to follow up ratio - WHT	2.08	1.94	1.83	1.94	1.93	2.03	**1.96**	2.14	**1.95**	BP
%..	Theatre Utilisation - Overall In Session Utilisation (%)	81.07%	88.47%	89.13%	87.58%	75.44%			85.00%	**81.91%**	BP

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

2017-2018

Safe, high quality care | Care at home | Partners | Value colleagues | Resources

		JUL	AUG	SEP	OCT	NOV	DEC	YTD Actual	17/18 Target	16/17 Outturn	Key
no..	Length of Stay	6.51	6.90	6.80	6.46	7.06	7.51	7.09	7.01	7.32	BP
%..	Delayed transfers of care	1.50%	1.22%	1.58%	3.16%	3.27%	2.16%	2.26%	2.50%	2.35%	L
no	Hospital beds open at month end	457	443	435	468	468	483			470	L
%..	Day case rates	86.73%	88.06%	87.42%	88.41%	90.32%	88.82%	87.97%		87.98%	BP
%..	Bank & Locum expenditure as % of Paybill	7.88%	7.24%	8.26%	8.11%	8.48%	8.53%	7.45%	6.30%	6.22%	L
%..	Agency expenditure as % of Paybill	4.35%	4.81%	3.81%	4.25%	4.41%	4.69%	4.25%	2.75%	6.35%	L
£	Surplus or Deficit (year to date) (000's)	-£9,565	-£10,918	-£11,361	-£14,923	-16976	-£20,342	-£20,342		-£21,392	L
£	Variance from plan (year to date) (000's)	-£739	-£1,285	-£1,872	-£2,088	-3093	-£3,991	-£3,991		-£15,192	L
£	CIP (£) (000's)	£2,858	£3,701	£4,476	£5,180	£5,924	£6,620	£6,620	£560	£6,600	L
%..	CIP % delivered (year to date)	42.76%	57.80%	61.00%	64.00%	68.00%	71.00%	71.00%	100.00%	71.00%	L
£	Income variance from plan (year to date) (000's)	-£189	-£226	-£877	£456	£653	£464	£464	£0	-£5,423	L
£	Expenditure - Variance from Plan (year to date) (000's)	-£555	-£1,016	-£941	£1,500	£2,245	£4,271	£4,271	£0	-£9,537	L
£	Cash Against Plan (variance) (000's)	£1,085	£32	£111	£94	£858	£526	£526		£700	L
£	Capital spend YTD (000's)	£2,502	£2,969	£3,415	£4,031	£4,818	£5,663	£5,663		£4,660	L
no	Monitor Risk Rating (Actual YTD)	1	1	1	1	1	1	1	3	1	BP
no	Total Referrals (Contracted)	8541	8324	7887	8449	7699		65550		89125	BP
no	Total Elective Activity (Contracted)	306	288	299	290	275	218	2894		3422	L
no	Total Non Elective Activity (Contracted)	58	56	27	34	53	138	577		689	L
no	Total Outpatient attendances (Contracted)	19157	18588	19189	20653	20830	15371	171185		248452	L
no	Total Day Case Activity (Contracted)	1912	1826	1893	1957	2147	1500	16513		21515	L
no	Total Emergencies Activity (Contracted)	2640	2605	2649	2845	2747	2689	23812		30275	L
no	Total ED Attendances Type 1 Pbr (Excl Badger) (Contracted)	5974	5935	6232	6637	6417	6577	54803		64686	L
no	Total AHP Activity (Contracted)	1737	1774	1736	1846	2145	1337	15748		24338	L
no	Total Critical Care Days (Contracted)	911	921	904	994	863	1232	8733		10760	L
no	Total Unbundled Chemo Delivery Activity (Contracted)	326	331	350	359	359	241	2843		3425	L
no	Total Maternity Pathway	1019	1146	1046	1083	894	720	8909		12382	L
no	Total Community Contacts (Contracted)	19930	19657	18184	21720	20614	13823	256781	379962	344377	L
no	Total Births	332	336	304	293	279	280	2781	4200	4190	L

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

Walsall Healthcare NHS
NHS Trust

People and Organisational Development Committee

Becoming your partners for first class integrated care

People & Organisational Development Committee – Key Messages

Please refer to dashboard and exception pages for further detail

People & Organisational Development Committee

NOTHING OF NOTE.

NONE APPLICABLE

PERFORMANCE NOT ACHIEVED: Sickness absence and PDR compliance both declined in December. Mandatory training slightly improved but remains below the compliance target.

FINANCE: Turnover remains within target. Please refer to Finance report for further details.

Walsall Healthcare NHS Trust

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

2017-2018

		JUL	AUG	SEP	OCT	NOV	DEC	YTD Actual	17/18 Target	16/17 Outturn	Key
	SAFE, HIGH QUALITY CARE										
%..	Number of RN staffing Vacancies Metric	10.90%	11.08%	10.94%	9.74%	8.85%	9.78%	**9.78%**			
	VALUE COLLEAGUES										
%..	Sickness Absence	4.75%	4.64%	4.73%	5.76%	5.55%	5.81%	**5.16%**	4.00%	**4.59%**	L
%..	PDRs	80.84%	77.74%	74.43%	75.19%	76.25%	75.90%	**75.90%**	90.00%	**84.66%**	L
%..	Mandatory Training Compliance	80.55%	79.73%	79.50%	79.71%	78.69%	79.65%	**79.65%**	90.00%	**80.71%**	L
	RESOURCES										
%..	Bank & Locum expenditure as % of Paybill	7.88%	7.24%	8.26%	8.11%	8.48%	8.53%	**7.45%**	6.30%	**6.22%**	L
%..	Agency expenditure as % of Paybill	4.35%	4.81%	3.81%	4.25%	4.41%	4.69%	**4.25%**	2.75%	**6.35%**	L
no	Staff in post (Budgeted Establishment FTE)	4153	4092	4097	4094	4073	4100	**4100**		**4201**	L
%..	Turnover	8.97%	9.25%	8.58%	8.79%	8.89%	8.93%	**8.93%**	10.00%	**9.39%**	L

Exception Pages

Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)

Walsall Healthcare NHS Trust

Total time spent in ED - % within 4 hours - Overall (Type 1, 3 and WiC)	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
Percentage of patients arriving in ED who are subsequently admitted or discharged within 4 hours of arrival	95.00%	87.00%	83.38%	82.86%	▲	

What is driving the reported underperformance?

Performance results:

Performance in December was 83.38% which is an improvement compared to 82.03% in November however below the agreed monthly trajectory of 87%.

Based on Calender Month	Oct-17	Nov-17	Dec-17
Type 1 attenders	6639	6416	6576
Type 3 attenders	3617	3324	3547
WiC attenders	-	-	3659
Breaches	1768	1747	2291
Admissions from ED	2193	2149	2253
% of Patients Admitted	33.03%	33.49%	34.26%
Ambulances to ED	2811	2713	2989
All Discharges	6246	6308	5435
Trolley Waits over 12 hours	0	0	0
ED Median Waits (mins)	177	171	179

In line with national agreement attendances at the Walk in Centre have been included within the calculated results as from 1st December.

The Trust was at escalation level 03 for 28 days which is a decline on the previous month (21).

- Average attendances per day were 212 compared to 214 (Nov)
- Average breaches per day were 74 compared to 58 (Nov)
- Admissions per day were 73 compared to 72 (Nov)
- Discharges per day were 175 compared to 210 (Nov)

There were significant daily variations in performance, at its lowest it was 76.21% and at its highest 93.22%.

Benchmarking:

For December, our position was 80th out of 133 and 6th out of 14 regionally compared to the previous month's respective ranks of 88th and 8th.

Contractual Status:

CQN/First Exception report remains open. Monthly penalties will be applied by WCCG £120 per breach based on the agreed trajectories. Fines for December equate to £33,000.

What actions have we taken to improve performance?

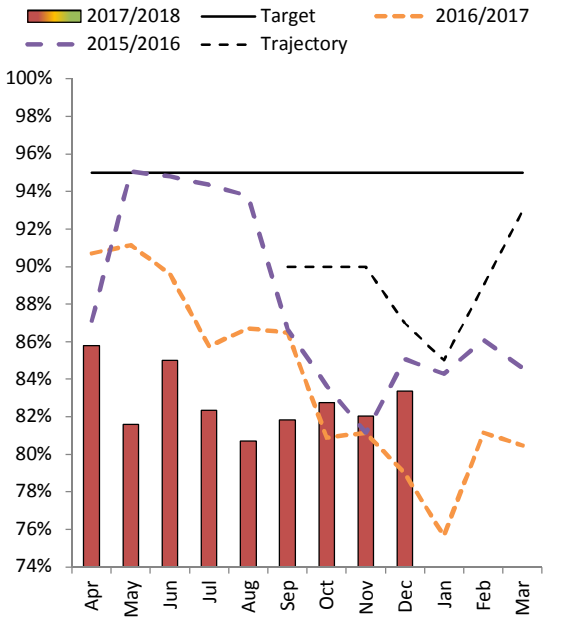
New Actions:

- A Patient Flow Steering Group has been established and is chaired by the COO. This has representation from all Divisions and is supported by Transformation Managers to develop key actions for improving patient flow.
- The Division of Surgery has relocated their Medical Day Case Unit. This move is the enabler to develop emergency pathways through the Surgical Assessment Unit.
- The Discharge Lounge has rellocated to a larger space on Ward 8. This is providing additional capacity to enable wards to make more early moves. The activity of the Discharge Lounge is being monitored through the Patient Flow Group.
- Plans are in place for the Emergency Care Intensive Support Team (ECIST) to visit the Trust as a "Critical Friend". Plans are in place for the team to review ED Pathways and Patient Flow across the Divisions. It is anticipated that they will provide recommendations that will be managed through the Patient Flow Group.

Continuing Actions:

- Ward Managers continue to attend Capacity Meetings throughout the day with the newly established Discharge Plans that are produced.
- General Managers continue to carry out daily rounds to the wards to support discharge planning and 7 day LOS review with clinicians.
- The Discharge Lounge continues to open from 9am (weekdays) to enable patients to move off wards earlier.
- Regular escalations continue with Health & Social Care to review the Medically Fit lists and continue to remove and reduce delays to discharge.
- An Acute Physician is still allocated to ED to support admission avoidance and assist in reducing trolley waits in ED.
- The ED Medical team continue to support the Ambulance Handover Nurse with Medical Led Triage during times of peak pressures and to support in reducing handover waiting times.

Contractual Financial Penalties — YTD £ £508,440



Trajectory					
Apr	May	Jun	Jul	Aug	Sept 90.00%
Oct 90.00%	Nov 90.00%	Dec 87.00%	Jan 85.00%	Feb 89.00%	Mar 93.00%
Expected date to meet standard	To Be Agreed				
Lead Director	Chief Operating Officer				

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Number of clinical ambulance handovers completed between 30 and 60 minutes of recorded time of arrival at ED Number of clinical ambulance handovers completed over 60 minutes of recorded time of arrival at ED	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
The number of clinical handovers completed over 30 minutes of recorded time of arrival at ED (Performance excludes ambulances with no handover time recorded)	0		246	1325	▼	
	0		35	169	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £	£434,000

Performance results:

246 ambulances had a recorded handover time between 30 to 60 minutes and 35 ambulances with a recorded handover time over 60 minutes. This is a very significant increase in numbers compared to 122 and 8 respectively recorded in November, however an improvement compared to December 201(

	Nov-17		Dec-17	
<15mins	1870	67.66%	1731	57.02%
15-30	670	24.24%	951	31.32%
30-60	122	4.41%	246	8.10%
>60	8	0.29%	35	1.15%
No Time	94	3.40%	73	2.40%
Total	2764		3036	

*Please note the percentages reported in the table above reflect all ambulances arriving to ED irrespective of whether or not a handover time was recorded, whereas the percentage reported on the main dashboard is calculated as a percentage of those ambulances where handover times were recorded.

Performance continues to be impacted upon by:

- Pin entry and no cubicle capacity due to peaks in capacity pressures (when ambulances arrive simultaneously).
- The average number of ambulance arrivals to ED per day in Dec was 98, which is an increase compared to 92 in Nov.
- There were over 90 ambulance arrivals to the department on 25 days during the month, an increase compared to Nov (19) and there were 15 days where the Trust saw over a 100 ambulances to ED which is almost double compared to the previous month (8).

Benchmarking:

The Trust is ranked 6th regionally out of 14 Trusts for December which is a decline when compared to the previous month ranking of 3rd.

Contractual Status:

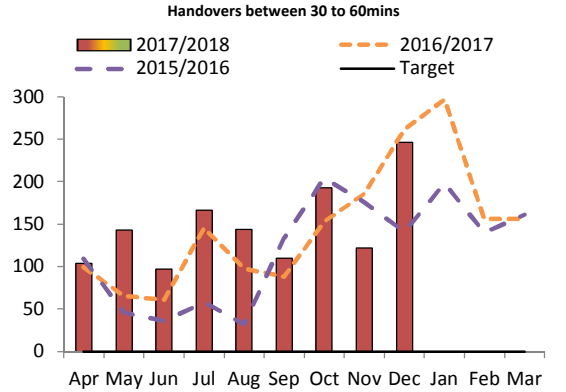
As stipulated in the national contract, £200 will be applied for every handover recorded between 30 and 60 minutes and £1,000 will be applied for any handover over 60 minutes. For December a fine of £84,200 will be incurred.

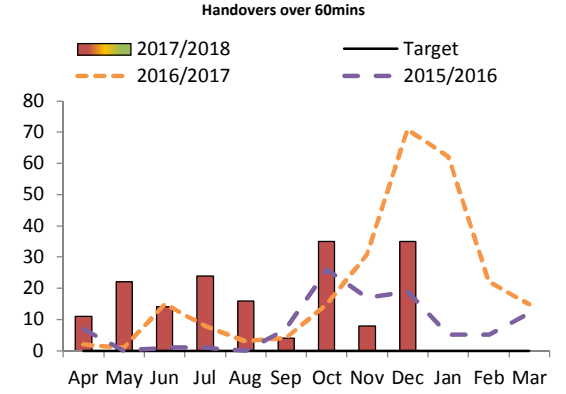
New Actions:

- Escalation actions have been in place over bank holiday and Christmas periods to support reducing the number of patients in ED waiting for beds. Protocols have been actioned to support both boarding and cohorting patients during times of increased pressures in ED.
- Additional nurse staff have been provided during times of increased pressures to support the care of boarded Patients in ED. This has supported the care of patients to enable the release of WMAS crews as quickly as possible.
- New High-Visability ID has been provided to the Ambulance Handover Nurse to assist the WMAS crews to easily identify the Handover Nurse when the ED has high capacity of patients.

Continuing Actions:

- The Discharge Lounge continues to open daily from 9am (on weekdays) to pull patients from wards and provide early capacity.
- The Ambulatory function for the FES has co-located with the AEC on Ward 29. The service supports a Frailty Model that will operate as a “front door” Assessment Unit and establish direct admissions from WMAS to avoid AMU admissions. Agreement to the details of wards and medical support is due.
- WMAS continue to attend the joint meeting with commissioners, WHT and Urgent Care Providers to support service improvements within ED and Urgent Care.
- Monthly ED dashboard and relevant analysis is discussed at the ED Senior Management Group meetings with particular focus on ambulance arrivals and ambulance handover.
- Patient details of re-attenders by ambulance continue to be shared with community teams to identify support that can be provided to safely avoid attendance to the ED.
- ED Medics continue to support medical led triage with WMAS arrivals during escalation periods.
- The HALO provided during Winter Pressures continues to be in place and works closesly with the Ambulance Handover Nurse in ED to support patient handover upon arrival.





Expected date to meet standard	New trajectories have been proposed by the MLTC Division and are pending Executive approval.
Lead Director	Chief Operating Officer

National Contract	X	#NAME?	X	Best Practice		CQUIN	

Walsall Healthcare NHS
NHS Trust

Cancer - 62 Day Referral to Treatment from Consultant Upgrade	Year Standard	Monthly Trajectory	Nov-17	YTD	Change on last month	Year End Forecast
	91.00%		87.84%	0.00%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	1/4ly Contractual Financial Penalties	YTD £

Performance results (Validated November 2017):
Performance of 87.84% in November is an improvement compared to 82.89% in October but does not achieve the current locally agreed target of 91%. Application of the new cancer breach allocation guidance would not have impacted upon this metric.

Unvalidated performance for December shows non-achievement of the target.

There were 4.5 breaches reported out of 37 treatments.

- Head & Neck 2 patients - 1.0 breach. Shared breaches with University Hospitals Birmingham NHS Foundation Trust. Referred on days 47 & 21 . Treated on days 76 (complex pathway) & 89 (multiple investigations).

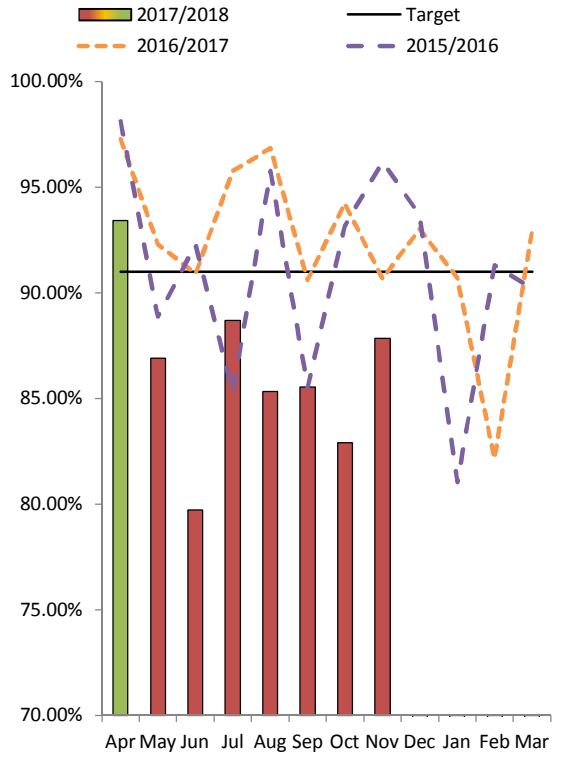
- Lung: 5 patients - 3.5 breaches. Shared breaches with University Hospitals Birmingham NHS Foundation Trust. Referred on days 70 & 139 . Treated on days 81 (multiple MDT meetings), 90 (multiple MDT meetings), 124 (delay in investigations) & 150 (complex pathway). Currently awaiting further information around one shared breach with Heart of England NHS Foundation Trust.

Benchmarking:
For Quarter Two 17/18, the Trust ranked 81st nationally out of 135 and 11th out of 14 regionally compared to Quarter One respective ranks of 78th and 11th.

Contractual status:
Contractual requirements apply.

New Actions:
- The Trust has a new Cancer Lead who will be meeting with all MDT leads to reinforce the monitoring of the upgrades.

Continuing Actions:
- NHSI is working with UHB and Wolverhampton regarding the tertiary process in order to streamline the pathway.
- From January 2018 UHB are introducing an electronic tertiary referral process which will incorporate additonal clinical information. This should result in a reduction in delays.
- The Trust continues to work with the cancer alliance to improve communication and the tertiary process.
- This metric has a locally agreed target and there is a variation in th process across different providers. The Trust raised this for discussion at Elective Access Performance Group with WCCG and NHSI. NHSI advised that they were unaware of any other locally agreed targets and were supportive of the view that a target of 85% would be more appropriate and in line with the 62 day GP target. WCCG are currently considering the request to report against a revised local target of 85%.
- Cancer upgrade patients PTL is an item on the weekly Cancer PTL meeting agenda.
- Capacity issues at tertiary centres are contributing towards delays. There are specific difficulties at University Hospitals Birmingham (UHB) tracking patients progress through their pathway. Delays are escalated in line with the Cancer Escalation Policy.
- Cancer trackers review and escalate issues for patients daily across all sites.
- All breaches are referred to the monthly Clinical Harm Group for assessment.
- Continue monitoring of bronchoscopy delays escalating to the Division of Medicine for recovery plans.



Expected date to meet standard	December 2017
Lead Director	Chief Operating Officer

National Contract		Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Year Standard	Monthly Trajectory	Nov-17	YTD	Change on last month	Year End Forecast
	92.00%	86.20%	83.57%		▼	

What is driving the reported underperformance?

Performance results (Validated November 2017)

The Trust failed to achieve the national standard with performance of 83.57%, a decline compared to 84.75% in October and below the 86.20% proposed recovery trajectory. This is the lowest reported performance since resuming national submissions in November 2016 (Octobers data).

At the end of November there was 1 patient breaching 52 weeks within General Surgery

		Sep-17	Oct-17	Nov-17
PTL Size		17313	16790	15931
No. over 18 Weeks		2587	2561	2617
No. over 52 Weeks		1	2	1
Clock Stops	Total	6182	6807	6854
	Admitted	886	915	995
	Not Admitted	5296	5892	5859
Specialties achieving 92%		10	10	12

Performance of Divisions (target 92%):
- MLTC achieved 81.86% compared to 84.08% in October.
- Surgery achieved 81.82% compared to 83.02% in October.
- WCCSS achieved 96.51% compared to 94.65% in October.

Benchmarking:

For November, the Trust ranked 112th out of 125 Acute Trusts nationally who submitted information and 11th out of 14 Trusts regionally. 65 Acute Trusts reported breaches of over 52 week waits in November.

Contractual status:

Contract Query Notices remain open with Walsall Clinical Commissioning Group (WCCG) and NHS England (NHSE). National monthly penalties of £300 per service user apply where the number of service users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the 92% threshold. The £5000 fine for any patient waiting more than 52 weeks remains in place.

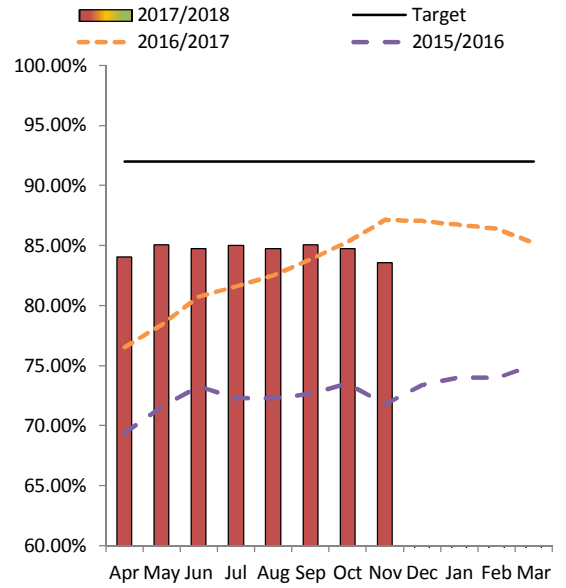
What actions have we taken to improve performance?

Data Quality:
- Work continues on reviewing multiple access plans in the same treatment function. Daily reports in place to support this work.
- New report in place this month to identify cancelled appointments with no further plan.
- Cashing up of clinics (ensuring all required data following a clinic attendance has been entered into Lorenzo) continues to be an area of focus to maintain the 100% standard. Daily clearance of completed e.outcome forms improved during the month. Issues with non completion of forms continues. Work commenced with the Care Groups to reduce levels of non compliance.
- On line RTT training completed for access team. Wider roll out underway, commencing with Medical Secretaries.
- Robotic software procured and project to be initiated in January.

Capacity Improvements:
- WLI clinics in place to support cancer delivery and long waiters in RTT.
- Work is on going with KPMG to identify opportunities to increase capacity; this work has been encouraging and resulted in increased bookings for clinics. Focus on replacing cancellations and improving DNA continues.
- Demand and capacity models to be refreshed, linking into the work on delivering the Trust RTT trajectory.

Scrutiny:
- Weekly via PTL operational meeting, diagnostics meeting, divisional meeting, long wait report meeting, specialty meeting.
- Monthly via PFIC, EAPG and Divisional Board.
- All 52 week breaches are referred to the clinical harm group for assessment, only low harms have been identified to date.
- A revised recovery trajectory for 2017/18 has been proposed and discussed with WCCG and NHSI.

Contractual Financial Penalties — YTD £ £3,505,048



Proposed Trajectory					
Apr	May	Jun	Jul	Aug	Sept
84.00%	84.60%	85.10%	86.20%	86.20%	86.20%
Oct	Nov	Dec	Jan	Feb	Mar
86.20%	86.20%	86.20%	87.00%	88.20%	89.10%

Expected date to meet standard	Proposed revised trajectory has been submitted to WCCG for consideration
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Stroke 90% Stay	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	80.00%		74.29%	82.87%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance Results

The 80% target for patients spending over 90% of their stay on a stroke unit was not achieved during December with performance of 74.29%. This is the third consecutive month this measure has not achieved and is a significant decline compared to 78.95% reported in November.

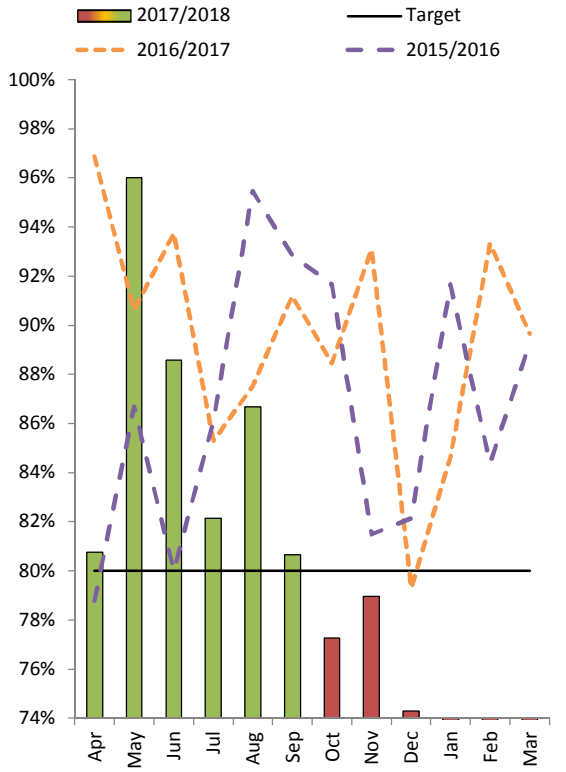
This measure was not achieved due in part to limited availability of beds on the stroke ward as there were general capacity pressures across the Trust which led to General Medical patients being placed there. In addition, the number of patients who were medically fit for discharge also increased.

Benchmarking:

There are no formal national reports published for this metric.

Continuing Actions:-

- The Capacity Team remain fully aware that the ring fenced beds on the Stroke ward must be protected for allocation to stroke patients where at all possible.
- Additional beds were opened beyond the funded bed base to support the capacity pressures across the Trust.
- Work was implemented in November in conjunction with Walsall Council around reconfiguring the discharge pathways for patients who are medically fit, which should lead to a reduction in the numbers of these patients within the Trust. This will alleviate pressures on the dedicated stroke beds.



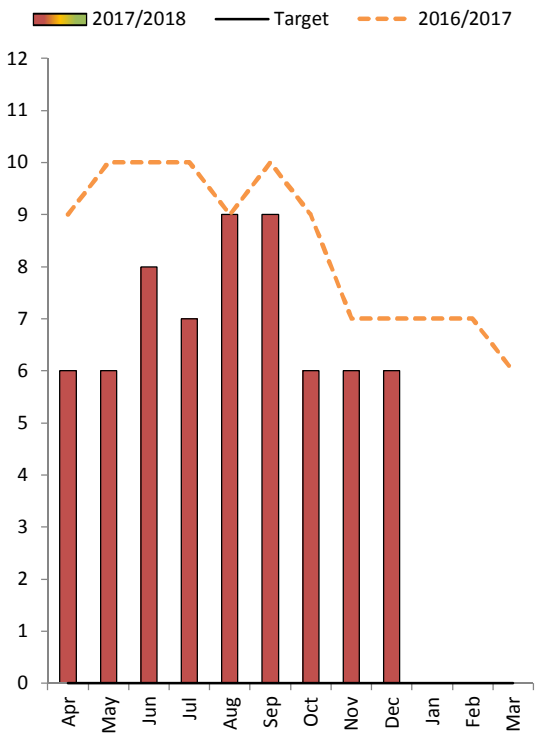
Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Number of Open Contract Performance Notices

Walsall Healthcare NHS Trust

Number of Open Contract Performance Notices	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
Total number of Open Contract Performance Notices	0		6	6	–	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties for numbers open - applied to individual performance areas.	YTD £
As at 31st December 2017, there are 6 formal contract notices that remain outstanding. The 6 notices which remain open relate to the following areas:- - Two contract notices relating to 18 Weeks Referral To Treatment (RTT) Pathways. • One remains open from Walsall Clinical Commissioning Group (CCG) • One remains open from NHS England for Oral Surgery RTT. - Total Time Spent in A&E Overall 4 Hour - escalated to first exception notice - An Information breach notice (EOL) - VTE initial assessment - Activity query notice (this was originally raised in August but inadvertently excluded from the figures which have now been respectively corrected)	All contractual notices are subject to formal communication on a regular basis. Open contract notices are a standing agenda item at the monthly Contract Review Meeting held between commissioners and WHT. Please refer to the individual exception pages for further details.		
		Expected date to meet standard	See individual exception pages
		Lead Director	Director of Finance

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Outpatient DNA Rates	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
		9.37%	14.36%	12.41%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance Results

This indicator measures the number of outpatient appointments where the patient 'Did Not Attend' against the total number of outpatient appointments.

The information is taken from a report on the InfoHub derived from data entered into the patient administration system (Lorenzo). It looks at outpatient activity for community and acute contracts. It calculates the number and percentage of DNAs (where listed as a DNA or a patient attended late or was not seen) against the number of appointments. The figure excludes any cancellations.

DNAs have an enormous impact in terms of cost and waiting time, significantly adding to delays along the patient pathway.

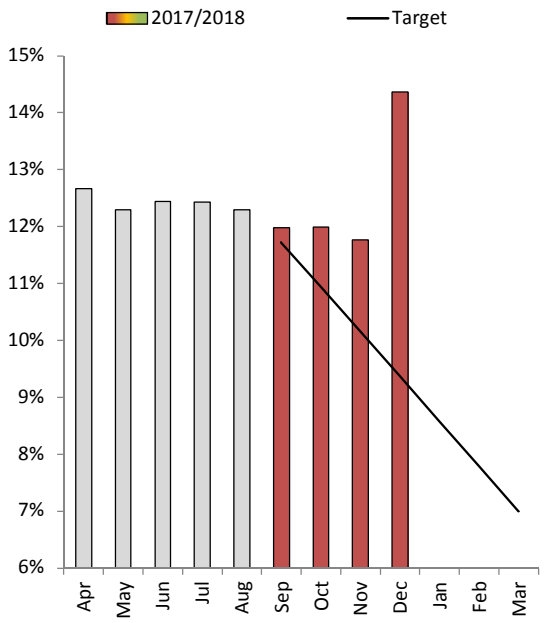
Performance of 14.36% in December is the highest figure recorded this financial year. This has increased by 2.5% compared to November (11.77%) and does not achieve the agreed monthly improvement trajectory of 9.37%.
Underperformance is partially attributable to seasonal/Christmas holidays. in comparison December 2016 recorded performance of 13.91%, however this was not the highest DNA rate recorded within the financial year.

Divisional Performance
- MLTC = 14.31% (compared to 11.97% in November)
- SURG = 13.56% (compared to 10.82% in November)
- WCCSS = 15.32% (compared to 12.70% in November)
.

Continuing Actions:-

- This metric is covered within the Outpatients Improvement Programme, the Executive Lead is the Chief Operating Officer and the Operational Lead is the Corporate Director.

- The Trust continues to roll out the text reminder service. Approximately 86% of all live acute clinics are currently included within the text messaging service.



Trajectory					
Apr	May	Jun	Jul	Aug	Sept 11.72%
Oct 10.94%	Nov 10.16%	Dec 9.37%	Jan 8.58%	Feb 7.79%	Mar 7.00%

Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Length of Stay	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	7.01		7.51	7.09	▼	

What is driving the reported underperformance?

Performance results:
Overall performance for LoS in December was 7.51 days. This is a deterioriation compared to 7.06 days in November. This indicator is not a contracted measure but is a core metric utilised by Trusts to monitor average LoS. The criteria for measuring patient's average LoS, based on definitions within the technical guidance, excludes patients with a zero length of stay and obstetric patients.

Divisional Breakdown:

	Ave LoS Nov	Ave LoS Dec	% LoS <72hr	% LoS of "0"
MLTC	8.36	8.74	55.93%	28.08%
SURG	6.27	7.02	60.81%	21.77%
WCCSS	2.50	2.53	88.72%	62.11%

The average LoS for all three divisions increased during December compared to November.

The following specialties saw the highest increases in the month:

- T&O - 10.25 days in December compared to 8.57 days in November.
- Gastroenterology - 14.54 days in December compared to 11.05 days in November.

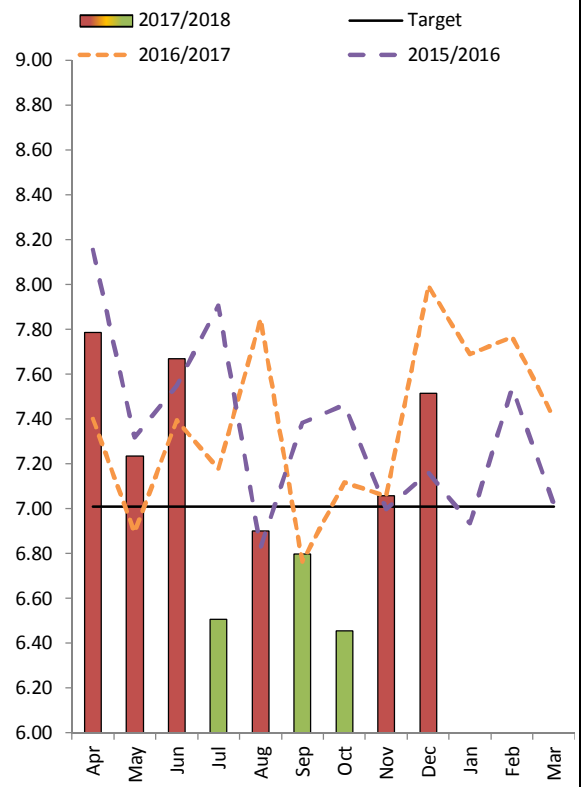
Benchmarking:
No formal national reports.

Contractual status:
No contractual requirements apply.

What actions have we taken to improve performance?

Continuing Actions:
- The Patient Flow group continues to meet and develop new actions as outlined above.
- Work continues to embed SAFER and Red and Green approach at ward level with clinically led discharges.
- As part of the ED Board System Recovery Plan there are proposals to introduce a multi-disciplinary assessment team at ward level who will focus on supporting earlier discharge. The aim is to increase the percentage of patients discharged within 24 to 48 hours who will be eligible to receive therapy treatment, support and continuing healthcare assessments out of the hospital environment. This will help to reduce the number of patients on the medically fit for discharge list.
- The role of the in-reach matron has changed to be aligned to all of the community place based teams. This supports reducing length of stay and prevention of readmission when a patient from the caseload is admitted.

Contractual Financial Penalties | **YTD £**



Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Delayed Transfers of Care	Year Standard	Monthly Trajectory	Nov-17	YTD	Change on last month	Year End Forecast
The number of beds days relating to patients who were classified as a delayed discharge taken as a snapshot on the last Thursday of the month	2.50%		3.27%	2.28%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results: Reported one month in arrears
The target of 2.50% or below attributable to delays as a total of available bed days was not achieved in November with performance of 3.27%. This is a decline in performance compared to 3.16% reported in October.

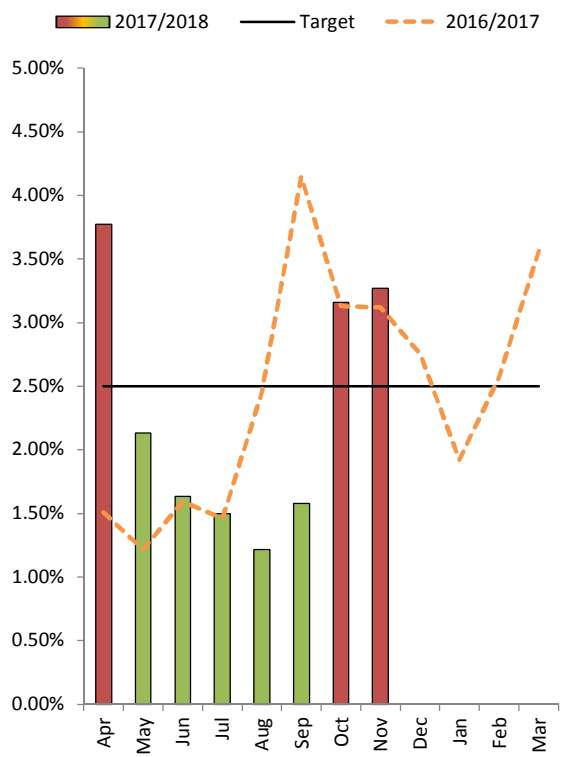
The DTOC reporting changed from 1st October 2017. Now every medically fit patient is reviewed daily and any DTOC patients are recorded. Previously this was only done once a week. This has had an impact on the reported delays at the end of the month and increase in the numbers. DTOC is therefore more accurately reported.

Benchmarking:
Benchmarking for this measure is based on the number of bed days impacted from delayed transfers every month.

Latest benchmarking shows, 417 bed days were impacted in November 2017 from delayed transfers taken at the snapshot position. This ranks the Trust 31st out of 133 Trusts nationally and 2nd out of 14 Trusts regionally.

Contractual status:
There is no financial penalty against the Trust for this metric.

Actions being taken to reduce the DTOC are:
- CHC assessments (DSTs) completion in the community will accelerate beyond the few voluntary cases we have previously completed. This will increase significantly following the management of change consultation period Feb / March involving the discharge liaison nurses.
- ICS model is developing training and guidance for the acute wards on discharge planning.
- ECIP team are in the hospital to work with teams to improve Trust performance.
- ICS model are developing patient information and patient choice policy with the Trust
- DTOC audit has commenced to check accuracy.
- ICS team have developed community therapy pathways in order to facilitate discharges sooner and conduct therapy assessments in the community.



Expected date to meet standard	To be agreed
Lead Director	Chief Operating Officer

g underta	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sleeping Accommodation Breaches	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	0		9	53	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £	£17,500

Performance results:
There were 9 patient breaches reported within the Trust during December This is a decline in performance compared to 6 reported in November however is within the monthly trajectory of 11.

For the 9 patient breaches reported in December the length of breach incurred for each patient ranged from one to two days. The patients breached on the 3rd, 6th, 7th, 8th and 30th December. Of the 9 breaches, 6 patients were from Walsall CCG, 1 patient was from Sandwell and West Birmingham CCG, 1 patient was from Cannock Chase CCG and 1 patient was from NHS Manchester CCG.

Bed capacity issues within the Trust continue to impact on the timely step down of patients from the Critical Care Unit. As regionally agreed, the rules which apply within HDU are that a patient on critic care should only be counted as a breach if another patient is ready step down whilst the first patient is still there. Patients should be transferred within 4 hours of decision to step down.

Performance is impacted upon by Estates configuration of the unit at present as there is no area for ring fenced step down beds.

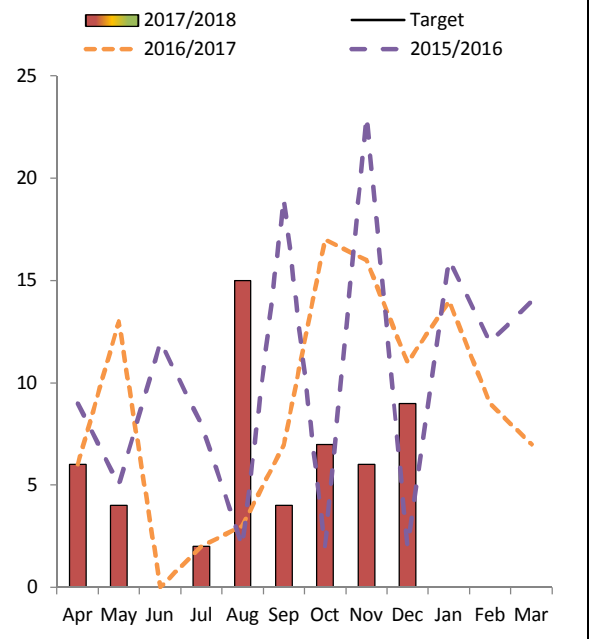
Benchmarking:
Latest benchmarking for November shows that 45 out of 137 Acute Trusts reported sleeping accommodation breaches.

Contractual status:
Mixed Sex Accommodation is a contractual indicator in 2017/18 with a financial penalty attached of £250 per patient involved, per day impacted upon. This results in a fine of £2250 for December as the breaches are calculated daily per patient rounded up to the nearest whole day.

Agreement has been made with Walsall CCG to extend the 4 hour step down tolerance to 12 hours which is in line with other Trusts, with effect from January.

New Actions;
Agreement has been made with Walsall CCG to extend the 4 hour step down tolerance to 12 hours which is in line with other Trusts, with effect from January.

Continuing actions:
- RCA documents are completed for reported breaches. The RCA documents are shared with the patient flow team and are tabled at Divisional Quality Meetings for discussion/learning to prevent future breaches.
- The critical care outreach team have transferred over to the Surgery Division. Once the team has been embeded they will produce a procedure to support the patient flow process
- A trajectory to achieve small improvement across the year was shared with WCCG and this has been agreed.
- The weekly meeting between Performance and the Care Group manager continues when necessary. This has supported timely dat validation and RCA's being undertaken as soon as possible after the breach has been reported. The receiving Ward of the patient will be approached to contribute to the RCA in order to identify any learning which could improve earlier step down.
- The business case for the new Intensive Critical Care Unit was approved by NHSI in March, this will have single sex accommodation. The project started in April and the anticipated date for completion is Winter 2018.
- Mixed Sex Accommodation breaches are a specific risk on the Critical Care Risk Register.
- All breaches are raised as an incident on the Safe Guard System.
- The critical care unit continues to focus on operating a "push" model
- Emphasis of the importance of the critical care step downs continues within bed bureau.



Trajectory to be agreed with WCCG					
Apr	May	Jun	Jul	Aug	Sept
					10
Oct	Nov	Dec	Jan	Feb	Mar
10	11	11	11	10	9
Expected date to meet standard	Due to limitations with Estates and capacity pressures, on occasion breaches may be unavoidable				
Lead Director	Chief Operating Officer				

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

HSMR (HED) SHMI (HED)	Year Standard	Monthly Trajectory	Sep-17	YTD	Change on last month	Year End Forecast
	100		78.27	93.69	▲	
	100					

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results:

Hospital Standardised Mortality Ratio (HSMR) compares a Healthcare provider's mortality rate with the overall average rate. The Trust receives this information from the HED system but historically received this from Dr Foster. Due to methodology differences, each system returns a different result. The latest published results report that HSMR was 78.27 for September 2017. For the financial year 2014/15 HSMR was 95.96, for 15/16 was 92.21 and for the financial year 2016/17 HSMR was 94.17. Previous months have been refreshed to reflect the latest published results.

HED have begun publishing a metric defined as the number of excess deaths within the HSMR, it is the difference between the expected deaths and actual deaths. For April 2017 to March 2018 there were 32 less deaths than expected.

SHMI is a measure of mortality which includes all in hospital deaths and all deaths within 30 days of an inpatient episode. SHMI is published in 2 ways, as a monthly metric by HED and as a rolling 12 month metric published quarterly by NHS Digital. HED monthly SHMI for August 2017 was 95.43.

SHMI Benchmarking Based on NHS Digital Data:

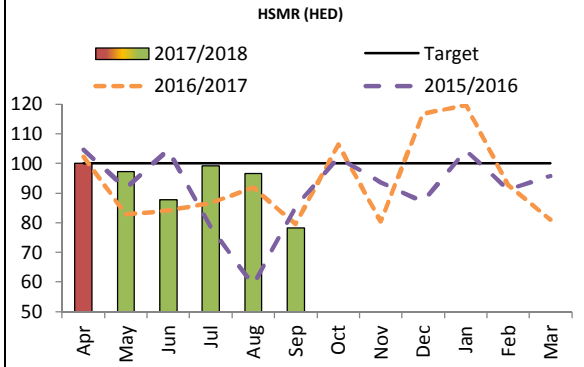
SHMI published by the NHS Digital has been released for the period from April 2016 to March 2017 which shows a SHMI rate of 1.06. This ranks the Trust 92nd nationally and 8th regionally.

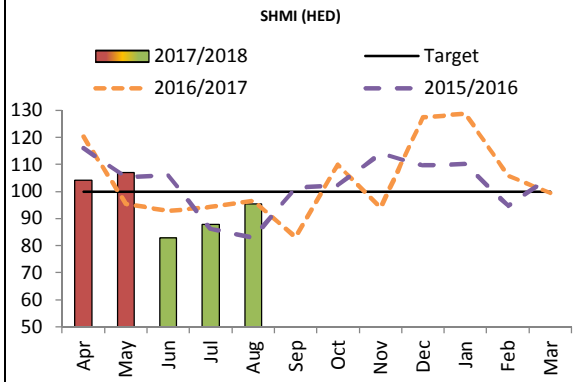
Contractual status:

No contractual requirements apply.

Continuing actions:

- RCP Training commenced in October with additional training dates agreed for January & February.
- After discussions with DWMHPT, the identification and support of multi agency reviews for mental health patients has been added to th Learning from Deaths policy.
- A review of deaths coded with COPD is to be undertaken as this diagnosis group appears to be an outlier in relation to the number of deaths. This review will be led by the respective Head of Nursing, Matron and Lead Clinician.
- A review of deaths for patients with pneumonia is to be undertaken as there appears to be a theme of patients who have had a Fractured NOF developing pneumonia. This review will be led by the respective Head of Nursing, Matron and Lead Clinician.
- The Learning from Deaths policy was ratified at TQE and has been included on the internal and external websites.
- The new multi functional mortality reporting process is currently being reviewed with the Business Manager to the Medical Directorate to establish roll out of the reports moving forward.
- A collaborative piece of work is ongoing to review deaths within 30 days of discharges from hospital as this contributed to 37% of the deaths reported within SHMI for May.
- Continue to maintain strong relationships with Public Health and the Walsall wide Mortality Group with CCG and GP's to develop health economy wide approaches to improving patient outcomes.
- Working with CCG & Social care to develop shared practice around patients with learning difficulties.





Expected date to meet standard	HSMR Achieving SHMI Achieving
Lead Director	Medical Director

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Infection Control	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
CDiff - Total number of cases of Clostridium Difficile recorded in the Trust	18	1	4	11	▼	
MRSA - total number of cases of MRSA recorded in the Trust	0		0	0	–	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance results:
During December 2017, there were 4 reported cases of hospital attributable toxin positive C.Difficile against a trajectory of 1.
The cases were reported on Ward 1, Ward 4, Ward 15 and Ward 16
Of the 4 cases reported, 3 were deemed unavoidable and 1 case was avoidable. The avoidable case was due to a delay in sending a sample and poor recording.

There were no cases of MRSA bacteraemia attributed to Walsall Healthcare during December 2017.

Benchmarking:
CDiff:
Data published one month in arrears by Health Protection England confirms that for November 2017, there were 0 cases of hospital attributable C.Difficile toxin at Walsall Healthcare. This compares to 5 cases at Dudley and 2 cases at Wolverhampton.
The Trust is in the 1st Quartile in terms of performance nationally.

MRSA:
Data published one month in arrears shows there were 0 cases of MRSA recorded regionally for November 2017.

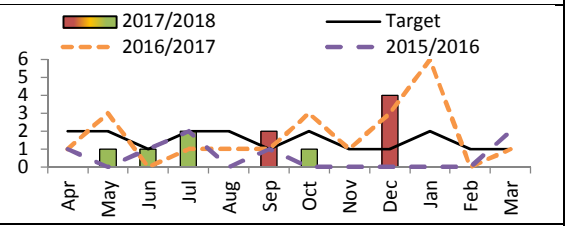
Contractual status:
CDiff:
The contract for 2017/18 invokes financial penalties if the number of avoidable cases during the year exceeds 18.

MRSA:
The national contract for 2017/2018 stipulates zero tolerance of MRSA cases. Consequence of breach is £10,000 in respect of each incidence in the relevant month.

New actions:
CDiff: - The avoidable case reported in December was discussed at Infection Control Committee. It was also shared at SNAG (Senior Nurse Advisory Group) with actions for all the senior nurses to ensur wards utilising the Bristol stool charts and sending samples in a timely manner. It will also be emphasised at both Trust Induction and mandatory update Infection control sessions.

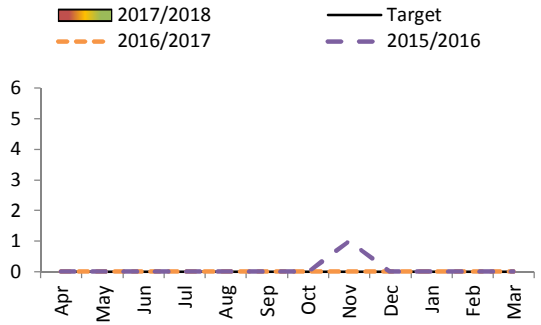
Continuing actions:
CDiff: - Infection Control continue to monitor the Matrons monthly environmental audits and carry out one audit a month for assurance. These are reported at Infection Control Committee monthly.
- Trust wide focus on re-iterating importance of cleanliness of equipment and cleanliness of the Trust environment.
- Infection Control Team are involved, from the beginning, in any meetings and discussions relating to new wards and decant facilities.
- Actions in relation to C.Difficile continue to be monitored at the Infection Control Committee as part of the on-going Infection Control action plan.
- For areas that have reported cases of C.Difficile, a checklist audit is undertaken by the Infection Control Team as part of routine practice to ensure standards are maintained.
- On-going assessment against national standards continues, which includes weekly C.Difficile ward rounds.
- Reviews and assessment of avoidability will be discussed at the bi-monthly RCA meeting, which is attended by Walsall CCG and Public Health representatives.
MRSA: - The "CleanIT" campaign education continues throughout the Trust.
- Work continues with the Continence and Urology services to improve the care of urinary catheters. This will be monitored via the NHS Safety Thermometer.
- The Infection Control nurses continue to follow up all positive MRSA results and re-screen at 28 days post admission.
- Increased patient information on peripheral cannulas.

CDIFF



Trajectory					
Apr	May	Jun	Jul	Aug	Sept
2	2	1	2	2	1
Oct	Nov	Dec	Jan	Feb	Mar
2	1	1	2	1	1

MRSA



Expected date to meet standard	January 2018
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Pressure Ulcers - (category 2, 3 & 4's) - Avoidable per 1000 beddays	Year Standard	Monthly Trajectory	Oct-17	YTD	Change on last month	Year End Forecast
Figures based on all avoidable pressure ulcers acquired within the Trust			0.61		▼	

What is driving the reported underperformance?

Performance results: Reported two month in arrears to allow RCA to be completed.

Previous month's figures have been updated to reflect the outcomes of RCAs. Please note unstageable PU's are now reported as incidents and included in the table below.

		Sep-17		Oct-17	
		Total	Avoidable*	Total	Avoidable*
Hosp	Cat 2	4	1	9	5
	Cat 3	0	0	0	0
	Cat 4	0	0	0	0
	Unstage	1	1	5	2
Comm	Cat 2	8	0	10	0
	Cat 3	0	0	1	0
	Cat 4	0	0	0	0
	Unstage	4	3	5	2
Rate per 1000 Bed days		0.35		0.61	

There were 30 PU related incidents reported in October.
The highest reported area of prevalence continues to be on patients heels. There have been 9 incidents confirmed as avoidable this month. The themes identified were:
Hospital – Lack of care plan & patient information
Community – Delay in upgrade of equipment, issue with checking equipment at monthly reviews

Benchmarking:

Due to the methodology used to monitor PU's performance comparative data is not available.

Contractual status:

There is a new 2 year national CQUIN for 2017-19 worth approx. £258K per year aimed at improving the assessment of wounds. The Q2 report has been submitted and approved by WCCG. Improvemer trajectories have been agreed for Q4.

What actions have we taken to improve performance?

Ward/ Team Actions Taken for avoidables:

All action plans include raising awareness of issues within the team. Hospital- Poor documentation see section below Community - delays in ordering equipment. Learning has already been disseminated through the Team

Education

In 2017 PU sessions were provided as drop in session across the hospital, attendance improved towards the end of the year but numbers remain low and were predominately student nurses and HCSW. These sessions will be repeated in Jan. Core half day sessionshave been organised for 2018. Nursing home link workers have been given PU update sessions.

Equipment

All base mattressses switched to new softform. Second phase of mattress swap is complete, 76 patients were deemed appropriate during the swap to be removed off their air mattress onto a foam mattress. Mattress education including a selection chart was given to staff on every ward. A small section on equipment is now part of the tissue viability mandatory training . The mattress SOP is still awaiting ratification from divisonal quality groups. A small working group to look at seating across the hospital are due to meet in Jan. TV have gathered information on cushion options group due to meet in Jan. LIA work to improve care of base mattresses is complete with final guidance to be shared and implemented in Jan.

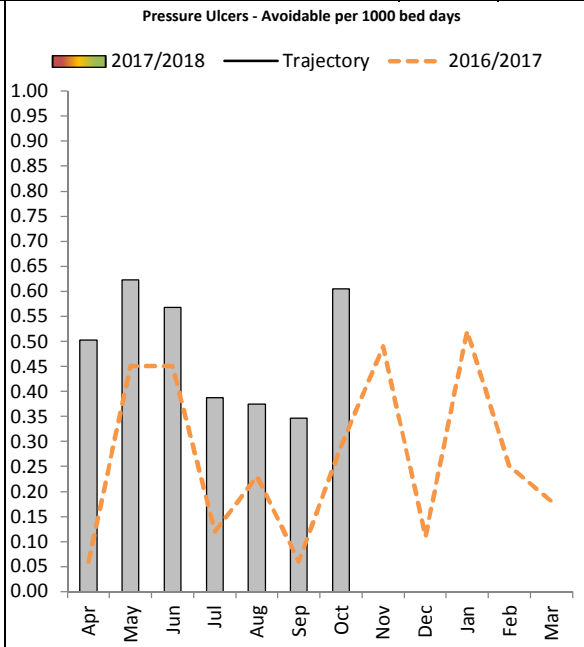
Documentation

Admission document & comfort rounds are undergoing slight alteration to include new proposed SKIN bundle form. The PU prevention pack will incorporate Waterlow/ SKIN bundle and patient infomation in one document, this is in draft and the aim is to pilot all documents in the next 2 months. A new patient information leaflet ar pressue ulcer fact sheet has been developed and ratified. This is waiting to go onto the TV intranet page for all staff to access

Wound Care Formulary Group

The wound care formulary group continue meet monthly with good represention from both hospital and community staff to look at dressing products that will offer savings to the Trust without compromising the patient needs.

Contractual Financial Penalties | **YTD £**



Trajectory (10% reduction by year end on Q1 Baseline)

The original proposal is now being reviewed by the Senior Nursing Team

Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb	Mar

Expected date to meet standard	To be agreed
Lead Director	Director of Nursing

National Contract		Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Falls - Number of Falls reported Falls - Rate per 1000 Bed Days	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
			95	760	▼	
	6.63		5.79		▼	

What is driving the reported underperformance?

Performance results:

There were 95 falls reported during December 2017, equating to a rate of 5.79 falls per 1000 beddays for the month which is a slight decline compared to 5.50 in November but achieves the Trust target of 6.63.

Based on Calendar Month		Oct-17	Nov-17	Dec-17
Count of Falls	Total	96	83	95
	MLTC	80	65	67
	Surgery	9	16	24
	WCCSS	5	1	1
	Comm / Corporate	2	0	2
	Other	0	1	1
Rate per 1000 beddays - All Falls		6.46	5.50	5.79
Rate per 1000 beddays - Moderate & Severe Falls		0.00	0.27	0.18

There were 17 reported incidents of patients falling more than once in December which is more than in November. In total these patients had 41 falls.

The highest number of falls were reported on Ward 04 (11 falls), Ward 16 (10 falls), Ward 03 (8 falls) & Ward 01 (8 falls).

There was one fall resulting in severe harm, located on Swift Discharge Suite with the patient suffering a fractured NOF.

NHS Safety Thermometer results for December show performance of 0.48% of Falls resulting in harm.

Benchmarking:

National benchmarking is via the National Inpatient Falls Audit 2015 which is endorsed by the Royal College of Physicians. The National figures for falls are 6.63 per 1000 occupied bed days. The figure for Serious and Moderate Harm caused by falls is 0.19 per 1000 occupied bed days.

Contractual status:

No contractual requirements apply.

What actions have we taken to improve performance?

New actions:

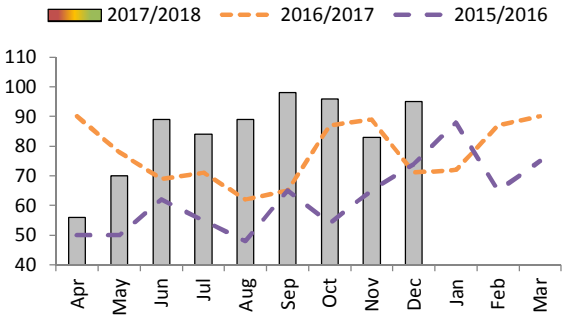
- Falls steering group continues with good representation across both community and acute trust. Terms of reference have been circulated for agreement.
- An audit is planned following the rollout of new risk assessment and care plans
- Falls prevention policy is being reviewed
- The Trust has been accepted as part of a collaborative with NHSI regarding enhanced care

Continuing actions:

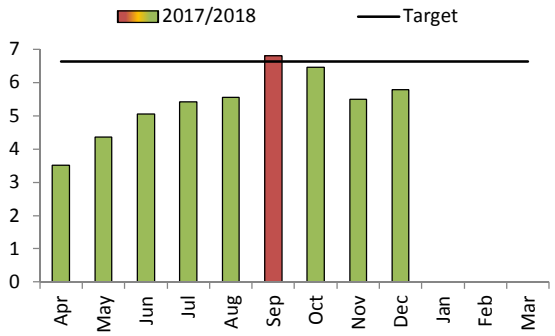
- Monthly falls audits continue
- Falls dashboard is shared with all wards and is monitored via the ward review process.
- All incidents relating to falls are recorded within the Safeguard system.
- Safety huddles on wards continue.
– Moving and handling training includes Falls scenarios and includes completion of the falls and bedrail assessments.
- A monthly monitoring meeting is held between the Corporate Senior Nurse and the Performance & Information Team. This meeting ensures there is a robust process for tracking and chasing outstanding RCA's for falls and ensures action plans are in place for all avoidable incidents and lessons learnt are shared.
- New format of NICE risk assessment has been taken to each ward and explained to staff. New care plans for Falls Prevention and Post Fall Care have been supplied to all wards and explained how and when to use.
- E-learning options being considered regarding Falls prevention
- Findings from audits completed on Wards 3, 4 & 9 found that the majority of patients were at high risk of falls. Also, there was duplication of paperwork and care plans were not personalised. a re-audit of falls recorded on these wards will be undertaken if the new documentation is improving care given to patients.

No Contractual Financial Penalties | **YTD £**

Number of Falls reported



Rate per 1000 Bed Days



Expected date to meet standard	Achieved in December 2017
Lead Director	Director of Nursing

National Contract		Local Contract	X	Best Practice		CQUIN	

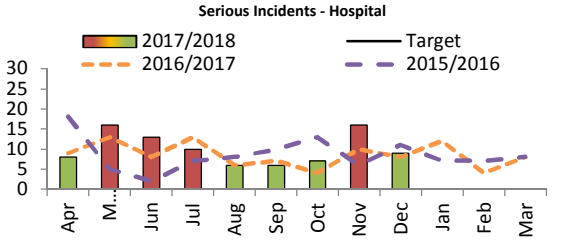
Serious Incidents (inc cat 3&4 pressure ulcers, HCAI's & Falls)

Walsall Healthcare NHS Trust

Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	102	11	9	91	▲	
	50	3	4	60	▲	

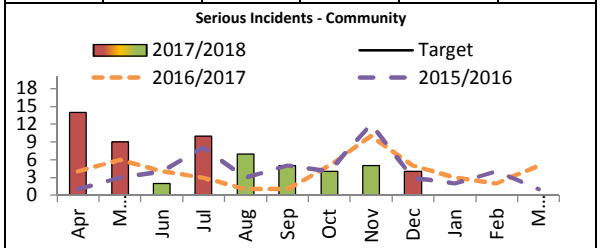
What is driving the reported underperformance?	What actions have we taken to improve performance?
There were 13 Serious Incidents reported to WCCG in December 2017, a decrease in reporting compared to the 21 Serious Incidents reported in November 2017. Breakdown of Serious Incidents:- • 6 x non-pressure ulcer related incidents • 1 x category 3 pressure ulcer – community acquired • 3 x unstageable pressure ulcers – community acquired • 1 x category 3 pressure ulcer – hospital acquired • 2 x unstageable pressure ulcers – hospital acquired Non-pressure ulcer Serious Incidents include: • 4 x infection control incidents • 1 x treatment delay • 1 x diagnostic incident	Please see monthly Serious Incident Report Trajectories have initially been rolled forward from 2016/17, revised trajectories awaited based on Q1 2017/18.

Contractual Financial Penalties — **YTD £**



Trajectory - Hospital

Apr	May	Jun	Jul	Aug	Sept
18	5	2	7	8	10
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
13	6	11	7	7	8



Trajectory - Community

Apr	May	Jun	Jul	Aug	Sept
1	3	4	8	3	5
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
4	12	3	2	4	1

Expected date to meet standard	Targets currently based on last years activity revised trajectories will be available from end of Q2.
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

C-Section Rates	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	30.00%		32.86%	27.94%	▼	

What is driving the reported underperformance?

Performance Results

Performance of 32.86% in December was a decline compared to 28.32% the previous month, this is the first time this financial year the target of 30% has not been achieved.

		Oct-17	Nov-17	Dec-17
Total	Number	75	79	92
	%	25.60%	28.32%	32.86%
Elective	Number	32	29	33
	%	10.92%	10.39%	11.79%
Emergency	Number	43	50	59
	%	14.68%	17.92%	21.07%

There were 92 c-sections recorded in the month which is a significar increase compared to 79 in November.

Benchmarking (published annually):

Latest benchmarking (based on 2015/2016 performance) ranks the Trust 109th out of 116 Acute Trusts who submitted data. Regionally, the Trust ranked 8th out of 10 Trusts.

Contractual Status:

No contractual requirements apply.

What actions have we taken to improve performance?

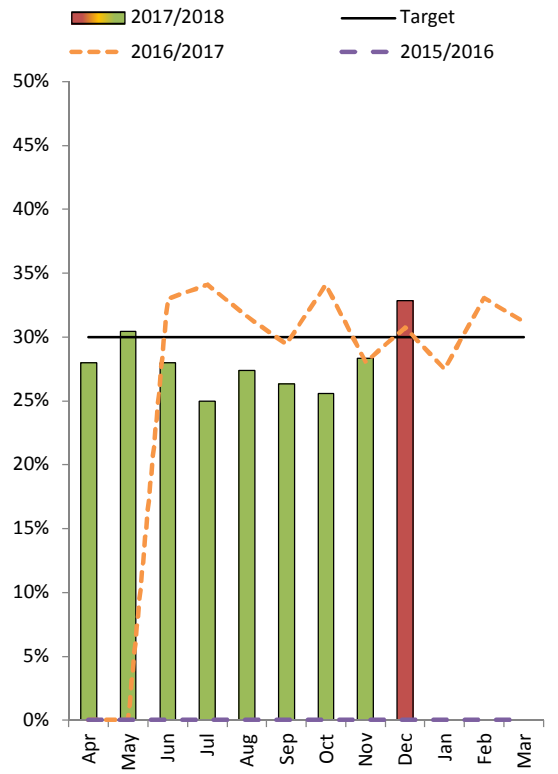
New Actions:-

- Discussions are to take place at SMG to look at a long term plan to ensure regular review meetings take place.
- Discussions will take place with locum doctors who have high c-section rates to advise them to seek senior review for decisions regarding c-section deliveries.

Continuing Actions:-

- Continue to assess c-section rates on a daily basis

No Contractual Financial Penalties | **YTD £**



Expected date to meet standard	To be confirmed.
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

% of Emergency Readmissions within 30 Days of a discharge from hospital	Year Standard	Monthly Trajectory	Nov-17	YTD	Change on last month	Year End Forecast
			10.35%		▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £

Performance results:
The percentage of emergency readmissions within 30 days of a discharge from hospital is reported one month in arrears.

This metric measures the percentage of patients who were an emergency readmission within 30 days of a previous inpatient stay (either elective or emergency). The criteria excludes Well Babies, Obstetrics and patients referred to the Early Pregnancy Assessment Unit. Performance is reported a month in arrears.
The performance for November is 10.35% which is an improvement compared to 10.75% in October 2017.

Of the patients who were re-admitted in November:-
- Approximately 22% of the readmissions were aged under 30 (a decrease compared to 25% in October).
- Approximately 33% of the readmissions were aged over 70 (an increase compared to 32% in October).

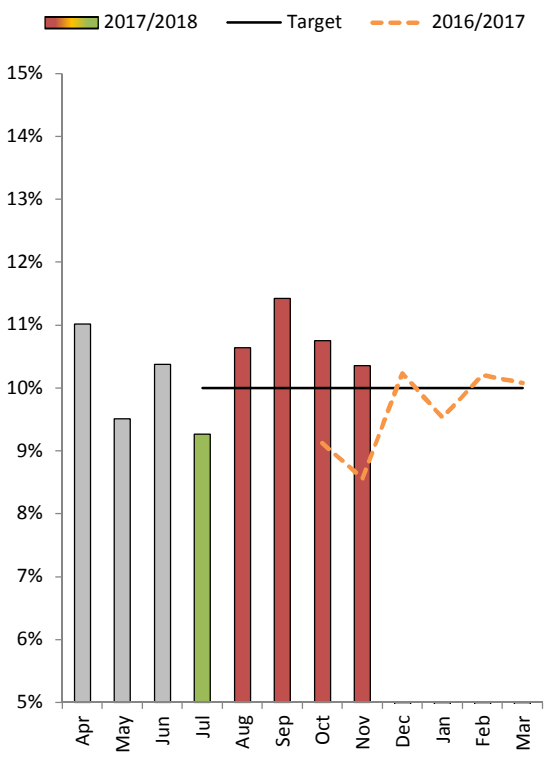
The average number of days between the original admission and the re-admission is 9.5 which is slight decrease compared to 10 days in October.

For those patients discharged in the month who were an emergency readmission within 30 days, the average length of stay of the readmission was 4.3 which is an increase compared to 3.7 in October.

Benchmarking:
There are no formal national reports published for this metric.

Contractual status:
No contractual target, however performance is reported monthly to commissioners.

Continuing Actions:
- A review of GAU readmissions is to be undertaken and a decision made regarding the potential exclusion of this cohort from this metric.
- The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.
- In line with this, work will be developed to link the work currently being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.



Expected date to meet standard	To be agreed.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Electronic Discharges Summaries (EDS) completed within 48 hrs	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
Number of EDS completed within 48 hrs of the point of patient discharge	100.00%		89.73%	88.86%	▲	

What is driving the reported underperformance?		No Contractual Financial Penalties	YTD £	

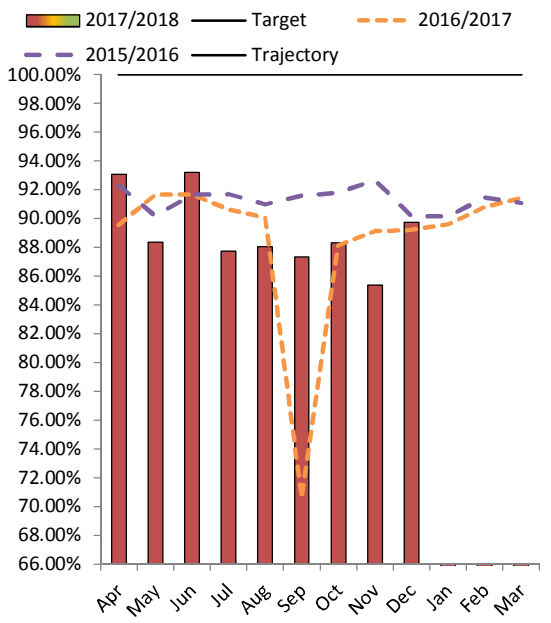
Performance results:
This indicator measures the percentage of EDS completed within 48 hours of the point of patient discharge. Performance has improved in December to 89.73% compared to 85.38% in November however remains below the locally agreed target of 95.00%.

Divisional performance for December 2017 was as follows:-
- Surgery: 91.25% (73.49% in November)
- MLTC: 89.30% (93.69% in November)
- WCCSS: 88.94% (91.97% in November)

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
The NHS contract states when transferring or discharging a Service User from an inpatient or daycase or accident and emergency service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any third party provider, using an applicable Delivery Method. The Trust has a local agreement to monitor against 48 hours. No financial penalties apply for failure to achieve.

Continuing Actions:
- A review of the discharge summaries is to take place to ensure all summaries are sent out and in a timely manner.
- Quantitave analysis that was presented at MAC to review EDS performance will be shared at the Ground Round meeting to reinforce the importance of accurate information being recorded
- EDS performance was discussed with WCCG at the last Clinical Quality Review meeting, a separate meeting is being arranged in January to agree improvements.
- Clinical Coding Lead has presented a qualitative analysis of EDS at MAC demonstrating poor quality information having a potential impact on income via coding. All the CDs have been requested by the MD to reinforce the importance of documentation with their teams.
- Medical champions have been identified for all ward areas who will be dedicated to working with all stakeholders to deliver the Quality and Safety agenda which includes documentation and communication. The Divisional Directors and the Clinical Directors will be responsible for ensuring EDS are completed.
- The Business Manager and the MD are following up outstanding EDS on a daily basis with intensive communication.
- The Organisational Development (OD) are running a programme of education and development sessions for middle grade doctors, topics will cover documentation and EDS.
- The GMC facilitated 2 sessions targeting all medical staff to focus on documentation and communication
- All clinical documents are now electronically sent to GPs.
- Trajectory to be reviewed and considered in conjunction with WCCG.



Trajectory					
Apr	May	Jun	Jul	Aug	Sept
Oct	Nov	Dec	Jan	Feb	Mar

Expected date to meet standard	Trajectory to be reviewed and considered in conjunction with WCCG.
Lead Director	Medical Director

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Dementia Screening 75+ (Hospital)	Year Standard	Monthly Trajectory	Nov-17	YTD	Change on last month	Year End Forecast
	90.00%		44.47%	56.86%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties apply	YTD £

Performance results (Validated November 2017):
The national dementia return continues in 2017/18 as a requirement of the standard contract for all acute trusts. This data collection reports on the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours in England who have been identified as potentially having dementia, who are appropriately assessed and who are referred on to specialist service The target for all 3 requirements (screen, assess and refer) remains at 90%.

During November 2017 the Trust failed to achieve the 90% screening target for patients aged 75 years and over with performance of 44.47%. This is a significant decline compared to October 2017 (60.52%).

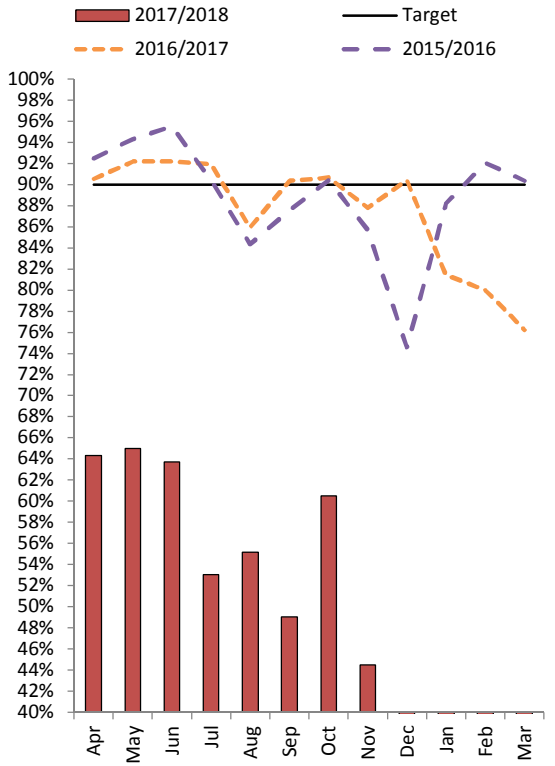
Issues:
There is currently no electronic system in place to capture this data. The results rely solely upon a manual process whereby notes are reviewed to establish if screening and appropriate assessment took place. This is still part of the peer audit which takes place once a month. In addition approximately 10% of patients notes are being reviewed for patients that have been discharged.

Benchmarking:
Latest benchmarking (based on October's performance) ranks the Trust 114th out of 125 Acute Trusts who submitted data. Regionally, the Trust ranked 14th out of 14 Trusts.

Contractual status:
No national penalties apply.

Actions:
- WCCG are aware of the issues in collating this information and have agreed an alternative methodology for this metric. This comprises of the audit being part of the monthly peer audit schedule and an additional 10% of patients discharged to be audited by the Lead Nurses for safeguarding Adults and Older People Mental Healt liaison team.
- The above approach was discussed at SNAG meeting who agreed to conduct these audits.
- Wards continue to be requested to support with the data collection process, health records library are supporting the retrieval of notes when requested.
- The current national submission requirements continue to be reviewed internally to establish whether the monthly audit results can be utilised for the submission.

Continuing actions:
- The revised paper assessment tool, which makes the process clearer and easier to undertake, has been circulated to wards and made available on stationary stores for wards to order.
- A revised flow chart has been circulated outlining the dementia screening process and emphasing that the screening can be done at any point during the patients stay in the hospital and must be noted on the EDS.
- Increased education and awareness of delirium and 6 CIT to support effective completion of screening process.
- Consideration of an IT solution is still an option.



Expected date to meet standard	End of Quarter Four 2017/18
Lead Director	Director of Nursing

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Friends & Family Test - ED (% Recommended) Friends & Family Test - Inpatient (% Recommended)	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	85.00%		77.00%		▲	
	96.00%		91.00%		▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	No Contractual Financial Penalties	YTD £	

Performance results:

This page relates to all of the areas covered by the Friends & Family measure.

Measure	Target	Nov	Dec
Inpatient	96%	92%	91%
Outpatient	96%	90%	91%
ED	85%	76%	77%
Community	97%	99%	99%
Maternity-Antenatal	95%	82%	80%
Maternity-Birth	96%	94%	83%
Maternity-Postnatal Ward	92%	79%	85%
Maternity-Postnatal Community	97%	100%	100%

Posters have been displayed within areas informing patients about the process to provide feedback on their care. Patients have the option to opt out of the electronic method by either informing the staff within the area or responding to the text message issued which provides an opt out opportunity.

Benchmarking:

For ED, the latest benchmarking (November) ranks the Trust 126th out of 131.

For Inpatients, the latest benchmarking (November) ranks the Trust 112th out of 127.

The number of Trusts that we are benchmarked against has reduced this month due to a data quality issue. A refreshed position is expected to be published.

Contractual status:

NHS standard contract applies but no contractual financial penalties.

New Updates/Actions:

- ED survey collections via SMS and IVM resumed on 15/12/17 after more than a month of Lorenzo's Emergency Care Data Set disruptio Response rates have been impacted significantly.
- Maternity Services have switched over to paper FFT surveys from 1st Jan 2018 for all touch points as an interim while ipads/tablets option is being finalised.

Inpatients:

- MLTC and Surgery are still trying to secure funding for FFT ipads. WCCSS are hoping to trial them in a few areas. Ipads will make FFT more inclusive, help improve response rates and be cost effective.
- The draft 'Quiet Protocol' to promote rest and sleep for inpatients is to be ratified at the next Senior Nurse Forum.

ED:

- ED selected as the area for rollout of the Always Event® programm in collaboration with by Patient Experience team.
- ED Patient Safety Checklist to be introduced.
- Volunteers supporting to improve waiting area experience.
- ED team's National survey and FFT action plan progressing. Patient Experience team providing support.

Outpatients:

- Team leaders promoting FFT to patients and discussing results within their teams. Focus on improving the patient registration information quality.

Maternity:

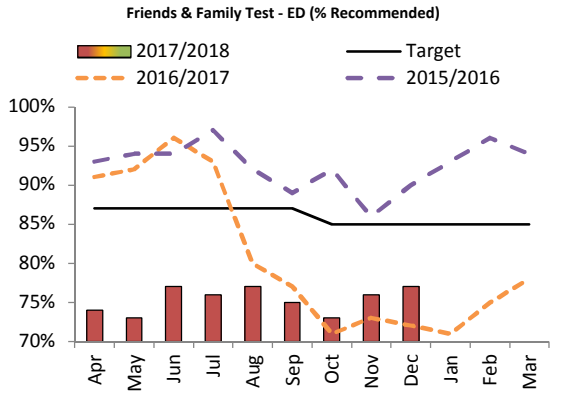
- Maternity Services switched over to paper FFT surveys from 1st Ja 2018 for all touch points as an interim while ipads/tablets option is being finalised.
- Antenatal TV screen draft content developed, will be finalised and uploaded with support of Communications team

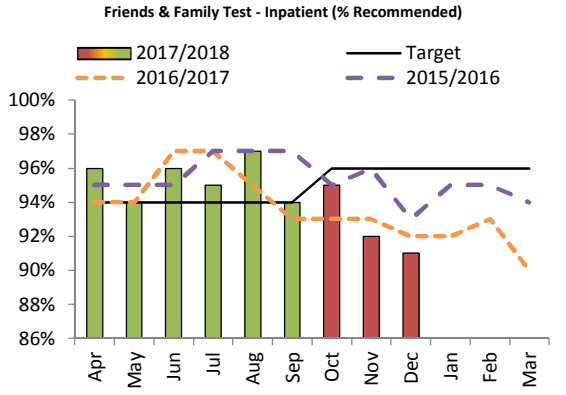
Community:

- Maintaining current level of support with Community Teams.

Continuing actions:

- FFT results reports regularly presented at the PEG, TQE, TSC & Trust Board.
- Increase use of 'Sound Bites' (audios of patient feedback)
- FFT results available to staff online and via printed weekly reports.





Expected date to meet standard	ED - End of Quarter 4
Lead Director	Director of Nursing

National Contract	X	Local Contract		Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Sickness Absence	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	4.00%		5.81%	5.16%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Sickness levels declined in December with performance of 5.81% compared to 5.55% in November 2017 and did not achieve the target of 4.00%. This represents a rise of 1.15% compared to same period 2016/17.

Monthly short-term sickness during December 2017 totalled an estimated cost of £181k and long-term sickness totalled an estimated cost of £359k.

There were 190 long-term episodes of sickness during December 2017 and 14 LTS cases extend to 6 months or more.
The largest cause of absence during December 2017 was Anxiety/stress/depression/other psychiatric illnesses - 1694 FTE Days across 86 episode(s) including 64 long-term.
The second largest cause of short-term absence was Other musculoskeletal problems - 1172 FTE Days across 67 episode(s) including 44 long-term.
The sickness absence during the past 12 months stands at 5.08%, 1.69% above the Trust target.

Benchmarking:
No national or regional benchmarking available for this measure.

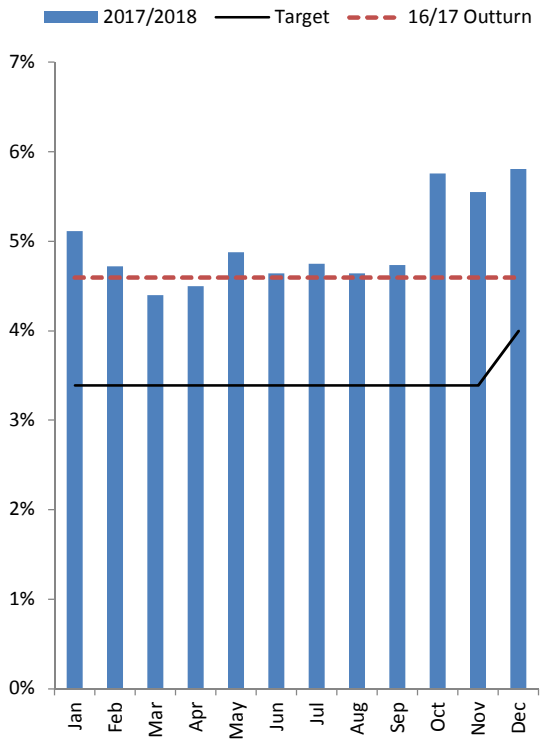
Contractual status:
No contractual requirements apply.

Continuing Actions:
- We have identified a delay with managers closing down episodes of sickness absence. This can contribute to apparent increases in absence; something which is monitored and addressed by the HR Ops Team.

- In respect to Mental Health the OH department offers weekly Stress Management groups for staff. Walsall & Dudley Mental Health Trust are putting on 3 half day training sessions for Managers around Resilience and Stress Management. OH triaging referrals for staff to the Listening Centre for 1:1 counselling support. Access to psychologist from OH. Mindfulness training is also available to all staff.

- The Health & Well-being hub continues to roll out schemes and embed/promote heathy lifestyle benefits.

- The HR Team have developed KPIs to support attendance management and continue to work with Occupational Health on a case by case basis.



Expected date to meet standard	March 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

PDR Compliance	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	90.00%		75.90%	75.90%	▼	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
The appraisal rate at the end of December 2017 was 75.90%, a decrease on November's 76.25%. This represents a fall of 0.35% month on month.

There were 164 Band 7 & above colleagues requiring an annual appraisal at the end of December 2017, and this resulted in a 71% compliance rate for this group.

The majority of divisions experienced a fall in compliance levels over the past month, of between 1% and 3%.

The Women's, Children's & Clinical Support Services division has th highest level of compliance at 85.04%.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

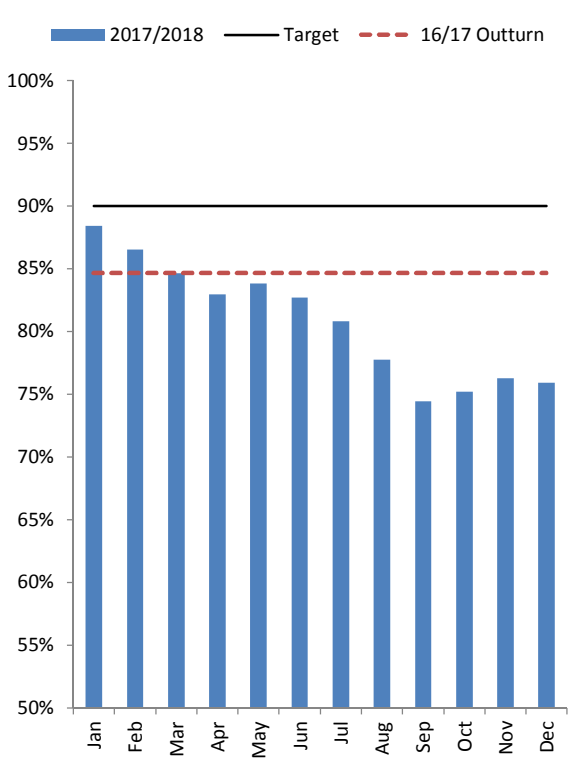
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- This will allow managers to focus on the performance of their individual teams, with easy to follow updates released on a weekly basis.

- It is hoped that this alternative approach to KPI reporting will promote a culture of ownership and competition.

- Allied to this will be the upcoming publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way.

- This approach to performance management has been implemented within other local organisations successfully, with tangible improvements evidenced when both managers and service leads share not only performance levels openly but also best practice.



Expected date to meet standard	March 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

Walsall Healthcare NHS Trust

Mandatory Training Compliance	Year Standard	Monthly Trajectory	Dec-17	YTD	Change on last month	Year End Forecast
	90.00%		79.65%	79.65%	▲	

What is driving the reported underperformance?	What actions have we taken to improve performance?	Contractual Financial Penalties	YTD £

Performance status:
Mandatory training compliance levels in December have slightly improved to 79.65% compared to 78.69% reported in November. A rise of 0.96% month on month. This represents a rise of 0.15% since the end of Q2 17/18 and a fall of 2.47% compared to the same period last year.

Three of the eight core mandatory competences saw compliance increase by up to 1% month on month.
The largest improvement owed to Fire Safety, whereby compliance rose by 1.17% month on month.
All divisions have experienced a fall in compliance levels over the pa month, of between 1% and 6%.

Women's, Children's & Clinical Support Services holds the highest level of divisional compliance, at 87%; which is 3% below the Trust target for Mandatory Training compliance.
Medicine & Long-Term Conditions holds the lowest levels of compliance, at 72%; this is 18% below agreed target levels.

Benchmarking:
No national or regional benchmarking available for this measure.

Contractual status:
No contractual requirements apply.

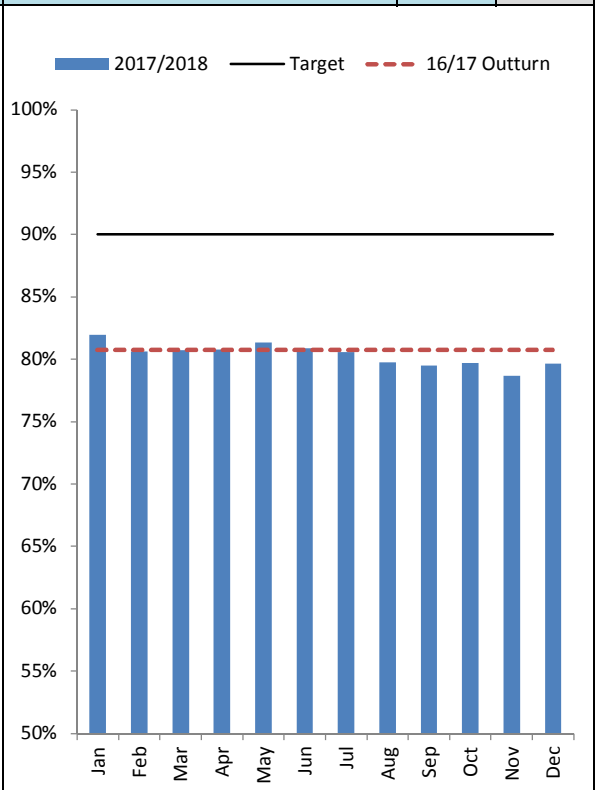
Continuing Actions:
- HR KPI reports have been developed based upon line management, rather than organisational, hierarchy lines.

- This will allow managers to focus on the performance of their individual teams, with easy to follow updates released on a weekly basis.

- It is hoped that this alternative approach to KPI reporting will promote a culture of ownership and competition.

- Allied to this will be the upcoming publication of HR KPI league tables, with the performance of services ranked in a meaningful and engaging way.

- This approach to performance management has been implemented within other local organisations successfully, with tangible improvements evidenced when both managers and service leads share not only performance levels openly but also best practice.



Expected date to meet standard	August 2018
Lead Director	Director of Human Resources

National Contract	X	Local Contract	X	Best Practice		CQUIN	

CQUINs

2017/18 CQUIN SCHEMES - Status as at 31st December 2017 (values based on initial contract & are subject to change if the contract value changes.)

CQUIN SCHEME / EXEC LEAD		% of each Indicator	Total year 1: £	Q1 - Confirmed	Q2 - Confirmed	Q3 - Available	Q4 - Available	ELEMENTS / Progress
Walsall CCG				**Risk Rating**				
NHS Staff Health & Wellbeing Director of OD	a)	33.33%	£460,151				£153,384	**Introduction of Health & Wellbeing Initiative** **By QTR 4:** Achieving a **5% point improvement in two of the three** NHS **annual staff survey questions on health and wellbeing, MSK and stress** or a set percentage. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question. The 5% point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey. For 18/19 this requires a 10% increase from the 2015 baseline or achieving the minimum threshold. **Question 9a**: Does your organisation take **positive action on health and well-being**? Providers will be expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely". Sliding scale for payment applies per question for improvements over 3%. Baseline 2015: 25.8%; Year 1 target 30.8% & Year 2 target 35.8%. Pulse survey reflects potential achievement at 75.69% which would secure 50% of this element
								Question 9b: : In the last 12 months have you **experienced musculoskeletal problems (MSK) as a result of work activities**? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 85% of staff surveyed answering "no". Sliding scale for payment applies per question for improvements over 3%. Baseline 2015: 75.45%; Year 1 target 80.45% & year 2 target 85%. Pulse survey reflects a decline in score and therefore a potential non-achievement at 65.75%
								Question 9c: During the last 12 months have you **felt unwell as a result of work related stress**? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 75% of staff surveyed answering "no" Baseline 2015: 58.44%; Year 1 target 63.44% & year 2 target 68.44%. Pulse survey reflects a decline and therefore a potential non-achievement at 57.82%. Sliding scale for payment applies per question for improvements over 3%. **Status:** Discussed at monthly H&WB steering group, communication campaign launched. Pulse survey ran August to September which included the above questions. Annual survey underway, communication campaign running. **Risk:** Agreed by Exec Director lead and H&WB steering group to place this element all at risk. Results are expected to be available January 2018.
	b)	33.33%					£19,173	**Healthy food for NHS staff, Visitors & Patients** **By QTR 4:** WCH will be expected to build on the 2016/17 CQUIN by: Firstly, maintaining the 4 changes that were required in the 2016/17 CQUIN. a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) .
							£19,173	b.) The banning of advertisements on NHS premises of HFSS;
							£19,173	c.) The banning of HFSS from checkouts;
							£19,173	d.) Ensuring that healthy options are available at any point including for those staff working night shifts. 50% payment for maintaining the above. Sliding scale for payment applies per question for improvements over 3%. **Status**: Letter to be drafted between the Trust and food providers committing to keep the changes and a paper to be drafted to go to board during Q4 summarising progress made to date. Meeting booked with WCCG early January 2018 to confirm Q4 submission requirements. **Risk:** Steering group confirmed to keep all this element at risk.
							£25,564	Secondly, introducing three new changes to food and drink provision. a.) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). 2018/19 - increases to 80%.
							£25,564	b.) 60% of confectionery and sweets do not exceed 250 kcal. 2018/19 - increases to 80%.
							£25,564	c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g 2018/19 increases to 75%. **Status**: meeting with WCCG took place early July, initial visual audit shows good compliance, detailed audit conducted during September for Blakemore's (SPAR), national guidance received in October, audit to be repeated. Meeting with WCCG planned for Jan 18 to agree Q4 submission content. Elior had signed up to the voluntary scheme to reduce SSB's to zero. **Risk:** Agreed by Exec Director lead and H&WB steering group place this element all at risk.
	c)	33.33%					£115,038 £38,346	**Improve uptake of flu vaccinations for front line staff** **QTR 4:** Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70% by February 28th 2018. Sliding scale for payment applies. year 2 increases to 75%. **Status:** Campaign has commenced, latest data shows 55% compliance. **Risk**: Agreed by Exec Director lead and H&WB steering group place this element at partial risk, i.e. achieving 50 - 60% compliance would provide 25% payment
Sub totals			£460,151	£0	£0	£0	£460,151	

Improving services for people with mental health needs who present to A&E COO	a)	10%	£257,685.00	£25,769				**Improving services for people with mental health needs who present to A&E** **QTR 1:** MH trust and acute trust to review most frequent A&E attenders who have attended 10-15 times or more within the last 12 months (i.e. throughout 2016/17). Jointly identify subset of people who would benefit from assessment, review, and care planning with specialist mental health staff. Record the number of attendances as baseline. Assure WCCG that work has been undertaken with partners to identify if the identified cohort also present frequently at other UEC system touch points. **Status: Confirmed by WCCG Achieved**. Baseline: there are 13 patients who fulfil the criteria with a corresponding 197 ED attendances in 2016/17.
		10%			£25,769			**QTR 2:** To work with DWMHPT to identify whether the presentations of the identified cohort were coded appropriately in A&E HES dataset. Submission deadline 29th September extension granted till 20th October. **Status:** Joint meeting took place 17 October 2017 (slippage on the date). Internal audit of A&E mental health coding completed, following the findings plans agreed for regular sharing of data regarding people attending A&E. The cohort has been reduced down to 10 patients (159 attendances)
		0%						**QTR 2**: Establish joint governance arrangements to review progress against CQUIN and associated service development plans. **Status:** Draft arrangements shared and agreed in principal, formal governance process to be confirmed.
		10%			£25,769			**QTR 2:** To work with other key system partners as appropriate/necessary to ensure that: • Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort of frequent attenders; • A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly;• Care plans are shared with other key system partners (with the patient's permission). **Status:** Draft arrangements shared and agreed in principal, formal governance process to be confirmed. **Confirmed by WCCG Achieved.**
		20%			£51,537			**QTR 2:** Bringing in other local partners as necessary/appropriate, agree service development plan to support sustained reduction in A&E frequent attendances by people with MH needs. This is likely to include enhancements to: • Primary care mental health services including IAPT; • Liaison mental health services in the acute hospital; • Community mental health services and community-based crisis mental health services; This work is likely to need to be undertaken with other partners outside of the NHS, including social care, public health and voluntary sector partners. **Status**: Draft arrangements shared and agreed in principal, formal governance process to be confirmed. **Confirmed by WCCG Achieved.**
		10%				£25,769		**QTR 3:** Jointly review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence that Q4 submissions are complete and accurate. Assurances provided to CCGs accordingly. **Status:** Monthly audits planned for frequent flyers who are not in the cohort (10 attendances within a 12 months rolling period). Audit extract updated following the ECDS upgrade. The original baseline patients has been adjusted to remove 2 patients who have been discharged from the MH Trust and replaced with 2 new patients. The new baseline is to be recalculated.
		40%					£103,074	**QTR 4:** 20% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. Target: to be recalculated. Sliding Scale for payment applies.
Sub totals			£257,685.00	£25,769	£103,074	£25,769	£103,074	
Improving the assessment of wounds DoN	a)	0%	£257,685					**Improving the assessment of wounds** Aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment **QTR 1:** Establish clinical audit plan. **Status**: Audit template designed, shared and agreed with WCCG.
		50%			£128,843			**QTR 2: By 30 November 2017:** Completion of Clinical audit to provide a baseline figure for the number of patients with chronic wounds that have received a full assessment. Full audit report and improvement plan with trajectory to be provided for commissioner. **Status:** Audit has been completed, compliance rate is 39.33%, an improvement trajectory of 55% has been agreed. **Risk: Confirmed by WCCG Achieved.**
		50%					£128,843	**QTR 4: By 31 May 2018:** Repeat clinical audit to demonstrate an improvement in the number of patients with chronic wound who have received a full wound assessment. Target is 55%. Sliding scale applies. 2018/19: Sustain the reduction for the selected cohort and reduce total number of attendances to A&E by 10% for all people with primary mental health needs. (Q4 18/19 compared to Q4 17/18)
								year 2 : Q2 Achieve the nationally set target
								year 2 : Q4 Achieve the nationally set target
Sub totals			£257,685	£0	£128,843	£0	£128,843	

NHS e-Referrals D of S&T	a)	25%	£257,685	£64,421				**NHS e-Referrals:** relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. All providers to publish ALL such services and make ALL of their First Outpatient Appointment slots available on e-RS by 31 March 2018 **QTR 1:** Providers should supply a plan to deliver Q2, Q3 and Q4 targets to include: A definitive list of all services/clinics accepting 1st O/P referrals and details of the NHS e-RS services they are mapped to, identifying any gaps to be addressed through this CQUIN. A trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4. **Status:** plan submitted to WCCG. Baseline 39% of clinics published, ASI rate 83%. Project team established, fortnightly meetings scheduled. ASI rate target of 4% or less challenged with WCCG & NHS Digital. **Risk**: **Confirmed by WCCG Achieved**
		25%			£64,421			**QTR 2:** 80% of Referrals to 1st O/P Services able to be received through e-RS. Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1. **Status:** Q2 submitted, 85% of specialities are now mapped to the DOS. ASI rates achieved 62.45% in September. (July 74% and August 70%). **Risk:** Targets; 80% available slots & 70% ASI rate.: **Confirmed by WCCG Achieved**
		25%				£64,421		**QTR 3**: As Qtr. 2 except 90% of Referrals to 1st O/P Services & achieve ASI issues in line with agreed trajectory (36%) **Risk:** Q3 at risk due to ASI rates .
		25%					£64,421	**QTR 4**: Same as Qtr. 2 except 100% of Referrals to 1st O/P Services & achieve 4% or less ASI issues. **Risk:** The 4% ASI rate has been raised with NHS Digital & WCCG, however as this is a national target they are not willing to locally change it, further discussions are ongoing.
Sub totals			£257,685	£64,421	£64,421	£64,421	£64,421	
Offering advice and guidance D of S&T	a)	25%	£257,685	£64,421				**Offering advice and guidance** The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. **QTR 1: 30 July 2017:** Agree specialties with highest volume of GP referrals for A&G implementation. Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18. Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18. Agree local quality standard for provision of A&G, including that 80% of asychronous responses are provided within 2 working days **Risk:** **Confirmed by WCCG Achieved.**
		25%			£64,421			**QTR 2: 31 October 2017:** A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory. Local quality standard for provision of A&G finalised and a Baseline data for main indicator provided **Status**: Project team established, fortnightly meetings scheduled. Consultant Connect currently provides 10.97% (Gen. surgery, gastro, urology, diabetics and endocrinology). plans to be agreed when WCCG decommission this service to transfer these services over to ERS. **Risk:** Q2 submitted **Confirmed by WCCG Achieved.**
		25%				£64,421		**QTR 3: 31 January 2018:** A&G services operational for first agreed tranche of specialties, Quality standards for provision of A&G met, Data for main indicators provided and Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19 **Status:** Still waiting for a meeting with WCCG to agree local tariff for A&G. A&G project board in place. Dermatology is a potential for the first service to activate ERS A&G once the tariff has been agreed.
		25%					£64,421	**QTR 4: 31 May 2018:** A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter, Quality standards for provision of A&G met and Data for main indicator provided
Sub totals			£257,685	£64,421	£64,421	£64,421	£64,421	
Personalised care and support planning DoN	a)	25%	£257,685		£64,421			**Personalised care and support planning: to introduce the requirement of high quality personalised care and support planning** **QTR 2: (end of Sept 17)** Submission of a plan to ensure care & support planning is recorded by providers. Status: Agreed with WCCG definition of long term conditions. Plan created. Linking into the Total Mobile b. Plan produced but recording system not in place = 50% of proportion of CQUIN value c. Plan produced and recording system put in place = 100% of proportion of CQUIN value Risk: none. **Confirmed by WCCG Achieved.**
	b)	15%				£38,653		**QTR 3**: identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served Q3 submitted to WCCG
	c)	30%					£77,306	**QTR 4a:** To confirm what proportion of relevant staff have undertaken training in personalised care and support planning.
	d)	30%					£77,306	**QTR 4b:** To confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level
								75% > of identified cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value (50-75% = 50% payment)
								50% > of identified cohort demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value (25-50% = 50% payment)
Sub totals			£257,685	£0	£64,421	£38,653	£154,611	
Preventing ill health by risky behaviours – alcohol and tobacco DoN		33% of Q1	£276,091	£69,023				**Preventing ill health by risky behaviours – alcohol and tobacco** **QTR 1: each element worth 33% of Q1** **a)** completing an information systems audit; b) training staff to deliver brief advice, c) collect baseline data (on elements a) to e)) Risk: **Confirmed by WCCG Achieved**
	a)	5%			£3,451	£3,451	£3,451	Tobacco screening: Percentage of unique adult patients who are screened for smoking status AND whose results are recorded **Q2 Confirmed Achieved**
	b)	20%			£13,805	£13,805	£13,805	Percentage of unique patients who smoke AND are offered very brief advice **Q2 Confirmed Achieved**
	c)	25%			£17,256	£17,256	£17,256	Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. **Q2 Confirmed Achieved**
	d)	25%			£17,256	£17,256	£17,256	Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems **Q2 Confirmed Achieved**
	e)	25%			£17,256	£17,256	£17,256	Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. **Status:** Q2 submitted and expected to achieve. Monthly audits continue (10 patients per ward) close monitoring of compliance and follow up with wards who are not performing the audit in full or have low compliance. Meeting arranged with WCCG during December to agree improvement trajectories. **Q2 Confirmed Achieved**
Sub totals			£276,091	£69,023	£69,023	£69,023	£69,023	

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) MD	a)	25%	£257,685	£8,053	£8,053	£8,053	£8,053	**Timely identification of sepsis in emergency departments** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis The indicator applies to adults and child patients arriving in hospital as emergency admissions A minimum of 50 records per month after exclusions for ED. 90% Target. Sliding scale 50-89% = 10%. **Status:** The audit methodology of NEWs scores continues not to identify the full required number of patients and continues to be time consuming. A centralised database is being created during Q3 to support the audit process. Risk: **Q1 achieved 95.33%. Q2 achieved 94.85%** Remaining quarters are at risk
				£8,053	£8,053	£8,053	£8,053	**Timely identification of sepsis in acute inpatient settings** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. The indicator applies to all patients on acute in-patient wards. A minimum of 50 records per month after exclusions for Inpatients. 90% Target. Sliding scale 50-89% = 10%. **Status**: as ED. Risk: **Q1 achieved 90%. Q2 achieved 90.91%.** Remaining quarters are at risk
	b)	25%		£3,221 £4,832	£3,221 £4,832	£8,053	£8,053	**Timely treatment for sepsis in emergency departments** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. Applies to adults and child patients arriving in hospital as emergency admissions. 90% Target. Sliding scale 50-89% = 10% **Status:** Actions taken; additional teaching, grand round presentation, raising awareness through care groups, wards and mandatory training. **Risk:** Q1 86.21% partial achievement 10%. Q2 88.57% partial achievement 10%. Remaining quarters at risk
				£3,221 £4,832	£3,221 £4,832	£8,053	£8,053	**Timely treatment for sepsis in acute inpatient settings** The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour. The indicator applies to adults and child patients on acute in-patient wards. 90% Target. Sliding scale 50-89% = 10% **Risk:** Q1 53.57% partial achievement 10%. Q2 63.27% partial achievement 10%. Remaining quarters at risk
	c)	25%		£16,105				**Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours** Review to show; Stop, IV to oral switch, OPAT (Outpatient Parenteral Antibiotic Therapy), Continue with new review date, Continue no new review date, Change antibiotic with Escalation to broader spectrum antibiotic, Change antibiotic with de-escalation to a narrower spectrum antibiotic, Change antibiotic e.g. to narrower / broader spectrum or as a result of blood culture results. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. Perform an empiric review for at least 25% of cases in the sample **Risk: Q1 achieved.**
					£16,105			Perform an empiric review for at least 50% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. **Risk: Q2 achieved.**
						£16,105		Perform an empiric review for at least 75% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal.
							£16,105	Perform an empiric review for at least 90% of cases in the sample. Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal.
	d)	25%					£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions: Target 2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value. **Status:** Improved processes for; follow up of restricted antibiotics, surveillance and system to drive better prescribing.
							£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions. Target 1% reduction for those trusts with 2016 consumption indicators above 2013/14 median value **Status**: Antimicrobial review rounds targeting high users.
							£21,474	**Reduction in antibiotic consumption per 1,000 admissions** 3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions. Target 2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value **Status:** New guidelines implemented in April 2017 to encourage the use of alternative antibiotics.
Sub totals			£257,685	£48,317	£48,317	£48,316	£112,737	
Supporting Proactive and Safe Discharge – Acute Providers COO (a&c) D of S&T (b)	a)	40%	£460,151		£184,060			Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories **Q2:** I) Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers **Status**: **Confirmed by WCCG Achieved.**
	b)	20%		£69,023				Emergency Care Data Set (ECDS) To have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017 Q1: Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017. **Status:** plan submitted pending WCCG decision on payment. **Risk: Confirmed by WCCG Achieved.**
						Q3 moved into Q4 as agreed with WCCG	£23,008	Q3: Type 1 or 2 A&E provider is returning data at least weekly AND 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 95% of patients have a diagnosis. Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT). **Status:** Due to the delay with the Lorenzo upgrade by the system provider it was not possible to achieve the Q3 requirements , following our request WCCG have agreed to move the CQUIN requirements from Q3 into Q4. project plan is progressing, initial data flows have commenced, **Risk:** Q4 at risk. The aim is to achieve weekly data flows during Q4, however the 95% compliance is unlikely to be achieved due to the time lag for data entry.
	c)	40%					£184,060	Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17) Baseline = 47.84%.
Sub totals			£460,151	£69,023	£184,060	£0	£207,068	
Sub Total WCCG			£2,742,503	£340,973	£726,580	£310,602	£1,364,349	

NHS England – Specialised Commissioners								
Paediatric Networked Care – non-PICU Centres COO	a)	40%	£15,151		£15,151			**Paediatric Networked Care – non-PICU Centres** **Part 1:** Local acute hospitals will be required to work with their regional PICU provider in providing fully completed PCCMDS data over a six month period August to December 2017 (request to extend to January) in order for the lead provider to submit a summary report by February 2018. Conduct a self assessment and submit data to PICU - due mid October. **Status:** Monthly audit data being submitted to BCH. Potential to utilise Lorenzo to record data is currently being considered.
	b)	30%	£11,363				£11,363	Partake in the lead PICU provider's review of referring acute hospitals against the Paediatric Intensive Care (PICS) standards in order for the lead PICU provider to submit a report.
	c)	30%	£11,363				£11,363	Ongoing participation with West Midlands Paediatric Critical Care Network meeting, including representation at meetings and implementation of clinical protocols as agreed by the Network. Risk: no risk forecast.
Sub totals			£37,878	£0	£15,151	£0	£22,727	
GE3: Hospital Medicines Optimisation MD	a)	33%	£25,221	£6,305	£3,153	£3,153	£3,153	**GE3: Hospital Medicines Optimisation** **Trigger1:** Adoption of best value generic/ biologic products in 90% of new patients within one quarter of guidance being made available. Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months **Status:** NHSE confirm CQUIN only to be pursued from Q2 when 2nd rituximab biosimilar on market. New template received from NHS E, pharmacy are working on completing the data. Meeting was scheduled for 20 Nov to clarify requirements for Q3 & Q4 has been cancelled by NHS E and is currently being rearranged. **Risk: Q1 & Q2 achieve confirmed NHS E**
					£3,153	£3,153	£3,153	Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is < 6 months **Status:** NHSE confirm CQUIN only to be pursued from Q2 when 2nd rituximab biosimilar on market **Risk**: **Q2 achieved confirmed NHS E**
	b)	17%	£12,993			£6,496	£6,496	**Trigger2**: Improving drugs MDS data quality to include dm+d as drug code in line with ISB 0052 by June 2017 or in line with agreed pharmacy system upgrade as well as all other mandatory fields All hospitals submit HCD data in agreed MDS format fully, accurately populated on a monthly basis and bottom line matches value for drugs on ACM **Status:** Minimum dataset (MDS) not confirmed by NHSE as of 16/6/17. Unclear how WMHT to achieve CQUIN without electronic prescribing, plus issues with available national coding sets. Further information requested from NHSE, meeting to be arranged.
	c)	33%	£25,221	£2,293			£22,928	**Trigger3**:Increase use of cost effective dispensing routes for outpatient medicines:- Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines (plan to be developed by drug category to take into account patient population). Transition to agreed cost per item reimbursement approach as per scheme. **Risk**: **Q1 achieved confirmed NHS E**
	d)	17%	£12,993	£1,529	£1,911	£5,732	£3,821	**Trigger4**: Improving data quality associated with outcome databases (SACT and IVIg) :– All hospitals submit required outcomes data (SACT, IvIg) in agreed format fully, accurately populated in agreed timescales. Implementation of agreed transition plan for increasing data quality. **Status:** plan to be approved. Require clarity from NHSE re: transition objectives. SACT plan to be agreed by service and submitted during Q3. **Risk: Q1 partial achievement** Q2 extension agreed regarding SACT plan. Remaining money moved into Q3.
Sub totals			£76,427	£10,127	£8,216	£18,533	£39,551	
WC5 Neonatal Community Outreach DoN	a)	25%	£9,470		£9,470			**WC5 Neonatal Community Outreach** **Trigger1:** All units to present their 2016/17 average occupancy rates for their funded cots and patient flow data. National Definitions on discharge criteria for outreach care, to be developed by neonatal intensive care CRG. All Units to present to their ODNs their current discharge definitions and criteria for outreach support. (ODNs will assess and analyse the difference between their current state definitions and criteria and the National Definitions for babies that fall into the criteria for outreach support.)
	b)	50%	£18,939			£18,939		**Trigger2**: Providers that have presented information to their ODNs outlining the number of babies that would have been discharged (linked to the new criteria) and the impact that this would have had on occupancy rates. To work with NICU to scope the additional support required to provide an outreach service in line with the National Definitions and discharge criteria. Plan adopted to create outreach units and target reduction in occupancy levels agreed. Status: Regional meeting held, options appraisal report to be submitted by 31 Jan 2018
	c)	25%	£9,470				£9,470	**Trigger3**: Providers (with support from ODNs) to recruit outreach teams to support all parts of the network to comply with national occupancy rate standards Risk: Q4 at risk, resource required to expand operational hours.
Sub totals			£37,878	£0	£9,470	£18,939	£9,470	
			£152,183	£10,127	£32,837	£37,473	£71,747	
NHS England – Public Health Dental								
West Midlands Secondary Care Dental Contract COO	a)		£34,962.00	£17,481				An initial audit shall be completed by 30 June 2017 and a report of the audit prepared and available for discussion with NHSE by 21 July 2017 Status: Audit complete, summary report to be compiled. Risk: **Achieved confirmed NHS E.**
								Subject to any issues being identified during the audit, a plan to be shared by the end of Quarter 2 to address/correct these by 30 Sept 2017
							£17,481	**Achieved confirmed NHS E.**
Sub totals			£34,962.00	£17,481	£0	£0	£17,481	
Total Schemes			£2,929,648	£368,581	£759,417	£348,075	1,453,578	

Glossary

KPI Monitoring - Acronyms

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
- 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
- MST – Medicines Safety Thermometer
- MUST – Malnutrition Universal Screening Tool

KPI Monitoring - Acronyms

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
- 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
- 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

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board			**Date:** 1st February 2018
Report Title	Winter update as at January 2018			**Agenda Item: 19** **Enclosure No.: 17**
Lead Director to Present Report	Philip Thomas-Hands, Chief Operating Officer			
Report Author(s)	Philip Thomas-Hands, Chief Operating Officer			
Executive Summary	This is a brief update on Trust services during the winter period 17/18. Some KPIs are included at this stage and the most recent NHSI guidance. All teams have worked well together so far to meet demands within a safe environment.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation				

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, empowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☐</td><td><u>Effective</u></td><td>☐</td></tr><tr><td><u>Caring</u></td><td>☐</td><td><u>Responsive</u></td><td>☐</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2"></td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2"></td></tr>
<tr><td><u>Report History</u></td><td colspan="2"></td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">1. Review of all KPIs after the winter is over to identify improvements to Trust services all year and lessons learned for next winter.
2. Work with ECIP on focused areas e.g. consistent SAFER working, use of discharge lounge and levelling of Ambulance demand.
3. Implement a de-escalation plan to Q4 with clinical support.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

1.0 Introduction

This a winter update, as at January 2018.

2.0 Winter plan

The winter plan 2017/18 has been followed with good clinical engagement across the period so far.

In December ward 14 was fully opened to 28 beds and ward 10 to 28 beds.

3.0 National guidance

The above was issued on 2nd January 2018 and is shown at ***Appendix 1***. ***Appendix 2*** shows our response. The activity cancelled during the winter is shown below;

WALSALL HEALTHCARE NHS TRUST

FINANCIAL IMPACT FOLLOWING PRIORITISATION OF EMERGENCY ACTIVITY (ED)

Description	Dec-17		Jan-18		Feb-18		Total	
	Activity	£m's	Activity	£m's	Activity	£m's	Activity	£m's
OUTPATIENTS	1,342	107,360	3,717	297,360	2,602	208,152	7,661	612,872
Outpatient reductions in attendances over the period								
ELECTIVE	108	130,464	432	521,856	302	364,816	842	1,017,136
Reductions within weekly planned elective activity								
EMERGENCY		(22,917)		(127,413)		(89,189)		(239,519)
Income reduced owing to contractual agreed cap and MT								
Temporary worker premiums / additional capacity areas		90,000		250,000		50,000		390,000
TOTAL		304,907		941,803		533,779		**1,780,489**

KEY ASSUMPTIONS

1 The above represents the reduction in activity over normal trading during the period of late December to February 2018
2 The Trust has applied an average charge per case that was not undertaken for a weighted activity list of £1,208 per episode
3 The emergency income is based on application of the marginal tarif, further work is needed to affirm this being the income benefit
4 The emergency income is impacted upon by the Trust agreeing a cap on charging for emergency activity as part of the contract for 2017/18
4 Estimations have been made in relation to costs associated with additional activity for temporary workforce premiums for additional capacity

4.0 Key Performance Indicators over the Winter Period

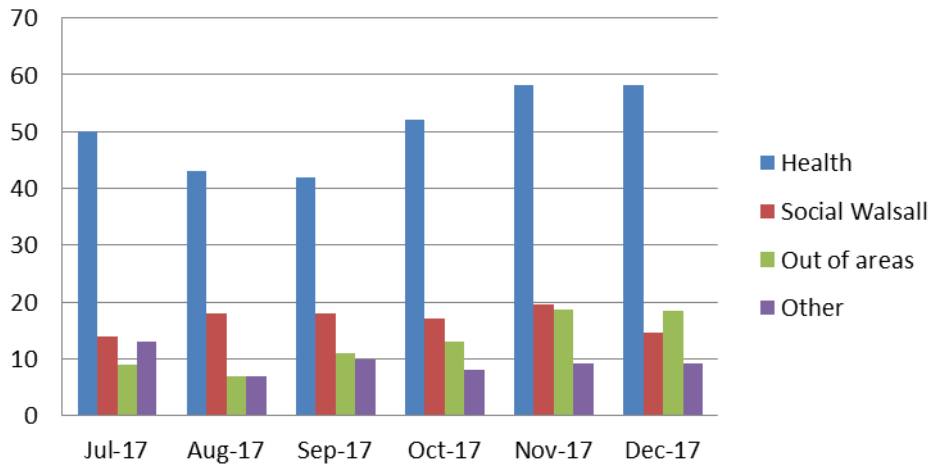
4.1 The following KPIs give an indication of the present winter position;

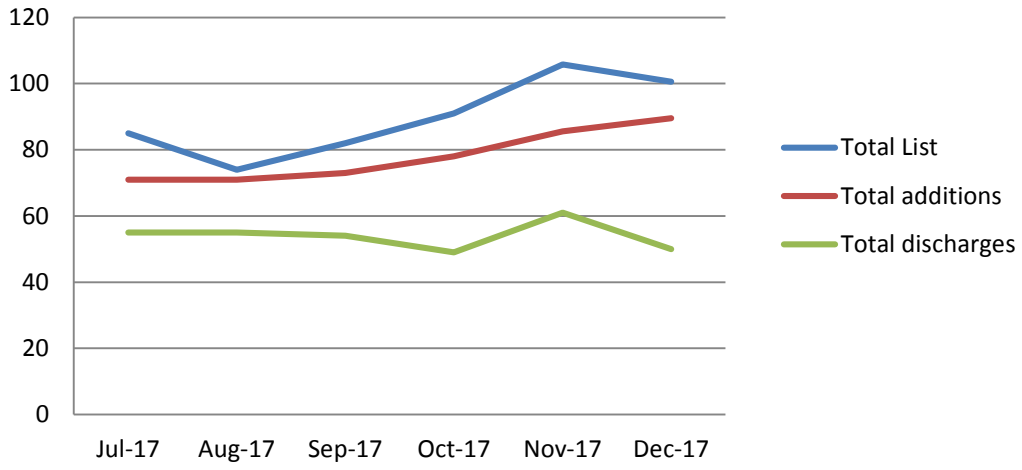
4.1.1

	Apr-17	*May-17*	*Jun-17*	*Jul-17*	*Aug-17*	*Sep-17*	*Oct-17*	*Nov-17*	*Dec-17*
% Time spent in Emergency Department (within 4 hrs) Type 1 and Type 3 including UCC	85.81	81.61	85.02	82.34	80.72	81.82	82.75	82.03	83.38
Emergency Department Attendances: All type activity.	9638	10011	10021	10217	9415	9642	10256	9740	13782
Emergency Department Attendances: Reported Breaches	1368	1841	1501	1804	1815	1753	1769	1750	2290
Ambulance: Number Attending Emergency Department	2556	2630	2571	2633	2396	2585	2811	2712	2989
Ambulance: Number Attending Emergency Department subsequently admitted.	1234	1270	1252	1286	1231	1242	1384	1234	1353
Clinically Stable Patients: Month Snapshot (Number)	76	60	58	55	52	67	71	79	78
Clinically Stable Patients- Monthly Average (Number)	76.2	74.12	68.5	59.67	51.45	58.48	65.67	76.36	76.7
Delayed Transfers of Care (BR)	3.77	2.13	1.64	1.50	1.22	1.58	3.16	3.27	2.16
% Emergency readmission within 30 days of discharge from hospital (BR)	11.02	9.51	10.38	9.27	10.64	11.43	10.75	10.35	
Emergency Admissions admitted via Emergency Department	1809	1990	2043	2070	2004	2090	2234	2109	2209
Emergency Admissions admitted via GP	345	391	334	413	372	322	362	448	301
Emergency Admissions admitted via other means	287	364	354	303	356	385	356	362	366

4.1.2
The MFFD numbers dropped in December with collaborative working with Intermediate Care. January saw a rise in this number as systems struggled to cope with the pace of rising demand against longer LOS,

Average Monthly MFFD





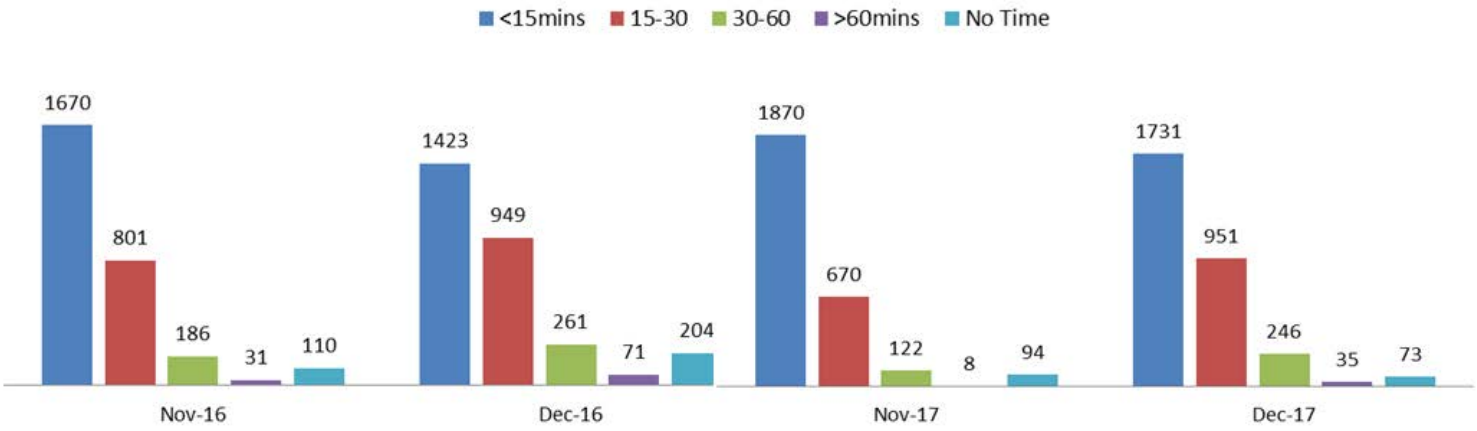
4.1.3

A significant rise in Ambulance attendances (over 90 per day for 80% of December days) has put strain on hospital systems as the
the level of acuity increased in December 2017 leading to longer LOS for patients in hospital (shown below)

Estimated Impact of December 17 Increased Patient Acuity vs Sept - Nov 17				
Average Cost M6-8 per Emergency Admissions	**Average Cost M9 per Emergency Admissions**	**Average Cost Increase**	**Estimated Cost Increase - December Emergency Admissions**	**Estimated % increase in Acuity - Dec 17 vs Sept - Nov 17**
£1,667	£1,838	£171	£458,049	10.02%

4.1.4

Handover rates (Ambulances waiting outside ED)



Overall the number of longer delays has reduced compared with last year.

4.1.5

Discharge Lounge

The Lounge was reviewed and re-promoted in early December to improve flow for patients when they were well enough to go home:

	Activity	Discharges before midday	Discharges before midday (%)
October (02/10 – 30/10)	524	147	28%
November (06/11 – 27/11)	393	131	33%
December (04/12 – 25/12)	441	184	42%
January 24th	460		

4.16
Number of bays closed by Infection Control from 01 December 2017 due to norovirus

Ward/Bay	Outbreak date closed	Outbreak date opened
Ward 7	06/12/2017	09/12/2017
Ward 15	06/12/2017	23/12/2017
Ward 2	10/12/2017	24/12/2017
Ward 16 Bay	11/12/2017	12/12/2017
Ward 16 Bay	07/12/2017	08/12/2017

This had a negative effect on flow and nurse resources allocation; such bays are "suspended" from use while patients in them recover and have to be nursed separately by nursing teams.

There have also been 18 bays closed to date due to Flu (mainly in January 2018).

5.0 Risks at this stage:

Risks	Mitigation
Nurse staffing for extra capacity	MD planning at bed meetings and support of DCNO and CNO
Consistent medical staffing across all the extra capacity	DD Medicine secured Medical team for extra capacity. Other areas negotiated with DD.
Patient waits in ED	Winter plan re escalation, discharge lounge and STP allocations in November 2017 established Acute Physician in ED
Care processes not maintained	Regular audits by Corporate Nursing taken place to address issues.

6.0 Conclusion
Despite significant demand pressures on the Trust systems within the community and the hospital KPIs have shown a steady performance at this point of the winter, as shown in ***Appendix 3***.

Appendix 1

NHS Improvement

OFFICIAL

NHS England

To

CCG Accountable Officers and Clinical Leads
NHS Foundation Trust Chief Executives
NHS Trust Chief Executives
CC:
NHS Foundation Trust Medical Directors
NHS Trust Medical Directors
NHS Foundation Trust Directors of Nursing
NHS Trust Directors of Nursing

NHS England
Skipton House
80 London Road
London
SE1 6LH

2 January 2017

Publications Gateway Reference: 07578

Dear Colleague

I am writing to make you aware of further guidance (Annex A) that the National Emergency Pressures Panel has today issued to support you as part of a new NHS Winter Pressures Protocol. This is in addition to the recommendations made by the panel on 21 December, the additional capacity that you are putting in place with the funding announced in the November Budget and your existing winter plans.

I am very grateful for the hard work and commitment of all your staff during the Christmas period. I hope that these recommendations provide further support to help with the pressures that you face. Your Regional Directors will be in contact to provide further support in operationalising these recommendations and please do provide feedback either through them or directly to me if there is further support we can provide.

Yours,

Pauline Philip

National Director, Urgent and Emergency Care,
NHS England and NHS Improvement

Annex A

OPERATIONAL UPDATE FROM THE NHS NATIONAL EMERGENCY PRESSURES PANEL

The National Emergency Pressures Panel (NEPP) met for the second time today (2 January 2018) chaired by Professor Sir Bruce Keogh.

The panel was set up earlier this year to advise Pauline Philip, NHS National Director for Urgent and Emergency Care, on pressure and clinical risk. It brings together clinical leaders and experts from organisations including the Royal College of Surgeons, the Royal College of Physicians, the Royal College of GPs, the Royal College of Nursing, Public Health England and the CQC.

The panel noted that the NHS has been under sustained pressure over the Christmas period with high levels of respiratory illness, bed occupancy levels meaning there is limited capacity to deal with demand surges, early indicators of increasing flu prevalence and some reports suggesting a rise in the severity of illness among patients arriving at A&Es.

The panel discussed the excellent work they have seen and heard about in recent weeks from frontline staff and in hospitals across the country. They formally recorded their thanks for the hard work of staff and discussed the further support that could be given.

Today NEPP are issuing further recommendations, that they believe will support hard-working frontline staff, thereby activating the new NHS Winter Pressures Protocol. These include:

- extending the operational recommendations, made on 21 December, to 31 January This includes the deferral of all non-urgent inpatient elective care to free up capacity for our sickest patients. As previously the panel has reiterated that cancer operations and time-critical procedures needed to prevent rapid deterioration in a patient's condition should go ahead as planned;
- over and above this, day-case procedures and routine follow-up and outpatient appointments should also be deferred or dealt with in different ways, e.g. telephone consultation, where this will release clinical time for non-elective care;
- the clinical time released from the above actions should be re-prioritised to:
    - implement consultant triage at the front-door so patients are seen by a senior decision maker on arrival to the hospital;
    - ensure consultant availability for phone advice for GPs;
    - maximise the usage of ambulatory care and hot clinic appointments as an alternative to Emergency Department attendance and/or hospital admissions;
    - staff additional inpatient beds;
    - provide additional Allied Health Professional input into rehabilitation and discharge; and,
    - ensure twice daily senior review of all patients to facilitate discharge.

- to ensure patient safety comes first CCGs should temporarily suspend sanctions for mixed sex accommodation breaches;
- whilst overall the NHS is doing better than ever before in vaccinating health care workers there is significant variation between organisations[1]. There should be an immediate prioritisation of the vaccination of all front line staff over the next two weeks.

The Panel will meet again before the end of January to review the pressures on the system and the impact of the recommendations above.

These recommendations are made in light of the actions that are already being taken to increase capacity in the NHS following the announcement of additional funds in The Budget on 22 November. A significant proportion of the additional capacity funded through November's Budget is due to open in the next fortnight.

The NHS is taking these steps to ensure patients receive the best possible care over this challenging period. Calling 111 is often a quicker and more convenient way of obtaining clinical assessment and advice in non-emergencies and allows staff in A&E to focus on the sickest patients. The Royal College of GPs has already set out three basic steps that all patients should consider before seeking an appointment with their GP for an acute illness, including self-care, using online guidance from NHS Choices and consulting with a pharmacist.

[1] https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-monthly-data-2017-to-2018

Appendix 2

NEPP Guidance - Questions	Yes/ No	If 'No' please explain the constraints and the timeframe to resolve (date for adherence)
Have you deferred all non-urgent inpatient elective care activity during January?	Yes	
Are urgent cancer operations and time-critical procedures continuing?	yes	
Have you cancelled day-case procedures and routine follow-up and outpatient appointments to release clinical time for non-elective care?	yes	
Are you prioritising the clinical time released to:		
· **implement consultant triage at the front-door**	yes	
· **provided consultant availability for phone advice to GPs**	No	Planning to Implement for remainder of January 18
· **provide alternatives to ED attendance and/or hospital admission**	yes	
· **staff additional inpatient beds**	yes	
· **provide additional AHP input into rehabilitation and discharge**	yes	
· **ensure twice daily senior review of all patients to facilitate discharge**	yes	Operate Consultant hot week model to allow continuous review of patients
Have sanctions for mixed sex accommodation breaches been suspended?	yes	
Are you prioritising vaccination of all front line staff in the next two weeks?	yes	Reviewing target focus for next 2 weeks with CNO.

Appendix 3

Community teams

	Summary of KPIs	Units	Planned / Actual	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	TOTAL
5	**PLACE BASED TEAMS** Mobile technology/admission avoidance (Matron)	Avoided Admissions	2017 Predicted	0	0	12	24	48	48	48	48	48	
			2017 Actual	0	0	40	74	34	74	97	100	107	
			Variance to plan	0	0	28	50	-14	26	49	52	59	250
6	**PLACE BASED TEAMS** Mobile technology/turnaround support in ED/Wards In Reach Matrons	Avoided Admissions	2017 Predicted	0	0	12	24	24	24	48	48	48	
			2017 Actual	0	0	0	0	24	52	96	68	13	
			Variance to plan	0	0	-12	-24	0	28	48	20	-35	25

	Summary of KPIs	Units	Planned / Actual	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	TOTAL
1	Rapid Response- increase in referrals - benchmarked previous 12 months with phased increase during 2017 due to staff recruitment. Aim for 10% increase/monthly up to 15% as staff in post	Increase in referrals	2016 Baseline	144	185	175	203	151	163	181	193	226	
			2017 Predicted referrals	158	204	193	223	166	187	208	222	260	
			2017 Actual referrals	183	196	202	190	201	187	216	247	258	
			Variance to plan	25	-8	10	-33	35	0	8	25	-2	59
2	Rapid Response Team - as above detailing number and increase in avoided admissions	Avoided Admissions	2016 Baseline	135	176	171	197	147	153	167	175	190	
			2017 Predicted Admission avoidance	165	176	182	171	181	169	194	222	232	
			2017 Actual Admissions avoided	155	173	181	176	180	176	206	237	248	
			Variance to plan	-10	-3	-1	5	-1	7	12	15	16	40

Walsall Healthcare NHS
NHS Trust

BOARD/COMMITTEE REPORT

Meeting	Trust Board Meeting			**Date:** 1 February 2018
Report Title	Performance Finance and Investment Committee Highlight Report and Minutes			**Agenda Item: 20** **Enclosure No.: 18**
Lead Director to Present Report	Non-executive Director and Performance, Finance and Investment Committee Member, Mr Sukhbinder Heer			
Report Author(s)	Non-executive Director Committee Member, Sukhbinder Heer and Trust Secretary, Linda Storey			
Executive Summary	The report provides a highlight of the key issues discussed at the most recent Finance Performance and Investment Committee Meeting held on 24th January 2018 together with the confirmed minutes of the meeting held on 27th November 2017. Both meetings were quorate. The meeting held on the 27th November 2017 was chaired by Mr John Dunn, Non-executive Director and Committee Chair. The meeting on the 24th January 2018 was chaired by Mr Sukhbinder Heer, Non-executive Director Committee Member.			
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	The Board is recommended to DISCUSS the content of the report and raise any questions in relation to the assurance provided.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performance and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>-</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>With local partners change models of care to keep hospital activity at no more than 2016/17 outturn</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>-</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Tackle our financial position so that our deficit reduces</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Link to Board Assurance Framework Risk Statements:
No. 6 ‘That we are not able to recover performance on the national elective standards including referral to treatment and cancer as planned’.
No. 9 ‘That we are not able to deliver our plan within the resources available’.
No. 10 ‘That we cannot deliver our planned programme of hospital estate improvement including a plan for the Emergency Department’.
No.11 ‘That our governance remains “inadequate” as assessed under the CQC Well Led standard’.
No. 12 ‘That the Service Improvement & Cost Improvement programmes do not deliver the financial impact resulting in non-delivery of the financial plan’.
No. 14 ‘New entrants into the market will succeed in attracting services resulting in income loss to the Trust’.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">There are no resource implications raised specifically as a result of this report.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">Compliance with Trust Standing Orders.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">The Committee reports to the Trust Board on a monthly basis following its meetings. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting.</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">The minutes from the Committee meeting held on 24th January 2018 will be submitted to the Board at its meeting in March 2018 at which the Board will also receive a highlight report from the Committee meeting to be held in February.</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
</table>

FINANCE PERFORMANCE AND INVESTMENT COMMITTEE HIGHLIGHT REPORT

1. INTRODUCTION

The Committee reports to the Trust Board each month following its meeting. The Board receives the approved minutes from the previous Committee meeting and a highlight report on the key issues raised at the most recent meeting. The report covers the key issues from the meeting held on 24th January 2018, together with the approved minutes of the meeting held on the 27th November 2017.

2. KEY ISSUES FROM MEETINGS HELD ON 24th JANUARY 2018

2.1 The meeting was quorate and Chaired by Mr Heer, Non-executive Director.

2.2 Financial Performance Month 8 and Month 9 and Forecast Outturn for 2017/2018

The Committee received the financial performance for month 8 and month 9 together with the forecast outturn for 2017/2018.

The key issue was that without further financial recovery action the deficit would be £27.7m against the agreed target with NHSI of a deficit of £20.5m. The Committee received a high level financial recovery action plan to bridge the gap of £7.2 m. The Committee was encouraged by the executive team's commitment and focus to deliver the plan.

The committee asked for the following:

1. The underlying actions to support the delivery e.g. the closure of Ward 14, recovery of income etc.
2. The resources required from KPMG and the Trust to deliver the action plan.
3. A weekly update on progress to be sent to the Chair of the Trust Board and Chair of the Performance, Finance and Investment Committee setting out any mitigations to close gaps.
4. Overarching action plan to be completed by Wednesday 31st January 2018.

2.3 KPMG Phase 3 Close Out Report and Phase 4 Programme

The Committee received KPMG's Phase 3 Close Out Report and Phase 4 Programme. The Committee agreed to review KPMGs performance after Phase 4 and asked that the Phase 4 programme be aligned to the financial recovery action plan.

2.4 Constitutional Standards

The Committee received the Constitutional Standards Report and congratulated the teams on meeting some of the key targets in a very challenging period.

2.5 Award of Contract for Orthopaedic Shoulder Implants

Reviewed a contract for orthopaedic shoulder implants and recommended that it be approved by the Trust Board for award.

3. RECOMMENDATION

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

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HELD ON MONDAY 27th NOVEMBER 2017 AT 2.00 P.M. IN MEETING ROOM 10, MLCC

Present:	Mr J Dunn	Non-executive Director (Chair of Committee)
	Mr R Kirby	Chief Executive
	Mr R Caldicott	Director of Finance and Performance
	Mr D Fradgley	Director of Strategy & Transformation
	Mr S Heer	Non-executive Director
	Mr A Khan	Medical Director
	Mrs L Ludgrove	Interim Director of Human Resources and Organisational Development
	Mr J Silverwood	Non-executive Director
	Mrs L Storey	Trust Secretary
	Mr P Thomas-Hands	Chief Operating Officer
In Attendance:	Mr Q Zada	Director of Operations, WCCSS Division (Item 142/17 only)
	Mrs J Lydon	Divisional Director, Clinical Support Services (Item 142/17 only)
	Mrs K Lindsay	Divisional Business Advisor WCCSS Division (Item 142/17 only)
	Mr C O'Toole	KPMG Items 138/17 to 143/17 only)
	Mrs C Dawes	Executive Assistant (Minutes)
Apologies:	None	

Mr Dunn opened the meeting and welcomed everyone. It was noted Mr Kirby would be late joining the meeting and the meeting was declared quorate.

138/17 Declarations of Interest **ACTION**

There were no declarations of interest.

139/17 Minutes of the Meeting held on 25th October 2017 and the Extraordinary meeting held on 29th August 2017

Resolution:
The minutes of the meeting held on 25th October 2017 and the Extraordinary meeting held on 29th August 2017 were approved as an accurate record.

140/17 Matters Arising and Action Sheet

The Committee received the status of the actions. The following verbal updates were received:

092/17 – Carter Benchmarking: It was noted this action was transferred to the Director of Strategy & Transformation.

126/17 – Division of Surgery Presentation: Discussion about managing the division would be taken outside of the meeting. Item closed.

Resolution:
The Committee:

- **Noted the updates received together with the actions to close expired actions.**

Mrs Ludgrove and Mr Thomas-Hands arrived at this point.

141/17 Impact of Ward Closure on Costs

The Director of Finance & Performance presented details on the Temporary Workforce changes through the period prior to and following the ward closures.

It was noted that the expected impact of the ward closures on temporary nursing costs had not materialised until two months after the ward closures and in addition there had been issues relating to annual leave with school summer holidays appearing to drive increases in temporary workforce. The rapid re-opening of Ward 14 had resulted in more temporary workforce than would normally be expected. The Committee was advised that this could be managed in future and the mix of bank usage had improved and was linked to the increased bank pay rate.

The Committee raised concern in the delays in realising the cost savings, the issues around annual leave and that a ward had since reopened. The Interim Director of Organisational Development & HR asked about what step down changes would take place to close a ward and whether this had been planned in that way. The Director of Strategy & Transformation confirmed that plans had included step down changes and explained that there were two issues to note. The first was that one of the wards closed was the winter ward which had been running at a premium rate and there were therefore no staff to relocate from the closure of that ward. The second ward had closed and the staff had been relocated to, other areas that required staff in medicine.

The Committee was advised that temporary staffing for October 2017 was lower than for September 2017 and significantly lower than the same period in 2016. Analysis had shown that the nursing agency usage had risen over the school summer holiday period and flattened thereafter.

A discussion was held about the reasons for using temporary workforce over the summer period and the associated controls for this and for the scheduling of annual leave. The Committee noted that whilst there were controls in place for authorising temporary staffing there remained a question as to whether they were being applied consistently. In addition, the Committee questioned whether the Trust now had an annual leave schedule and policy for nursing staff.

The Committee was advised that the Trust had allowed staff to take leave in the school holiday period as requested because of staff retention reasons, which was an unusual position. The Interim Director of Nursing had established a project group to review all processes and controls. Standard Operating Procedures for nursing annual leave had been drafted but not yet launched.

The Chair requested the Interim Director of Nursing be invited to the

January 2018 meeting to explain the processes for annual leave rostering for nursing and those for agency staff booking . **LS**
The Committee agreed that the report on the Impact of Ward Closure on Costs should be revisited at the January meeting and question posed as to whether cost could be reduced if operational need reduced. **LS**

Resolution:
The Committee:

- **Received and noted the content of the report.**
- **Requested that the Interim Director of Nursing be invited to the January meeting to explain processes on annual leave and agency booking for nursing staff.**
- **Requested that the report on Impact of Ward Closure on Costs was revisited at the January meeting.**

Mr Zada, Mrs Lydon and Mrs Lindsay joined the meeting.

142/17 Presentation from the Division of Clinical Support Services

Mr Dunn welcomed Mr Zada, Mrs Lydon and Mrs Lindsay and introductions were made. He clarified the purpose of the presentation was to outline the current position and to highlight any issues.

Mr Zada highlighted the following key issues:

- The division was overspent by £114k year to date. This was linked to additional sessions for the mobile MRI during the installation of the new MRIs. In addition there were a number of management vacancies with some roles being amalgamated into the Head of Diagnostics post with a new member of staff joining the Trust at the beginning of January 2018.
- Overspends were driven by Waiting List Initiatives in Radiology, Mobile MRI, private ambulance usage outside of the WMAS contract and microbiology agency.
- CIP had over-delivered by £17k.
- The Pharmacy SubCo was unlikely to deliver in year and the forecast had been removed from in-year delivery due to project timescales.
- Cell Salvage – due to deliver from Sep 17 in original plan forecast – forecast revised due to project timescales.
- The above under delivery was offset by over delivery on schemes such as CMU pacemaker, follow up activity and therapies workforce review.
- Further schemes were under development – for example a review of externally referred tests in Pathology to bring in house or use a cheaper alternative.

Questions and Comments

The Committee noted that the figures presented were for the whole division of Women's Children's and Clinical Support Services and it was proposed that the attendance at future presentations included both teams. **LS**

A discussion was held about the location of the Pharmacy Subco and it was noted that the location proposed for its operation required significant investment whereas changes to the Purple Hub as an alternative would require minimal investment.

The division was asked why September and October expenditure was significantly up on previous months in order that appropriate support could be offered if required. Mr Zada explained that the increase was due to activity going up and a fixed budget. Mr Zada explained that a request had been made for increased money when activity went up. In addition, it was explained that money had not been received for the MRI mobile capacity and no winter pressures funding had been received.

Mr Dunn thanked the divisional team for their presentation and asked what their biggest items where support was required. Mr Zada responded advising Diagnostic CDs were important from a quality and service delivery perspective and there was also a requirement for assistance with the strategic understanding of the Black Country Pathology Service work.

Mr Dunn asked that the division's next presentation include a full picture on the integration of the Black Country Pathology Services, the big issues and the opportunities available to bring in extra income to the Trust.

Resolution:
The Committee:

- **Noted the content of the Divisional presentation from Clinical Support Services.**
- **Proposed that future presentations be joint with the Women's and Children's part of the division.**
- **The division's next presentation to include a full picture on the integration of the Black Country Pathology Services, the big issues and the opportunities available to bring in extra income to the Trust.**

Mr Zada, Mrs Lydon and Mrs Lindsay left the meeting at this point

143/17 FIP3 / Financial Recovery Programme

The Director of Finance and Performance and Mr O'Toole gave an overview of the FIP3 Programme work to date and highlighted the following:

- The KPMG support on grip and control processes would conclude mid-December.

- A close out report from KPMG would be received by the Executive Team at its meeting that week.

- A post KPMG commission would focus on capability and capacity in areas such as theatres, outpatients and temporary workforce.

- Embeds had been working in MLTC division around the winter pressures and patient flow – the role in phase 4 would be to look at job planning.

Questions and Comments

There was a discussion on the proposal to commission KPMG for Phase 4

of the FIP programme and the Chair requested a further meeting be arranged prior to the Trust Board on the 7th December 2017 to understand the scope of commission, the cost of the support and to get clarity on what was expected to be delivered against what had already been delivered prior to a decision being made.

Resolution:
The Committee:

- **Noted the update on the FIP3/Financial Recovery Programme.**
- **Requested a meeting prior to the Trust Trust Board on the 7th December 2017 to discuss the proposal to commission Phase 4 of the programme**

Mr O'Toole left the meeting at this point.

144/17 Communications Plan

The Director Strategy & Transformation gave an overview of the updated Communications Plan highlighting a proposal of communications activities for the period of November 2017 to February 2018 in support of the Trust's key areas of focus, namely; financial recovery; quality improvements, especially in ED and Maternity services; organisational culture; CQC Report; winter pressures.

Communications plans for Financial Recovery and Maternity Services were already in train.

The overall objective of the plan was to provide a clear understanding of the improvements achieved across the organisation and going forward, the vision, expectations and implications for its employees and other stakeholders. The plan will be delivered in three phases:

Phase 1: The vision (December/January)
Phase 2: Engagement (January/February
Phase 3: Motivation and behaviour change Q4 and beyond.

It was noted a rolling programme of Executive walkabouts were being scheduled to deliver the message across the organisation.

The Committee noted the comprehensive plan and questioned whether delivery of the messages should be given by clinical teams as the leadership teams had been redefined as a Clinically Led Model.

Resolution:
The Committee received and noted the content of the Communications Plan.

145/17 Lorenzo Post Implementation Review

The Director Strategy & Transformation gave an overview of the Lorenzo Post Implementation Review.

The committee received and debated the content of the report and action plan and agreed to recommend it to the Trust Board for their consideration.

Resolution:
The Committee:

- **Received and noted the content of the Lorenzo Post Implementation Report.**
- **Agreed to recommend the report to the Trust Board for their consideration**

146/17 Financial Performance Month 7

The Director of Finance gave an overview of the Finance report for October 2017 and highlighted the following:

- A deficit of £14,923k against the planned deficit of £12,835k, resulting in an unfavourable variance of £2,088k (£1,872k September). There had been an in-month deterioration of £200k.

- The overall clinical income position was down against plan. The under-performance was largely a consequence of reduced obstetric activity and outpatients' utilisation. The 2017/18 contract agreement for acute services with Walsall CCG was on a cost and volume basis for elective care, with payment for emergency activity that exceeded 1% of contract.

- The budgeted resource was overspending largely as a consequence of nursing expenditure exceeding budgeted allocation (wards and specialist nursing) though in addition medical budgets were also overspent.

- The CIP plan of £5,101k under achieved for Month 6 by £626k with actual efficiencies delivered of £4,476k, although £1,788k was delivered non-recurrently.

- If CIP had been phased in equal twelfths, the in-month delivery would be higher and the Trust would be reporting an overspend to Month 7 of £2.3m.

- The Trust's planned cash holding in accordance with borrowing requirements was £1m. The actual cash holding was £1.1m. The Trust's agreed borrowing for 2017/18 was £20.5m, reflecting the deficit plan. The Trust would have to submit a request to the Department of Health for increased borrowing due to overspending against plan. The interest payable on the load would add to future savings requirements.

- Capital expenditure of £4.0m (main spends related to the ICCU scheme (£2.1m) Medical Equipment (£500k) and Community Mobile technology (£500k).

- Temporary workforce expenditure of £1.798m in October 2017 (£1.750m September 2017) a £48k increase in month and £431k increase over April expenditure (£1.367m).

Mr Kirby joined the meeting at this point.

Questions and Comments:

The Committee noted the content of the report and commented that time was fast approaching when the figures needed to show a marked

improvement or be presented as a reforecast position.

There was a discussion about the Quarter 2 Review with NHS Improvement that was scheduled later in the week. The Committee noted that a plan was available but had not yet seen evidence of the turnaround and questioned whether assurance could be given to the Trust Board that the £20.5m deficit plan would be delivered. The Executive team responded advising there were some concerns with a couple of workstreams which required support to deliver but overall were confident the plan would be delivered successfully.

The Chair summarised discussion noting that the Trust was off plan, actions were being taken to mitigate this but there remained a considerable risk to the delivery of the financial plan.

Resolution:
The Committee received and noted the content of the Month 7 Financial Report.

147/17 Improvement Taskforce
Item not discussed at the meeting.

148/17 Lorenzo Post Implementation Review
The Committee returned to its earlier conversation on the Lorenzo Post Implementation Review to update the Chief Executive.

It was agreed that the draft Board report would be shared with DXC prior to publication in the Board papers.

149/17 Constitutional Standards Operational Update
The Chief Operating Officer gave an overview of the Constitutional Standards relating to Emergency Department, Elective Access and Cancer. The A&E Board Recovery Plan 2017/18 was shared for information. The key messages were highlighted as:

Emergency/Urgent Care:

- October performance had increased to 82.75% compared to 81.82% in September.
- An extra ward had been opened over the previous weekend due to capacity issues. Beds were now being taken out of circulation as they become available.
- Continue to focus on SAFER, Red to Green, ED processes, ward reconfiguration and Medically Fit for Discharge (MFFD).
- October saw continued high levels of ambulances to ED (90+ ambulance arrivals on 21 days in the month to the department).
- Admissions had increased from 91 per day in September to 95 per day in October
- The trajectory for four hour performance was to achieve 90% in

September with a dip in December performance and an improvement back to trajectory in February and March 2018. It was expected that the Trust would achieve an actual performance in the late 80%'s by the end of October.

Elective Access:

- Performance in September was just under trajectory at 84.75%.

- The resubmitted forecast was to achieve just below 92% at the end of March 2018. NHS Improvement had been in agreement with the trajectory, further work had been requested by the commissioners and a response was awaited from NHS England.

- Validation percentage could not be affected as the PTL was now clean which had highlighted clinical and theatre utilisation issues.

- October saw a reduction in WLI activity compared to September although levels remain high due to need to support cancer and long waiting patients. The focus was to reduce WLI sessions and focus on improving the core utilisation in outpatients. Work is on-going with support from KPMG with both outpatient and theatre work streams.

- The trajectory assumed delivery without WLI activity.

Cancer:

- All Cancer standards were achieved in September with the exception of 62 day Consultant upgrade.

- Draft September data showed improvement and potentially achieving all standards.

- There were two 52 week breaches in October

Diagnostics:
September performance was 99.64% thus achieving the 99% target.

Questions and comments:

The Chair summarised by noting the high level of activity and the improved performance together with the difficulties with patient flow due to the reduction in bed stock. The Committee acknowledged the improvements being made and expressed their thanks to all staff groups involved.

Resolution:
The Committee:

- **Received and noted the content of the Constitutional Standards Operational Update.**
- **Noted the high level of activity and improved performance.**

150/17 Performance and Quality Report by Exception

The Performance and Quality Report was noted and the following key issues highlighted:

- It was noted that the Interim Director of Nursing was undertaking a

piece of work on the midwifery/obstetric deliveries in order to inform planning of services.

Resolution:
The Committee:
- **Received and noted the content of the report.**
- **Noted that the Director of Nursing was undertaking a piece of work on the midwifery/obstetric deliveries.**

151/17 Annual Objectives Performance Review

The Director Strategy & Transformation provided an update on the progress of the Trust Objectives that were allocated to the Committee.

The report was presented in a new format following feedback from the Trust Board after Quarter 1. Assurance against the delivery of the objectives had been provided categorised by the three lines of defence and the Board Assurance Framework risk position factored into the update.

Minor amendments were highlighted prior to submission to the Trust Board at its December meeting.

The Committee received and noted the content of the Annual Objectives Performance Review and requested that the next quarterly report include the numbers for 2016/2017 for Objective No. 4 in order that the Committee could identify whether the Trust was getting the results from the outputs.

Resolution:
The Committee:
- **Received and noted the content of the Annual Objectives Performance Review.**
- **Requested amendments to the report prior to submission to Trust Board**

152/17 Final Internal Audit Reports

Investment Effectiveness

The Committee received and noted the content of the final Internal Audit report on Investment Effectiveness. The overall result for the audit was 'Requires Improvement', although it was assessed that there was substantial assurance for the business case process, it could not be sufficiently evidenced that there was systematic completion and appropriate governance reviews of post implementation reviews. The Committee noted the requirement to ensure that it received post implementation reviews for all investment cases that it had reviewed.

Cancer Waits

The committee received and noted the content of the Internal Audit Report which concluded an outcome of 'substantial'.

Resolution:
The Committee:
- **Received and noted the content of the Final Internal Audit Reports on Investment Effectiveness and Cancer Waits.**

- **Noted the requirement to ensure that the Committee received post implementation reviews for all investment cases that it had reviewed.**

153/17 **Winter Plan**

The Chief Operating Officer presented the Winter Plan advising the Escalation Plan was being updated following meetings with the clinical teams and the Flu Plan was to be updated.

The committee commented that it was a comprehensive plan and noted amendments were required prior to it being presenting to the Trust Board.

Resolution:

The Committee:

- **Received and noted the content of the Winter Plan**
- **Noted amendments were required prior to submission to the Trust Board and its meeting on 7th December 2017.**

154/17 **Risks Monitored by the Committee**

The Trust Secretary presented the updated Board Assurance Framework and the Corporate Risk Register. It was noted each sub-committee had received their specific risks.

The Committee was advised that work had been undertaken to map each of the corporate risks to the Trust objectives.

There was a discussion on the specific risks monitored by the Committee and it was noted a report was awaited on the fire stopping as work had been undertaken on the retained estate to lay new cables in the roof space. Assurance was given that the PFI estate was sufficient.

The Committee concluded that the report accurately represented the status of the risks monitored by the Committee.

Resolution:

The Committee:

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

155/17 **ANY OTHER BUSINESS**

There was no further business raised.

156/17 **Date of Next Meeting**

The next meeting of the Committee would be held on the rescheduled date of **Thursday, 4th January 2018 at 2p.m.** in Room 10, Manor Learning and Conference Centre, Walsall Manor Hospital.