Paper 14

Recommendation ☐ **DECISION** ☑ **NOTE**	
Reporting to:	**Trust Board**
Date	23rd November 2017
Paper Title	Trust CQC 2017 Safest and Kindest Quality Improvement Plan Update
Brief Description	This appraisal identifies the progress made against the Trust's Quality and Safety Improvement Plan: Safest and Kindness. It provides an overview of the themes across the Care Groups and categorises the frequency in terms of the prevalence of themes and how this correlates with local CQC insight intelligence. The 'Safest and Kindest Quality Improvement Plan' will evolve over the coming year in order to make a real difference to our patients, staff and the organisation. The purpose of this paper is for the Trust Board to review the 'Safest and Kindest Quality Improvement Plan' methodology in terms of its progress/escalations.
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Angela Hughes: Quality Assurance Lead Helen Jenkinson: Deputy Director of Nursing and Quality Lynette Williams: Clinical Information Officer
Recommended / escalated by	To evaluate the effectiveness and the progression of the Quality Improvement Safety Plan "Safest and Kindest Every Day Plan".
Previously considered by	N/A
Link to strategic objectives	**Strategic Objectives 2017/18** SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce

Link to Board Assurance Framework	**BAF Risks** If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561) If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951) If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134) If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204) If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185) If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186) If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668) If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment (RR 670) If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (RR1187) If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423) Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

Contents

1.0 Introduction

1.1 Context

The Trust will use the guiding principles of 'Safest' and 'Kindest' to represent the core values of the quality improvement plan. It will be referred to as 'Safest and Kindest Quality Improvement Plan' which encompasses the vision and drive of the service.

'Safest and Kindest Quality Improvement Plan' brings together an update on fundamental action plans throughout all of our core services. The Quality & Safety Committee will receive quarterly updates regarding progression and assurance.

A draft strategy and standing operating procedure (SOP) has been compiled which will include the governance and accountability relating to contribution and monitoring of the 'Safest and Kindest Quality Improvement Plan'.

The 'Safest and Kindest Every Day Plan' will evolve over the coming year in order to make a real difference to the organisation.

The CQC action plan updates are now part of the continuous 'Safest and Kindest Quality Improvement Plan' update. Throughout each action plan there will be 6 overarching principals to drive forward progress and ensure a robust response:

- Leadership nurtures cultures that ensure the delivery of continuously improving high quality, safe and compassionate care.
- Communication: raising awareness and understanding
- Audit - actions will be monitored through spot checks / audit
- Governance - Instilling a robust overarching governance process
- Education – identifying education requirements
- Training - provision and access to training

1.2 CQC Insight: Intelligence monitoring tool

The CQC officially launched its insight tool in August 2017; the purpose of insight is to provide a wide set of qualitative national and local information data, which is updated monthly.

The Trust is required to review this information and Executives, Associate Directors and the Care Group Leads will receive the monthly update. It is expected that if there is extraordinary change in a certain month, these will be escalated within care Groups and the Director of Nursing, Midwifery and Quality will escalate to Executives.

A quarterly appraisal of the insight intelligence data will be incorporated into this report and part of the 'Safest and Kindest Quality Improvement Plan'. Refer to page 21

1.3 Accountability in relation to 'Safest and Kindest Quality Improvement Plan'

The 'Safest and Kindest Every Day Quality Improvement Strategy 2017-2018 identifies what Shrewsbury and Telford Hospital intends to achieve in terms of quality and safety. The 'Safest and Kindest Quality Improvement Plan' denotes how this will be achieved and a SOP has been devised to provide assurance of the process and individual responsibility. The Quality and Safety committee has the responsibility to ratify the strategy and SOP.

2.0 CQC Regulation Actions

2.1 Regulation actions update

Summary Overview – November 2017						
Regulation 11 – Need for consent (when a person who used services lacked capacity to make an informed decision, staff did not always act in accordance with the requirements of the Mental Capacity Act 2005)						
Number	**Action Plan**	**Detail**				
MD005	Trust	Documentation on defined ceiling of treatment decisions/nurses understanding inconsistent				
Summary progress update on Regulation 11		Total	Delivered	On Tack to deliver	Some Issues	Not on Track
		14	6	8	0	0

Regulation 12 – Safe care and treatment (staff did not always assess the risks of people in good time and in response to changing needs; learning from incidents was not always shared and promoted within and between service specialities and across the trust; medicines were not always managed safely)						
Number	**Action plan**	**Detail**				
AA002	Maternity	Entonox gas containers – storage				
AA004	Medicine	Inconsistent approach to oxygen prescribing				
AA031/32	Maternity	Act on audit results/unsafe storage of IV fluids				
MD007	Trust	Medicines securely and appropriately stored				
SD008	Trust	Signage on store room containing portable Entonox				
AA057	Maternity	Storage of medicines				
MD018	Trust	Midwives consistently prescribing medicines in labour				
AA002	Surgery	Falls risk assessment not completed				
AA033	ED	Risks identified but no interventions to mitigate put in place				
MD009	Trust	Relevant learning from incidents is shared				
Summary progress update on Regulation 12		Total	Delivered	On Track to deliver	Some Issues	Not on Track
		20	9	11	0	0

Regulation 15 – Safety & suitability of premises (people who use the services and others were not protected against the risk associated with unsafe or unsuitable premises because of inadequate maintenance)						
Number	**Action plan**	**Detail**				
MD0016	Trust	Theatre storerooms suitably maintained & regularly cleaned				
MD0017	Trust	Equipment in theatres is repaired or replaced as required				
MD0024	Trust	ED emergency equipment – oxygen in corridors				
AA001	EoLC	Mortuary – cleaning schedule				
IA002	Trust	Mortuary – maintained and regularly cleaned				
Summary progress update on Regulation 15		Total	Delivered	On Track to deliver	Some Issues	Not on Track
		6	6	0	0	0

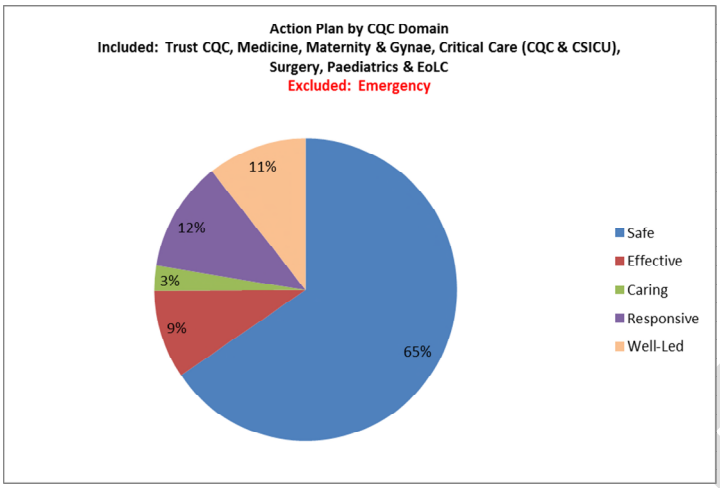
Regulation 18 – Staffing (there was not always sufficient numbers of suitable staff deployed to meet the care and treatment needs of patients)						
Number	**Action plan**	**Detail**				
IA001	Trust	High staffing vacancies and reliance on medical locums/temp nursing. Templates not reviewed against dependency				
MD002	Trust	Patient acuity tool				
Summary progress update on Regulation 18		Total	Delivered	On Track to deliver	Some Issues	Not on Track
		9	4	3	2 (Awaiting a date for care group Medical Directors to present their plans to Execs)	0

Table 1

3.0 Safest and Kindest Quality Improvement Plan

3.1 Safest and Kindest Quality Improvement Plan update

This graph represents the collective CQC actions for the following actions plans: Overarching Trust Action Plan, Medicine, Maternity & Gynae, Critical Care, Surgery and EoLC. The breakdown reflects all CQC actions into their CQC domain categories. This illustrates how it correlates with the overall rating which identifies good for caring and effective, hence fewer actions. Significantly 65% relate to actions to promote safety, and will therefore underpin the Trusts' drive to be the Safest and Kindest.



Graph 1

Trust CQC Overarching Plan									
Action Type	**Total Number**	**Delivered**		**On Track to deliver**		**Some Issues**		**Not on Track**	
		No	Change	No	Change	No	Change	No	Change
Total	**46**	**9**	**+4**	**33**	**-7**	**4**	**+3**	**0**	**-**
Immediate Action	4	3	-	0	-1	1	+1	0	-
Must Do Action	25	4	+3	18	-5	3	+2	0	-
Should Do Action	17	2	+1	15	-1	0	-	0	-

Table 2 - Further detail of the actions with some issues is page 8

Core Care Group Service Individual Action Plans									
Source of action plan	**Total Number**	**Delivered**		**On Track to deliver**		**Some Issues**		**Not on Track**	
		No	Change	No	Change	No	Change	No	Change
Emergency CQC	49	Action plan is in the process of being devised, the need for completion has been escalated to Director of Transformation							
Medicine CQC	14	3	-	11	-	0	-	0	-
Stroke	73	19	-	30	-	22	-	2	-
Surgery CQC	51	6	+2	41	-2	4	-	0	-
Critical Care CQC & critical care standards**	62	28	-	14	-	10	-	10	-
EoLC CQC	22	11	+5	11	-5	0	-	0	-
Paediatrics CQC and CIIC*	130	84	-	39	-	7	-	0	-
Maternity & Gynae CQC	71	14	+6	45	-8	12	+2	0	-
Maternity Sign up to Safety	119	106	-	7	-	6	-	0	-
Maternity Saving Babies' Lives	24	13	-	7	-	4	-	0	-

*relates to 2014 inspection – outstanding actions have been carried forward and combined with CIIC actions 2016
**Critical care have combined CQC and Critical Care Standards 2014 into one overarching plan

Table 3

Analysis
It is evident that maternity services have collectively 214 actions and represents the service with the most actions to drive forward quality improvements. Maternity services volunteered to participate with 'Sign up to Safety' and proactively embraced the opportunity to develop and enhance the service. The recommendations of the internal review of Maternity Services 2007-2017 have now been incorporated within this 'Sign up to Safety' plan. It is envisaged that in the future any other reviews will be incorporated into this overarching action plan and it will also incorporate 'Saving Babies Lives'. Thereby avoiding duplication and enabling correlation of themes.

Other external action plans (unable to use standardised template)			
Source of action plan	**Delivered**	**In progress**	**Not on track**
CCG: Review of health services for Children Looked-after and Safeguarding in Telford and Wrekin	17	22	1
WMQR Theatres	27	10	0
Women and Children's inpatient survey	3	1	0
Schedueld care inpatient survey	3	2	0
Unscheduled Care inpatient survey	No return submitted – escalated to Assistant Chief Operating Officer and Associate Director of Patient Safety		

Table 4

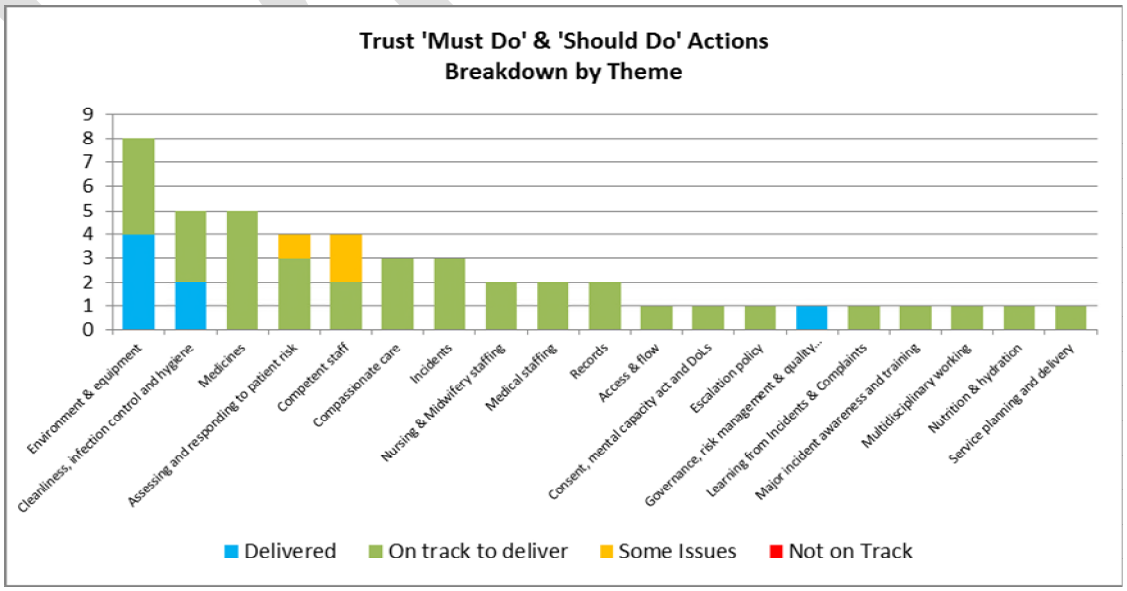
Analysis
CCG: Review of health services for Children Looked-after and Safeguarding in Telford and Wrekin, not on track: audit of the Domestic Violence guideline has been scheduled for July.

4.0 Detailed breakdown

4.1 Trust CQC Overarching Plan

Trust CQC overarching plan									
Action Type	**Total Number**	**Delivered**		**On Track to deliver**		**Some Issues**		**Not on Track**	
		No	Change	No	Change	No	Change	No	Change
Total	**46**	**9**	**+4**	**33**	**-7**	**4**	**+3**	**0**	**-**
Immediate Action	4	3	-	0	-1	1	+1	0	-
Must Do Action	25	4	+3	18	-5	3	+2	0	-
Should Do Action	17	2	+1	15	-1	0	-	0	-

Table 5 - Refer to page 8 for detail on the some issues categories.



Graph 2

Analysis – Top 5 Themes CQC Trust Action Plan	
Environment & equipment	• Mortuary hoist • Equipment in theatre needed a replacement programme • Facilities in A&E for children didn't meet ROCP standards • Emergency equipment in ED when patients in corridors • Gas signage to denote flammable gases
Cleanliness, infection control and hygiene	• Mortuary • Theatres storerooms • Hand washing facilities in ED • Washer for sterilising mortuary equipment
Medicines	• Safe storage of medicines • Monitor fridge temperatures daily • Midwives noncompliance with NMC prescribing of drugs in labour • Audit prescriptions not complete • Signature for medication
Assessing and responding to patient risk	• Triage in A&E • WHO checklist needs embedding • ED paper and electronic records not completed in a timely manner • Not meeting 4 hour target
Competent staff	• Mandatory training • Access to ALS training for theatre staff • Appraisals • Competency framework required for specialist nursing staff

Table 6

Key achievements in relation to action plan – CQC Trust

Steady progress is being made towards completion of actions with 26% of the action plan due to be delivered within the next quarter. Each CQC '*must do' & 'should do'* recommendation incorporates any relevant regulation actions and these have been underpinned with sub actions which focus on the six overarching principals to provide assurance (leadership, communication, audit, governance, education and training).

The following four actions have been delivered this quarter:

1. A review of access to emergency equipment in emergency department corridors has taken place and assurance has been provided via mitigating actions
2. EoLC team have updated the risk register to ensure all issues have been recorded and regularly reviewed.
3. Standardisation of ED triage process and improving effective handover with ambulance staff
4. Surgery have met it RTT for admitted pathways for surgery: consistently delivered since September at 93.88%

Significant progression has been made in relation to the long term strategy for recruitment and retention of nursing and medics. Plans are aligned to business and financial plans that articulate the needs from now and define 1, 3 and 5 years.

Actions that have some issues – CQC Trust

1. **Advance Life Support (ALS) training (Theatre recovery staff)** – Securing funding identified as an issue within Scheduled Care (Action Owners - Executive sponsor: Director of Nursing, Midwifery & Quality; Responsible Lead: SCG Head of Nursing)
   NB. Currently reliant on the ALS qualification of anaesthetist
2. **Mandatory training** – Revision of risk training matrix is in progress but operational pressures may delay responses from clinical areas targeted for submission in January 2018. (Action Owners - Executive sponsor: Director of Workforce; Responsible Lead: Head of Education)
3. **ED PRH** – completion of paper and electronic records in a timely manner. National update on ECDS implemented in October has increased the time taken to complete a record from 1.5 minutes to 6 minutes and additional work validating records. Work is ongoimg to try and address these issues. (Action Owners - Executive sponsor: Medical Director; Responsible Lead: Director of Transformation)

Actions that are not on track to deliver (require escalation) – CQC Trust

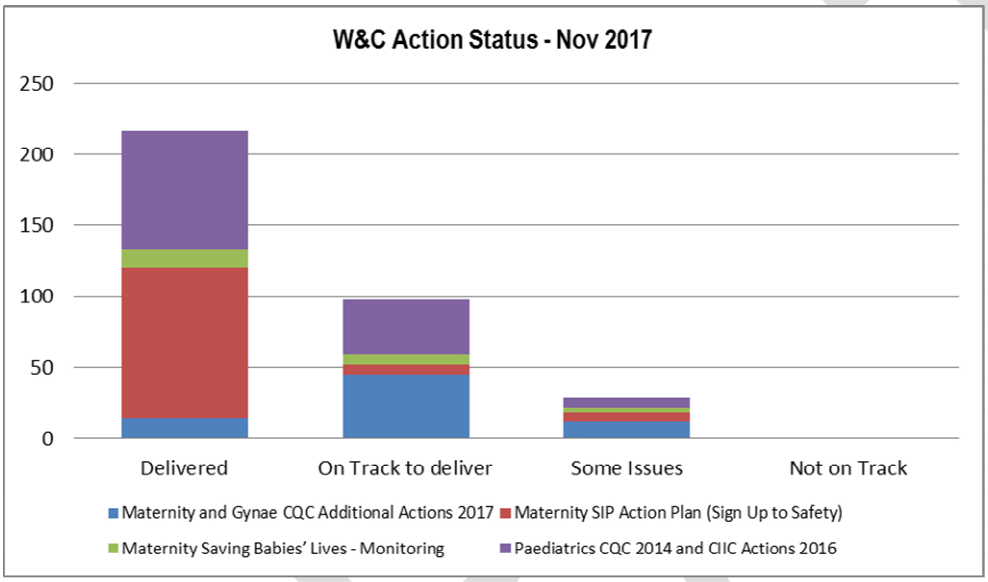
None

4.2 Maternity & Gynaecology and Paediatrics

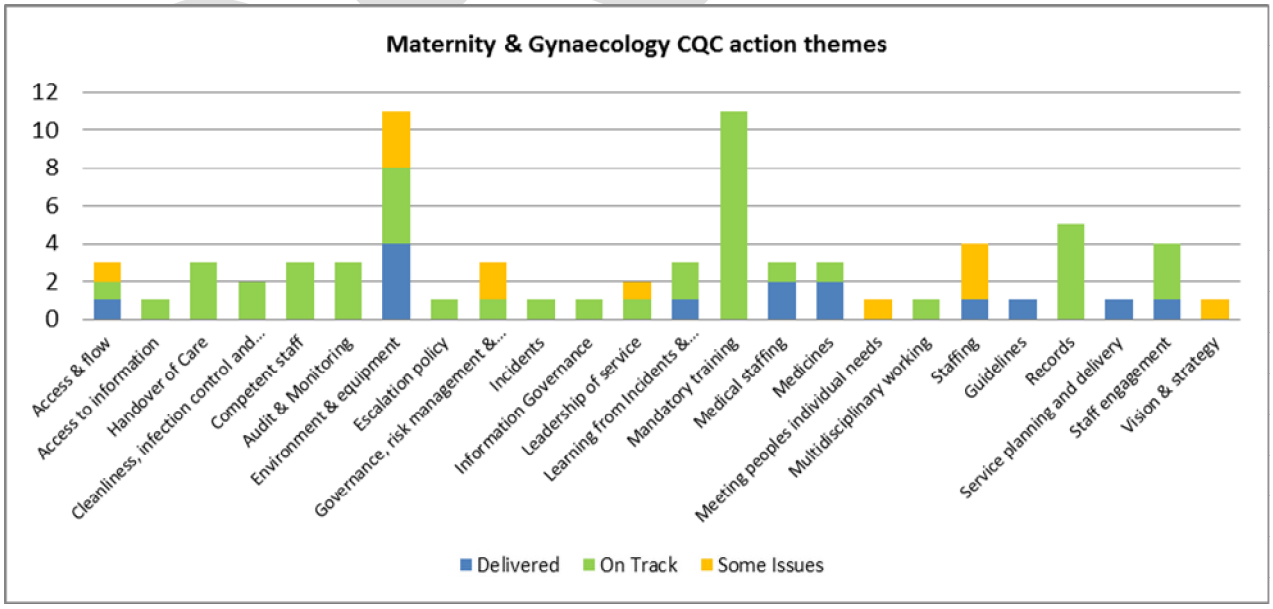
Maternity & Gynaecology Core Care Service Individual Action Plans									
Source of action plan	Total Number	Delivered		On Track to deliver		Some Issues		Not on Track	
		No	Change	No	Change	No	Change	No	Change
Maternity & Gynae CQC	71	14	+6	45	-8	12	+2	0	-
Maternity Sign up to Safety	119	106	N/A	7	N/A	6	N/A	0	N/A
Maternity Saving Babies' Lives	24	13	N/A	7	N/A	4	N/A	0	N/A
Paediatrics CQC and CIIC*	130	84	N/A	39	-	7	N/A	0	N/A

Table 7

This table shows the status of actions in relation to each respective action plan and their number of specific actions. Collectively over 200 actions have been delivered, with nearly 100 on track to deliver. This demonstrates significant progress towards improving the quality and the provision of care within maternity services.



Graph 3



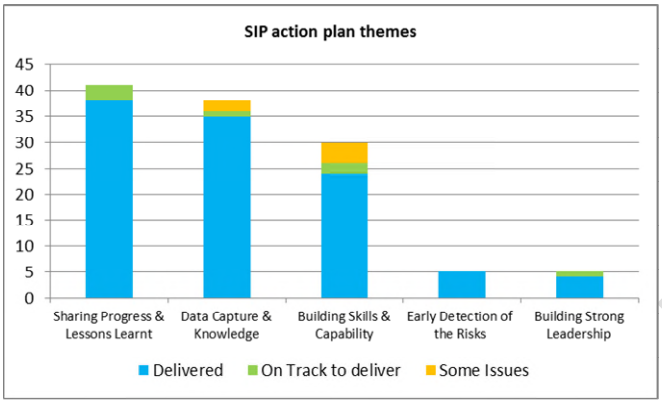
Graph 4

Graph 4 analyses the CQC top 5 themes:

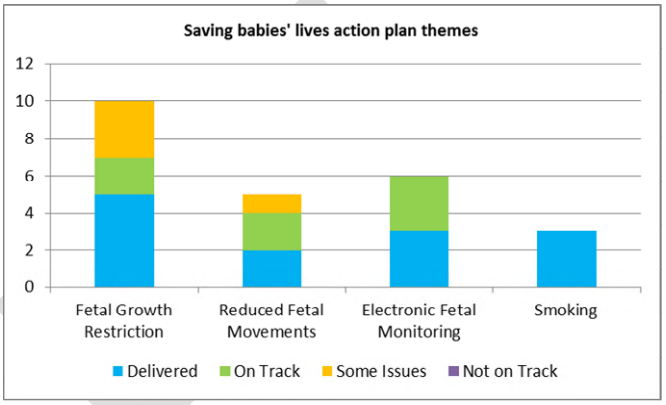
- Environment and equipment
- Mandatory training
- Records
- Staffing
- Staff engagement

Correlation of themes between action plans

When compared with themes for the 'Sign up to Safety' (SIP) plan and 'Saving Babies Lives' training is also evident in the theme of building skills and capacity and in the 'Saving Babies Lives' which has 'training and competency' running through its main themes. Similarly 'staff engagement' is evident in both the CQC and SIP action plans.



Graph 5



Graph 6

This table represents the prevalence of triangulation of themes across maternity action plans.

Analysis - Top 3 themes triangulated across all plans – Maternity, Gynaecology & Paediatrics				
Top Themes	Maternity and Gynae CQC Additional Actions 2017	Maternity SIP Action Plan (Sign Up to Safety) Inc. Maternity Review – C.O.	Paediatrics CQC 2014 and CIIC Actions 2016	TOTAL
Staffing	7	3	3	13
Training	11	1		12
Environment/Equipment	7	1	3	11

Table 8

NB: The Saving Babies' Lives Action Plan has not been included in this analysis as it is purely an action plan related to Monitoring data

Key achievements in relation to action plan – Maternity, Gynaecology and Paediatrics

1. **Staff being on call overnight and then working the next day**
   Following a review by on call staff, a new system of on call arrangements delivered a reduction in on-calls for staff by over 50% and an increase in staff on the night shift at RSH MLU.

2. **Immediate disposal of samples following testing**
   Memo to remind staff that samples bottles or any clean clinical item should not be stored in a sluice and that spot checks were being undertaken.

3. **Timely access to paediatric support for the WMLU**
   A clear process statement was provided by the Neonatal Clinical Director and was discussed at Maternity Governance, supported with a flow chart for display at the Wrekin MLU.

4. **No record of minimum or maximum temperatures for the specimen storage fridge on Delivery Suite**

   Further enquiry revealed that there was an automatic defrost every 3rd day was a normal process for this model.

5. **Ward 14 was supporting medical outliers alongside gynaecology patients because of the lack of available medical beds. This increased acuity on the ward and there was no process to match nursing skills to patient needs.**
   Beds were reconfigured and breast surgery patients are now accommodated on Ward 14 rather than medical outliers.

6. **The Trust did not have a consultant midwife in post**
   Birthrate Plus has demonstrated a shortfall of clinical midwives across the service; this along with the outcomes of the CCG MLU Review and the LMS work will be prioritised. Although the service does not have a consultant midwife, it does have specialist midwives in all areas where deemed necessary and exemplary practice.

Actions that have some issues - Maternity, Gynaecology and Paediatrics

Maternity CQC action plan	• **"Home from Home" Environment** The development of the Local Maternity System (LMS) is well underway. It will take in to account the environments that the MLU care is being provided in. Sustainability will form part of the work streams, this will include buildings, suitability and environment. LMS plans to be finalised by end of October 17. • CCG MLU Review due October 2017 aims to assess the sustainability of our current MLU's and our service provision. Dependent upon the outcome of the review, and the subsequent recommendations is the future model of care and delivery (Action Owners - Executive sponsor: Head of Midwifery; Responsible Lead: Deputy Head of Midwifery)
	Midwifery Staffing Arrangements • Better births (2016) recommend one to one care delivered by a small team of midwives. Ludlow now has 5.0 WTE. This will improve the one to one care ratio. This continues to be monitored via clinical maternity dashboard - Workforce is included in the LMS work streams, this will be further impacted upon by the outcome and recommendations of the CCG MLU Review - Staffing numbers will be dependent upon the outcomes and recommendations as these may have an impact upon the staffing levels required in each area. • Transitional model - due to increasing occasions of activity and staffing levels initiating escalation, the Trust approved recommendations from the Care Group to temporarily suspend intrapartum and postnatal inpatient stays at 3 smaller MLU's (BN, OS, Ludlow) - this has allowed a relocation of 7.4WTE in to the consultant unit to ease pressure created by workload and a shift in birthing numbers towards the consultant unit and away from the MLU's. (Action Owners - Executive sponsor: Head of Midwifery; Responsible Lead: Deputy Head of Midwifery)
	Bed Occupancy • Efficient use of beds postnatally relies upon adequate flow - this is impacted upon by the absence of a formalised Transitional Care (TC) facility. Birthrate Plus acknowledges this and in addition this will be dependent upon the outcome of the MLU review and the LMS work. (Action Owners - Executive sponsor: Head of Midwifery; Responsible Lead: Deputy Head of Midwifery)
	Team-Working, Communication and Governance Processes. • The Transitional Model commenced 01.07.17 and is due to end 31.12.17 and will be followed by the preferred option is agreed. • Predicted time scales for implementation are subject to, and dependent upon, the outcome of both the CCG MLU Review and the LMS work streams. (Action Owners - Executive sponsor: Head of Midwifery; Responsible Lead: Deputy Head of Midwifery)
Sign up to safety (SIP)	**Building Skills & Capability** • Staffing level increases, as part of the LMS and MLU reviews co-produced with commissioners • 12-24 hour cover as per BirthRate Plus - in Workforce Plan. BirthRate Plus Acuity Tool to be implemented • Remove registered midwives from scrubbing in theatre and release resource - Business case (2014 being revisited to identify alternative costing options • Saving Babies' Lives - Confirm funding for scanning

	Data Capture & Knowledge • Management of antepartum haemorrhage - Obstetric audit awaiting Antenatal roll-out • Risk assessment on discharge with compliant planning of place of delivery - Newly proposed - Standards to be defined
Paediatric CQC & CIIC	**Lack of paediatric pain team** • Discussed regularly at Paediatric Governance. If required, staff can contact anaesthetics and the Adult Pain team for support and Advice
	Progression towards CQC Outstanding Status • Workshops to identify multiple areas for improvement - Neonatal & Paediatric Representation, CIIC meetings, Walk-around, benchmarking and linking with the Key Lines Of Enquiry for Outstanding
	Lack of paediatric qualified and competent staff at ED RSH • ED-related, On-going issue. Will be resolved following the outcome of the Sustainable Services Programme and Future Fit Project.
	Resuscitation and Stabilisation: Trust-Wide protocols for resuscitation and stabilisation • CIIC Consultant Lead to liaise with Dr Sethuraman to develop (Child specific)
	Administrative, Clerical and Data Collection Support – CAU • Aware of administrative/clerical deficit. Currently the nursing team is the priority
Saving Babies' Lives	**Fetal Growth Restriction – Monitoring** 1. **Training programme on use of charts/low risk women** To introduce training program within PROMPT – April 2018 2. **Ongoing audit of Small for Gestational Age (SGA) birth rates, with reporting of antenatal detection rate** • To investigate the adequacy of reporting through MIS • To establish a working party to identify themes and implement learning • Maternity Information System (MIS) team: Customised birth weight centiles function to be included within Medway (agreement to purchase)
	Reduced Fetal Movements - feedback to gauge whether messages have been assimilated as intended (Information Leaflet etc.) • To liaise with Trust Patient Experience Lead, to request the design of a Survey for distribution to women who present at Triage with concerns regarding RFM

Table 9

Actions that are not on track to deliver (require escalation) - *Maternity, Gynaecology and Paediatrics*

None

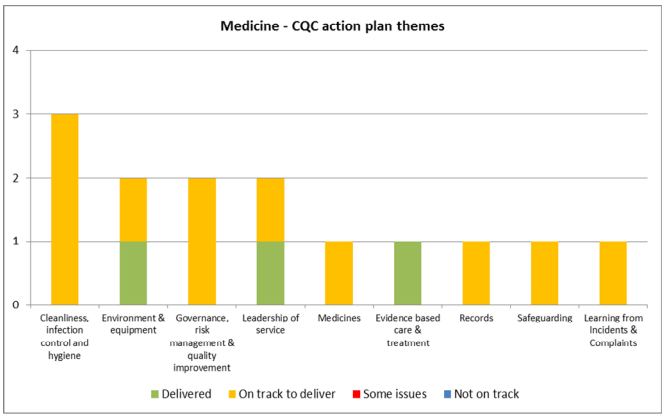
4.3 Emergency Medicine

Action plan is in the process of being devised, the need for completion has been escalated to Director of Transformation

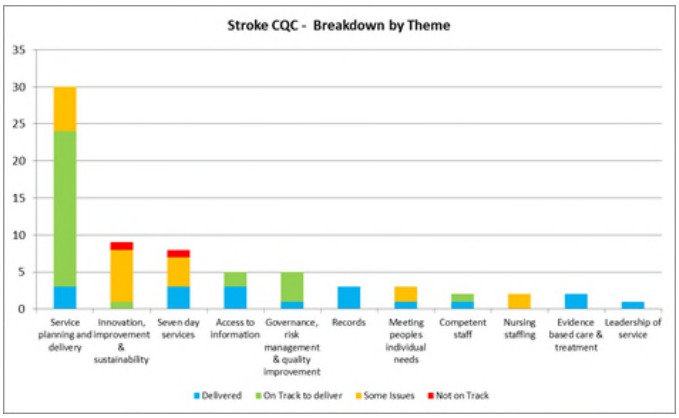
4.4 Medicine

Medicine Core Care Service Individual Action Plans									
Source of action plan	Total Number	Delivered		On Track to deliver		Some Issues		Not on Track	
		No	Change	No	Change	No	Change	No	Change
Medicine CQC	14	3	-	11	-	0	-	0	-
Stroke	73	19	-	30	-	22	-	2	-

Table 10



Graph 7



Graph 8

Analysis Top 5 Themes - Medicine		
Stroke	Service planning and delivery	Direct access to acute stroke unit within 4 hours Staffing - Consultant cover/stroke prevention team/social worker Repatriation Screening for cognitive and mood changes Discharges/reduce length of stay/review mixed sex policy Improvement in referrals to TIA service Stroke specific neuro-psychological support Improvements to coding/regular review of SSNAP data Pathway reviews Environment and sharing best practice
	Innovation, improvement & sustainability	Improvement in time to receive a scan Timely transfers Therapy support Follow up after discharge – 6 month reviews Transport
	Seven day service	Stroke clinicians Provision of therapy Follow up care
Medicine	Cleanliness, IPC & hygiene	Inconsistent hand washing Untidy ward area Medical staff – IPC training compliance
	Environment & equipment	Security access to wards Resource room ward 16

Table 10

Key achievements in relation to action plans - Medicine

CQC

- Steady progress is being made towards completion of actions and the care group regularly review and actively progress the action plan through USCG forum and Care Group board. A database and email process has been implemented to track medics who are not up to date with IPC and safeguarding training. Engagement from IPC who will take the training to the wards to help improve performance.

Stroke

- Implementation of 7 day consultant rota introduced in October with analysis due of benefits in reduction in length of stay, access to stroke beds and access to TIA (Transient Ischaemic Attack) appointments to be analysed against 2 months of data. Working with colleagues in Radiology towards improvements in requesting and access to scanning improving performance in this area, alongside a number of exercises looking at front end processes and pathways and stakeholder engagement.

Actions that have some issues - Medicine

CQC

- No issues identified however, SSU training/appraisal figures for nurses may be impacted due to winter pressures due to the need for ward nurses to be clinical on wards. The Trust has a plan to deliver mandatory/statutory training for clinical staff in the summer months; this is being led by the workforce team.

Stroke:

Recruitment – Working towards 7 day therapy cover plans on hold due to current recruitment issues

Commissioner review/engagement issues:

- Community rehab into SaTH
- Dedicated social worker on ward/board rounds
- Access to community rehab for patients > 65 not eligible for EDS which will form part of the stakeholder engagement meeting next week
- Patients < 65 referred to community neuro service waiting 2 weeks for assessment/16 weeks treatment
- Transport for patients to patient groups/meetings

Neuro-psychologist support – Business case submitted in 2014 but not supported, forms part of the stakeholder meeting next week

Follow up and review of care plans six months post discharge – review alongside commissioners on options to address this, including the reinstatement through the Stroke Association

RSH stroke services going forward – Options to be reviewed as part of stakeholder group and for potential public engagement.

Actions that are not on track to deliver (require escalation) - Medicine

CQC – none

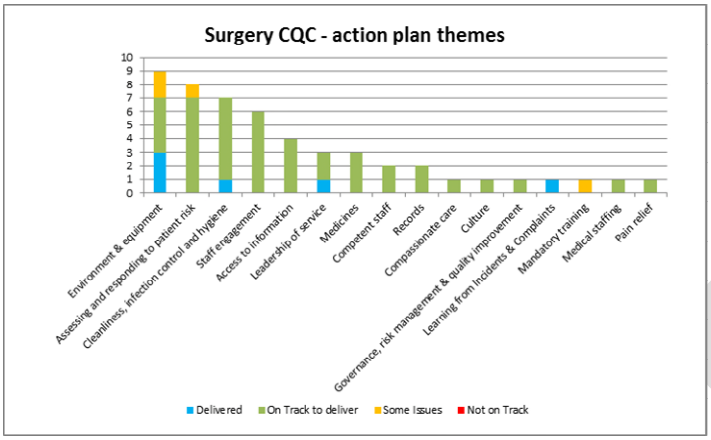
Stroke:

- **Therapies** - Major risk to safe delivery/performance with significant workforce gaps in Physiotherapy and difficulty in recruiting into vacancies with subsequent risk to delivery of overall stroke targets and service with plans for 7 day working on-hold. Recruiting issues for SaLT vacancies/maternity cover ongoing due to national shortages.
- **Patients receiving a scan within 1 hour –** Out of hours scanning cover, business case being developed with a plan for uplift in BpT to cover improved reporting.

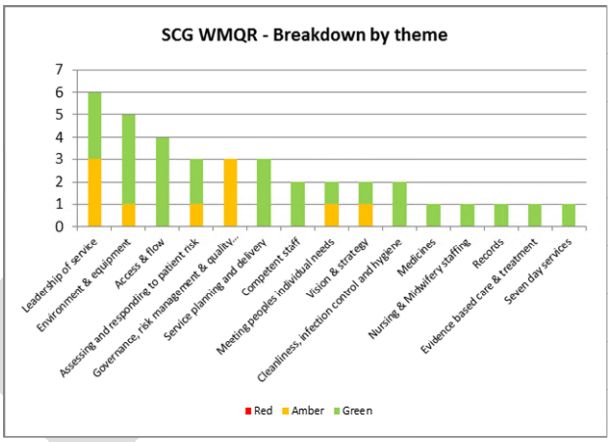
4.5 Surgery

Surgery Core Care Service Individual Action Plans									
Source of action plan	**Total Number**	**Delivered**		**On Track to deliver**		**Some Issues**		**Not on Track**	
		No	Change	No	Change	No	Change	No	Change
Surgery CQC	51	6	+2	41	-2	4	-	0	-
External plan with different RAG status				**Delivered**		**Amber**		**Red**	
WMQR theatres	37			27	N/A	10	N/A	0	N/A

Table 11



Graph 9



Graph 10

Analysis – Top 5 themes triangulated across all plans - Surgery	
Equipment and Environment CQC Action plan and WMQR	• This category has the majority of completed actions. Several actions are on track to complete within the next quarter. There remain a couple of actions with some issues that impair completion which specifically relate to funding/facilities
Assessing and Responding to Risk	• All actions remain on track for completion with one action with issues that may hinder completion – this is with regard to delays in discharge due to TTO/Discharge summary completion. Work is on-going within the Care Group.
Access and Flow	• All actions remain on track for completion – no areas of issue
Leadership of Service - WMQR	• A number of actions remain amber many of which are anticipated to be completed within the next quarter.
Access to information	• All actions remain on track for completion – no areas of issue

Table 12

Key achievements in relation to action plans - Surgery

CQC –

- Steady progress is being made towards completion of actions. Completed actions include work to the environment and cleanliness – this has been reflected in improved quality walks this month. The majority of actions remain on track for completion within the next quarter.

WMQR - Steady progression is being made towards completion of actions and anticipates this will be reflected in the next quarter. Examples include:

- Theatre and anaesthetic services including ITU working towards a shared rota
- Multidisciplinary theatre documentation devised, currently undergoing ratification prior to embedding process

Actions that have some issues - Surgery

CQC

- **Delay in the implementation of replacement of lights within theatre** this delay is due to allocation of funding (Action Owner: Assistant Chief Operating Officer)
- **Replacement programme for equipment within theatres** this delay is due to allocation of funding (Action Owner: Assistant Chief Operating Officer)
- **Delays with patient discharges due to TTO's -** work is on-going with criteria led discharge and escript to look at ways for nursing teams to support the medical teams with the discharge summary and TTO however issues around IT and escript are causing a delay, this is being expedited at Trust level by the Director of Nursing. (Action Owner: SCG Head of Nursing)

WMQR

- **Surgical Admissions Service –** Patients are sitting in a clinic area awaiting theatre which is shared with urology clinic and a busy corridor due to lack of alternative premises which comprises patient dignity.
- **Some theatres and anaesthetics rooms do not have emergency call bells** – Currently on the risk register. Business case submitted and funding needs be secured. Awaiting prioritisation on the capital planning list.

Actions that are not on track to deliver (require escalation) - Surgery

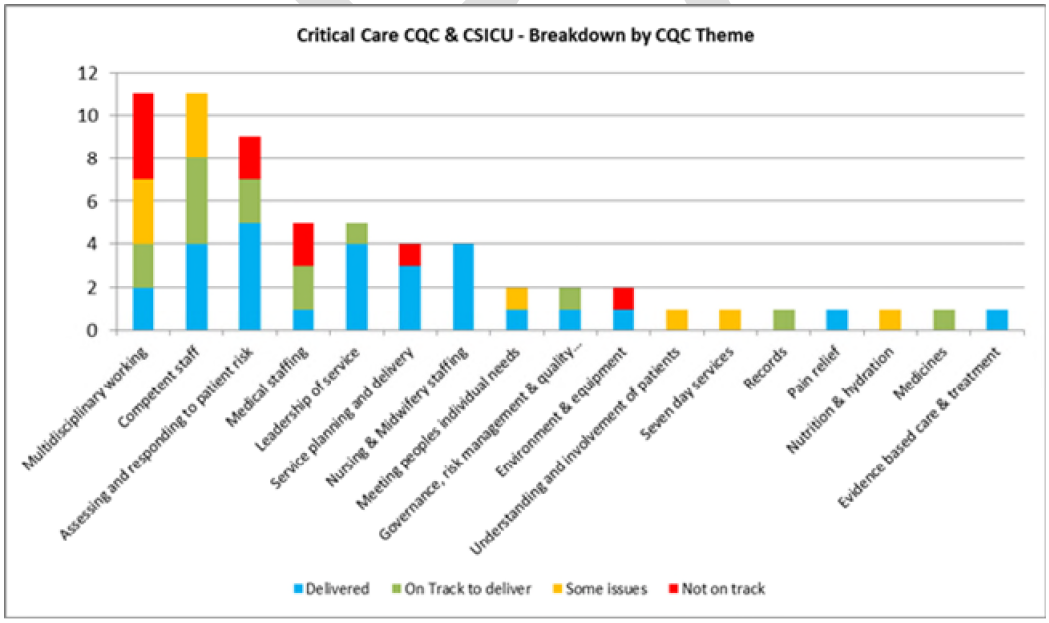
None

4.6 Critical Care

The CQC critical care action plan has been merged with Critical Care Core standards (2014) and the top 4 key themes are referred to in detail below. Several of these actions will be difficult to achieve until SSP plan is finalised. However, the Trust is sighted on these and are included on the risk register and regularly reviewed at the Team Around Critical Care (TACC) meetings.

Critical Care Core Care Service Individual Action Plan									
Source of action plan	Total Number	Delivered		On Track to deliver		Some Issues		Not on Track	
		No	Change	No	Change	No	Change	No	Change
Critical Care CQC & critical care standards**	62	28	-	14	-	10	-	10	-

Table 13



Graph 11

Analysis Top 4 Themes – Critical Care	
Multidisciplinary working	• Assessment of rehab needs of all patients within 24 hours of admission to critical care • Communication and swallowing needs assessed for patients with a tracheostomy • Patients who require rehabilitation offered 45 minutes of active therapy as required for a minimum of 5 days per week • Tracking of rehab outcomes from acute to primary care • Dedicated therapy provision • Dedicated pharmacist provision • Standardised handover procedure for medical/nursing and AHP staff
Competent staff	• Appropriate training for non-registered support • 50% of nursing staff in possession of post registration award in critical care nursing • Provision of supernumerary practice for newly appointed staff • Dedicated clinical nurse educator in post • Level 2 patients have required nurse/patient ratio • Intensive care trainees have relevant experience and provider complies with requirements of the Faculty of Intensive Care Medicine • Pharmacists provided a service to critical care have required specialist knowledge and minimum competencies • Staff appropriately trained with use of equipment • Regular clinical governance meetings
Assessing and responding to patient risk	• Delirium screening • Standardised approach to the detection of the deteriorating patient • Admission to ITU within 4 hours of decision to admit • Patients transferred to other ITU's for non-clinical reasons • On admission all patients have a treatment plan discussed with a consultant in intensive care medicine • Patients reviewed in person by a consultant in intensive care unit within 12 hours of admission to unit • Clear and safe pathway for escalation of care from level 2 to level 3 • Transfer from clinical care to a ward areas must be formalised
Medical staffing	• Recruitment of intensivists in order to reach ITU standards

Table 14

Key achievements in relation to action plans – Critical Care

- Steady progress is being made towards completion of actions. Actions on track include partnership working with nurses and therapies to develop pilot for rehabilitation practitioners. New processes implemented include a standardised multi-disciplinary handover process for patients discharged and a pain assessment tool for patients who were unconscious or unable to express pain. All actions relating to nurse staffing have been delivered.

Actions that have some issues – Critical Care

- Dedicated pharmacist provision with relevant experience and competence. (Action Owner: Support Services - Care Group Director)
- Dedicated dietician provision – partially compliant (Action Owner: Support Services - Care Group Director)
- Patient assessment of rehab needs. (Action Owner: Support Services - Care Group Director)
- Provision of ITU follow up clinics. (Action Owner: Matron)
- Regular multi-professional clinical governance meetings. (Action Owner: Matron)

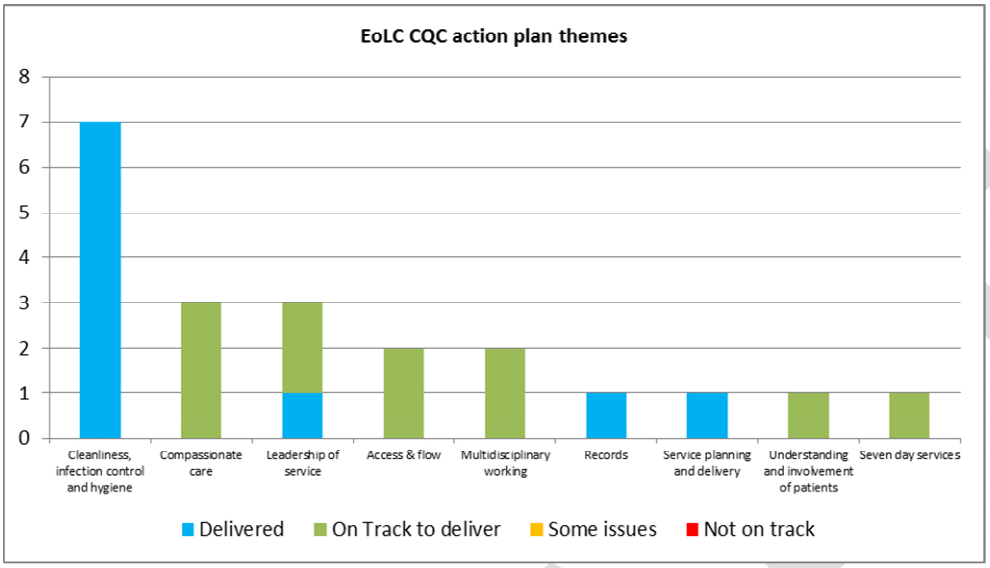
Actions that are not on track to deliver (require escalation) – Critical Care

- Recruitment and retention of intensive care medicine consultants – partially compliant currently out to advert.
- Dedicated critical care therapy provision
- Discharge from ITU to a general ward should occur within 4 hours of the decision to transfer out. This is difficult to achieve and is interdependent due to current flow and capacity issues (locally agreed target of 12 hours in place).
- ITU facilities don't comply with national standards – on risk register to be addressed as part of SSP

4.7 EoLC

EoLC Core Care Service Individual Action Plan									
Source of action plan	Total Number	Delivered		On Track to deliver		Some Issues		Not on Track	
		No	Change	No	Change	No	Change	No	Change
EoLC CQC	22	11	+5	11	-5	0	-	0	-

Table 15



Graph 12

Analysis Top 3 themes - EoLC	
Cleanliness, Infection control and hygiene	• No specific audit programme in place – mortuary • IPC training not mandatory for mortuary staff • Storeroom cluttered mortuary • IPC control measures not fit for purpose • No regular arrangements for deep cleaning • Dirty and clean scrubs used by the mortuary • Leaders in the mortuary did not complete hand hygiene or cleanliness audit
Compassionate care	• Below national average on all five clinical quality indicators • Staff not keeping family members informed • 76 percent of respondents said staff did not provide an information sheet following a discussion about End of Care Life
Leadership of service	• Staff at PRH did not feel they were being supported by Senior Managers • Mortuary staff did not have regular team meetings • Clarity needed on who is executive sponsor

Table 16

Key achievements in relation to action plans - EoLC

- Roll out of swan rooms continues across site
- Swan bags available on all wards for patients not on EoLC pathway
- Staff engagement in mortuary.
- Cleanliness issues addressed in mortuary – audit plan to provide assurance. SOP for mortuary cleanliness developed – will be audited against credits for cleaning standards.

Actions that have some issues - EoLC

None

Actions that are not on track to deliver (require escalation) - EoLC

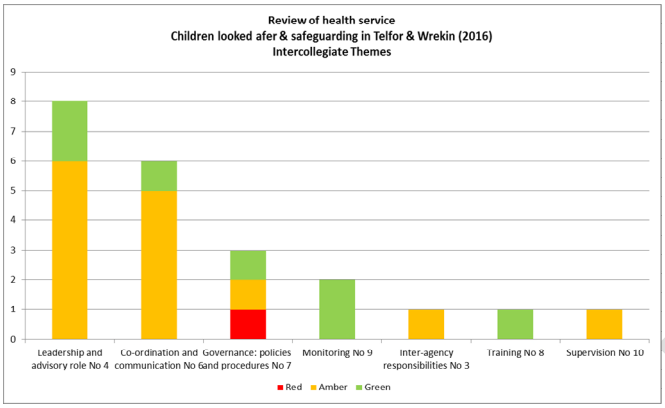
None

4.8 Action plan for the review of health services for Children Looked-after and Safeguarding in Telford and Wrekin action September (2016)

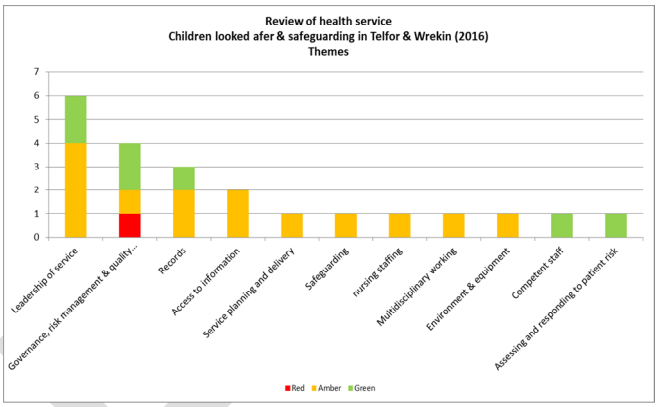
Safeguarding children and young people: role and competencies for health care staff intercollegiate document – Third Edition: March 2014

Other external action plans (unable to use standardised template)			
Source of action plan	**Delivered**	**In progress**	**Not on track**
CCG: Review of health services for Children Looked-after and Safeguarding in Telford and Wrekin	17	22	1

Table 17



Graph 13



Graph 14

Actions that are not on track (require escalation) - Children looked after & Safeguarding – Telford & Wrekin

Audit of domestic violence policy scheduled for July, exceeded original deadline

5.0 Progression of the Quality improvement plan

Perceived challenges	Progress update
Standardisation of action plans into one consistent format in order to triangulate themes and learning	CQC action plan are all standardised with filters in line with CQC themes, WMQR
Identify which action plans to incorporate into 'Safest and Kindest Quality Improvement Plan'	Currently this will be all of the CQC action plans, WMQR CGE safeguarding
Standardised proforma to collect information which may be problematic due to format of existing action plans	A standardised proforma has been devised to facilitate the process

Table 18

6.0 Format for current CQC Quarterly Engagement Meeting

Requirements:

- Completion of comprehensive CQC engagement template underpinned with intelligence from CQC Insight.
- Core services selected by CQC
- Each core service required to present a PowerPoint point presentation, with operational leads in attendance to answer questions.
- Each core service: clinical walk about across RSH and PRH
- Executive interviews

NB: The following services were selected in July 2017: Critical Care, Outpatients, Radiology, Paediatrics and Ophthalmology. These services were not assessed in December, 2016 hence the rationale for the review

6.1 Overview of current engagement process

Thurs 9th November 2017 AM		Complete
Values Guardian meeting	Values Guardian Values Guardian	
Thurs 9th November 2017		
Stroke	Consultant Matron Operations Manager USCG Head of Nursing	
Neurology	Consultant Consultant USCG Head of Nursing Operations Manager	
Visit Core Services		
Weds 15th 2017 November PM		
Discharge Co-Ordinators	Senior Discharge Co-Ordinator PRH Senior Discharge liaison sister PRH Senior Discharge Co-Ordinator Senior Discharge Sister RSH	
Visit core service		
Cancer	Lead Cancer Clinician Cancer Performance Manager Centre Manager, Oncology & Haematology Matron, Oncology & Haematology Lead Cancer Nurse Radiotherapy Manager Medical Director	
Tuesday 5th December 2017 - Engagement Visit		
Engagement visit - Executive Interviews	Chief Executive Chief Operating officer Deputy Chief Operating officer Director of Nursing & Quality Deputy Director of Nursing & Quality	
8th February 2018		
CQC attend Trust Board		

Table 19

6.2 Insight summary

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison
Trust & Core Service Analysis – Trust Composite Indicator (12 specific indicators) Of the many quality indicators presented by Acute Insight, 12 have so far collectively demonstrated a statistically significant relationship with the trust's overall rating in the first round of CQC's new-model comprehensive inspections (2013-2016).				
Patient-led assessment of privacy, dignity (PLACE)				
82.7% (Source: PLACE)	67.2% (Feb-16 to Jun-16)	60.8% (Mar-17 to Jun-17)	↓	Much worse
Action plan in place to address any issues highlighted. Action plan discussed at Patient Environment group which is a sub group of Quality & Safety and chaired by Neil Nisbett and Martin Foster. Going forward we plan to carry out internal ward visits with estates & facilities prior to PLACE to see how we are progressing. **Additional Patients** Privacy & dignity can be an issue when the wards receive additional patients and when areas not usually used for patients are utilised such as corridors. All additional patients receive a risk assessment but we are aware that we need to include analysis on the length of time patients are boarded and ensure any level of harm is recorded. The trust is keen to reduce boarding of patient and has long-term objectives to address.				
Patient spending less than 4 hours in major A&E				
85.4% Monthly A&E SitReps – Sep-17	79.3% Aug-16	76.1% Aug-17	→	Much worse
The patients spending more time in majors are predominantly those waiting to be admitted, however there are some patients who don't require admitting to hospital but do require a little longer to observe for complications or to receive minor treatments that take longer than four hours. RSH has a CDU to accommodate these patients; at RSH we intend to implement the same model. Within the major's stream we have also put in place a 'fit to sit' model to help with the process, this prevents patients from taking up a cubicle for the duration of their time in the A&E. The Trust currently audits patients who have waited longer than 4 hours in ED in relation to safety and quality; there is still work to be done on our patient experience in ED. A report is in the process of being submitted to CQRM & Q&S				
Flu vaccination uptake (%)				
67.3% Department of Health Jun 2017	43.3% Sep-15 to Feb-16	70.6% Sep-16 to Feb-17	↑	About the same
Update: October 2017 We have vaccinated a total of 2145 who can be classified as Healthcare workers (HCW) = 48.47%. The target set by NHSE through the CQUIN is to achieve a vaccination rate of 70% of all our HCW.				
Trust & core Service Analysis – Trust wide **The intelligence section:** The second substantive section of Acute Insight contains intelligence that might indeed provide indications of the quality of care at the trust.				
Patient-led assessment of environment for dementia				
76.1% PLACE – Aug-17	58.2% Feb-16 to Jun-16	56.7% Mar-17 to Jun-17	→	Worse
There was a reduction in the percentage for RSH of 2.98% and an increase at PRH of 0.11% giving an overall average decrease of 1.44% across both sites. The national average increased between 2016 and 2017 by 1.42%. We have had some further ward moves at PRH in September 2017. We still have 40 dementia friendly clocks to go up at this site RSH, all done at PRH. We have improved the activities room ward 15 for dementia friendly café, ordered a clock, signage ordered and different height chairs ordered. We have signage arriving for ward 10 and more clocks. We do not have TV's but have two digital reminiscence therapy units and two hand held tablets at RSH, one of each of these at PRH used with people living with dementia on various wards. AMU has a resource box now with activities for people with dementia. Wards are accessing the Dementia cafes both sites each month for Pts and carers for support/activities. We				

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison
have a number of dementia friendly chairs, lockers delivered and disseminated across both sites. Whilst dementia patients have their minimum standards achieved current staffing levels do not always allow us the opportunity to offer an enhanced service. The Trust completes risk assessments for the need for EPS where appropriate				
Sick days for medical and dental staff				
1.12% (Source: ESR Data warehouse)	N/A	2.03% (Jun-16 to Jun-17)	NA	Much better
In terms of medical and dental sickness and absence we are undertaking a range of interventions to manage sickness and support health and wellbeing for staff. We have identified that in Unscheduled Care sickness, management referral to occupational health and return to work interviews needed strengthening for the medical workforce to address some of these issues and support our medics. The care group has therefore invested in a specific post to support this agenda and ensure our systems, processes and line management support is in place and strengthened for our medical and dental staff across the care group.				
Never Events				
-	2 Aug-15 to Jul-16	4 Aug-16 to Jul-17	↓	About the same
For year 2017/18 there has been 1 never event 19/10/17 Patient undergoing left cataract surgery with a plan for a 21.5 dioptre lens to be inserted had a 21.0 dioptre lens put in.				
Deaths in low-risk diagnosis groups				
0.55 Dr Foster intelligence	0.41 Jan-15 to Dec-15	0.51 Jan-16 to Dec-16	↓	About the same
Still below national average but showing slight decline, will be monitored via the Trust mortality group				
Identified level of potential support needs by the provider				
Source: NHS Improvement SOF	N/A	Providers receiving mandated support Jul-17	NA	Worse
➢ Financial risk				
Trust & core Service Analysis – Urgent & Emergency				
Patient spending less than 4 hours in A&E in any type				
88.8% Monthly A&E SitReps – Sep-17	82.2% Aug-16	76.6% Aug-17	↓	About the same
There are a number of changes within the departments to have impact on the overall pathway that patients follow, these include • Putting in place a dedicated Director of Transformation to manage improvements • Better data and breach analysis to understand what is happening and make relevant changes focused on patient care and experience • Streaming patients at the front door to relevant parts of the service or into a primary care service such as MIU or UCC • Ambulance handover process has been streamlined to prevent delays in returning the ambulance crews, this has a dedicated nurse who undertakes this duty between 11.30am and 11pm • Work force changes – an additional three ENP's have been recruited and take up post in January 2018, additional market testing to see if there are more ENP, ACP and paramedics who would consider a role in the A&E's, success in this area will give a permanent workforce and an ability to modernise the skill mix and reduce the need for temporary staff including locum doctors • Both A&E's now also have a practice development nurse (temporary position) to help support new recruits and the longer term development of staff				

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison
Patients spending less than 4 hours in type 3 A&E, including MIU's				
99.4% Monthly A&E SitReps – Sep-17	100% Aug-16	100% Aug-17	→	Much better
One of the MIU's has been closed and this along with NHS111 has increased attendance at A&E, in total 3 to 5%. Putting in place a new UCC at PRH will help address this.				
Trust & core Service Analysis – Medicine				
SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator				
-	Level D Jan-16 to Mar-16	Level D Dec-16 to Mar-17	→	Worse
We are performing slightly worse this year compared against the same quarter last year (Apr-Jul) by 12% (we were a C last year and a D overall). We have implemented a number of improvements with further improvements in improving patient flow and direct access to stroke beds over the last couple of months which are resulting in improvements in the key indicator 2.1 Percentage of patients directly admitted to stroke unit within 4 hours of clock start over the last 2 months (August and Sept) reaching 70% and 71% of patients achieving this target, which will in turn mean that the key indicator 2.2 will improve as the proportion of patients admitted within 4 hrs will have a positive effect on the median time to arrive on the stroke unit. We are already performing at level b levels and above for key indicator 2.3 Percentage of patients who spent at least 90% of their stay on stroke unit and our interim figures indicate that we will maintain in this area.				
Emergency readmission: chronic obstructive pulmonary disease & bronchiectasis				
100 HES	86 May-15 to Apr-16	82.5 May-16 to Apr-17	↑	better
Emergency readmissions: Pneumonia				
100 HES	88.3 May-15 to Apr-16	79 May-16 to Apr-17	↑	better
Respiratory discharge is a current VMI value streams which may have had a positive impact on emergency readmissions.				
Emergency readmissions: Fluid and electrolyte disorders				
100 HES	86 May-15 to Apr-16	73.5 May-16 to Apr-17	↑	better
Emergency readmissions: UTI				
100 HES	77.3 May-15 to Apr-16	80.2 May-16 to Apr-17	↑	Much better
No additional comments				
Response rate – medical inpatients (%)				
- Friends & Family test	27% Jul-15 to Jun-16	21.6% Jul-16 to Jun-17	↓	
This is being monitored via the trust dash board and also at Senior Leadership confirm and challenge				
Trust & core Service Analysis – Surgery				
RTT, on completed admitted pathways in surgery, within 18 weeks				
70.1% NHS England	61.4% Jul-16	51.2% Jul-17	↓	worse
The trust achieved the 92% RTT in September 2017 and will achieve going forward. This is a much improved position. We are measured nationally on the incompletes target. The completed admitted target for general surgery has improved at 84.16% today (19/10/17).				
Trust & core Service Analysis – Maternity				
Cleanliness of toilets and bathrooms (maternity survey Sep 2016)				
-	8.2	9.2	↑	About the

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison
CQC – Maternity Survey Sep-17	Feb-13	Feb-15		same
Cleanliness continues to be monitored through RATE and Ward environment checks				
Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)				
5.2 MBRRACE – Aug-17	5.4 Jan-14 to Dec-14	6.0 Jan-15 to Dec-15	↓	Much worse

The Trust has reviewed the MBBRACE report (2015) and the Clinical Directors for Neonatology and Obstetric have devised a draft report which is in the process of being reviewed through the Care Group and Trust Governance process.

Learning points for CQC following MBRRACE 2015 report

Data quality

- The total number of births recorded by the Trust for 2015 was 4701. Within the MBRRACE report for 2015 the total number of cases delivered within the Trust was given as 4423. This represents a discrepancy of 278. This discrepancy has been reported to MBRRACE and has been acknowledged by MBRRACE. It is unclear why there was such a discrepancy. Data for 2016 has been checked with MBRRACE and correlates.

- Due to data entry issues within SaTH the lethal congenital anomalies (6/14 neonatal deaths) for that year were not acknowledged in the final report. This figure is unusually high for that year. Data entry has improved for the deaths of 2016.

Stillbirths

Two key themes were present in the stillbirth cohort

Antenatal detection of IUGR

- Women are currently stratified at booking according to risk of having a fetus with FGR. Those women at highest risk are offered a number of ultrasound scans in the 3rd trimester depending upon their level of risk. Currently SaTH are unable to achieve RCOG guidance due to the increased cost associated with extra scans. Discussions have been held with the CCG and NHSE without resolution.

- All maternity staff have received additional training in the identification of IUGR during 2016.

- The Trust is exploring the potential to interface the Maternity EPR with the GAP software. Funding is in place and the Trust is awaiting software testing. This will enable accurate audit of mechanisms to detect IUGR.

Reduced fetal movements

- All women are now provided with a leaflet highlighting the importance of reduced fetal movement at around 16 week's gestation. Going forward all women will be provided with a folder for their hand held records that displays the importance of fetal movement monitoring.

- All women are reminded of the importance of monitoring fetal movements throughout the third trimester.

- All women are encouraged to attend their local maternity unit for assessment and monitoring on the same day if they experience reduced fetal movements. The monitors, with on-board electronic analysis, are now located in all of the MLUs and the CU to enable rapid local access to fetal monitoring.

Neonatal deaths

The key learning points derived from the 14 cases from 2015 were:

- Perinatal Hypoxia - seamless coordination of complex care delivery including prompt monitoring of clinical status & initiation of multiple treatments to ensure full stabilisation prior to communication with NICU for transfer. In particular the development of the "Golden Hour" flow chart for management of Hypoxic Ischaemic Encephalopathy was designed to complement the ABC of Cooling Proforma to ensure timely initiation and support for babies requiring stabilisation with this condition. A poster was presented at the national meeting Each Baby Counts, Royal College of Obstetrics &

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison

Gynaecology in 2016 sharing our learning & improved practice demonstrated through audit.

- Sepsis Management - timeliness of antibiotic prescribing
- Blood pressure management - initiation of treatment for hypotension
- Team working - ensuring your voice has been heard in an urgent situation & that assistance is readily available
- Newborn Resuscitation - re-checking of resuscitation stations and timeframe for airway & breathing support and commencement of cardiac compressions
- Preparing a baby for transfer - improving medical documentation in case notes detailing baby's clinical situation and decision making by transport team with SaTH immediately prior to transfer in case notes
- Perinatal palliative & end-of-life care - need to ensure multi-disciplinary team are engaged

Maternity issues within the neonatal death cohort

There were no specific maternity themes within the cohort of neonatal deaths. However there were actions related to each of the three cases that have altered clinical management within the unit.

- Consistent and regular monitoring of the fetal heart during the transfer from an MLU to the Consultant Unit.
- Initiation of a VBAC clinic that allows exploration of women's views around their birth choice and then a clear record of agreed decisions.
- Improved alignment of midwifery and medical handovers with an improvement in the quality and completeness of clinical information shared at handover.

There has been a complete review of fetal monitoring in labour with an emphasis on improved training. All staff members required to assess CTGs are trained in the following aspects of CTG interpretation

1. E-learning using K2
2. Annual update on NICE guidance
3. Twice weekly CTG teaching on Delivery Suite for available staff members
4. Delivery Suite Coordinators will receive enhanced CTG training

In addition the Trust has invested in a CTG archiving system that will allow intrapartum CTGs to be archived electronically for review and teaching as well as being displayed live outside the labour room in order for staff to assess using fresh eyes on a regular basis throughout labour.

Raising concerns – maternity survey 2016				
- CQC – Maternity Survey Sep-17	9.2 Feb-13	8.1 Feb-15	↓	About the same

Since the last CQC Patient Experience Survey we continue with to gain feedback via the Friends and Family Test. The Trust has employed Values Guardians for both patients and staff to talk to. A new Patient Engagement Officer has been employed and is linked with the Maternity Engagement Group.

Treatment with respect and dignity – maternity survey 2016				
- CQC – Maternity Survey Sep-17	9.7 Feb-13	9.1 Feb-15	↓	About the same

Since the last CQC Patient Experience Survey we continue with to gain feedback via the Friends and Family Test. The Trust has employed Values Guardians for both patients and staff to talk to. A new Patient Engagement Officer has been employed and is linked with the Maternity Engagement Group.
Trust Values and Trust Leadership Academy training have been implemented. Maternity complete monthly self-assessments and patient experience on the RATE (electronic survey and audit) tool being implemented and 2 areas within Maternity are in the process of applying for Exemplar assessment.

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison
Trust & core Service Analysis – Children & Young People				
Did you have confidence and trust in the members of staff treating your child				
- CQC – Children's Survey Jan-17	NA	9.3 Aug-14	NA	Better

- Ward manager now has monthly communication meetings with band 6 nurses
- Ward manager undertakes monthly monitoring of paediatric notes to look at care and aspects of communication
- Appointment of CPE 2 days a week, helps with supporting confidence with nursing clinical skills
- Paediatric team received annual VIP award because of feedback from Telford and Wrekin heath watch regarding care and effective communication
- Twitter account enhance the channels of communication

Trust & core Service Analysis – Outpatients				
Cancer – First treatment in 31 days of decision to treat (%)				
97.5% NHS England Aug-17	98.3% Apr-16-Jun-16	99.2% Apr-17 to Jun-17	→	Better
SaTH continue to achieve this target				
Cancer – First treatment in 62 days of urgent national screening				
92.3% NHS England	98.4% Apr-16 to Jun-16	90.6% Apr-17 to Jun-17	↓	About the same

The reduction in performance (as reported on a monthly basis via Open Exeter) is a result of:-

1. Patient choice - patient requested treatment not available at SaTH due to high BMI. Required referral to other centre and additional OPAs as result. April breach. Breast screening.
2. Medical delay - patient required fitness for surgery assessing prior to treatment planning. May breach. Colorectal screening.
3. Patient choice - speaks limited English and although she attended early OPA's with a friend who speaks English, the clinical team felt that a Polish Interpreter should attend all OPA's and this had to be coordinated with patient, her friend and the interpreter. May breach. Gynaecology screening.
4. Patient choice - patient delayed first OPA (patient cancelled 25.04.17 & 01.06.17 due to husband being ill). June breach. Breast screening.
5. Other reason - complex treatment plan. Patient required joint surgery with Gynae team. Surgery date planned as soon as possible given complexity of surgery required. June breach. Colorectal screening.

Current year end position – 90.96% (target 90.00%). 94 patients treated, 85.5 in target.
Breach reports are completed for all patients who breach a 62-day screening target.

Outpatient DNA's (%)				
7.4% HES Jul-17	4.4% Mar-16	4.2% Mar-17	→	Better

The above figures have risen steadily since March 2017 but have fallen again in August 2017. In the last 12 month period the average DNA rate for the Trust was 4.71% in comparison to a peer average of 7.82% (3.11% difference). The Trust continues to outsource letter printing within Patient Access and the use of an Outpatient reminder service to improve DNA rates. The climb in DNA rates isn't unusual - we have seen this pattern in previous years and appear to be a seasonal variation.

Patients waiting over 6 weeks for diagnostic test (%)				
1.9% NHS England Sep-17	0.3% Jun-16	0.0% Jun-17	→	Better

A dashboard has been developed which is used to monitor our performance against the DM01. The areas included are Radiology, Endoscopy and Audiology. We are working with the information team to produce a Diagnostic PTL. This will be used for monitoring Radiology and Endoscopy patients. Audiology is not included in this PTL at present because of the complexity of integrating a standalone system with the data ware house. The vast majority of their cases have to be undertaken within 21 days as a requirement from AQP and one stop clinics from ENT so including Audiology at this stage would have greatly delayed the production of a diagnostic PTL where we had the capability of monitoring the Radiology and Endoscopy referrals.

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison

Featured Data Sources

This section contains a number of feature pages dealing in greater depth with particularly important intelligence streams such as safety incidents and staff and patient surveys.

Incidents

Median time taken to report incidents was 63 days for this organisation compared to 23 (Apr 16 – Sep 16)

Long term sickness has impacted on the ability to upload incidents in a timely manner. The Trust has recognised the majority of low harm incidents were only uploaded to the NRLS after investigation. The Trust has recently learnt that other Trusts upload incidents to the NRLS as they occur. Now the team is back to full capacity we will be adopting this model which will bring the reporting time in line with the National average.

Safety thermometer

- **Pressure Ulcers**
  In the September NHS ST submission, Ward 23 reported four new grade two pressure ulcers. However, this does not match data on Datix for the same period when they did not report any. This could be because patients had been transferred to the ward with existing skin damage and therefore it is not a specific issue to that ward. Our Tissue Viability Nurses have confirmed that Ward 23 is not a ward that they have particular concerns about in relation to in service pressure ulcers.
- **Falls**
  The last falls reported by Ward 21SD were in July 2017 when two falls with no harm were reported. The last time the ward reported a fall with harm was February 2017 when three patients experienced low harm. This ward is our supported discharge ward and patients are therefore encouraged to mobilise within their ability. The staff have, as all wards, a number of strategies in place to keep people as safe as possible whilst encouraging them to be independent. There is no adverse trend data relating to this ward in relation to patient falls
- **CAUTI**
  Ward 7 has not reported a CAUTI since July 2017 when three patients had a catheter associated with an "old" UTI. There were two patients with a new CAUTI in June and none since then. We are vigilant in relation to catheter care and our IPC team have no specific concerns relating to catheter care with this ward.

Maternity & Mortality Outliers

Mortality outlier alert: Fluid and electrolyte disorders

Deep dive performed and response shared with CQC – learning disseminated including shared learning with community hospitals

Governance

We have a Trust Mortality Group who reports to the Quality and Safety Committee. Mortality issues are also discussed in the speciality governance meetings and care group boards. Specific Patient Safety Advisor for mortality, who works closely with Medical Director.

Additional Information

The Trust is meeting the targets described in the national framework document 'Learning from deaths'. Patient outcome data will be published by the Trust Board end of Quarter 3.

A Trust response is being prepared to the TARN report from July 2017 which showed a negative survival rate for the Royal Shrewsbury Hospital. This will be shared with the CQC when complete**.**

Maternity outlier alert: maternal readmissions

Update: action plan completed

Care Quality Commission Maternity Outlier alert for maternal non-elective readmissions within 42 days of delivery at the Shrewsbury and Telford Hospital NHS Trust

a) Those women coded as Z39.1 "care and examination of lactating mother".

These women were admitted for breastfeeding support or advice. The majority of these admissions were to a maternity led unit (MLU).

A review of the notes for 50% of these cases (20 sets) was undertaken (see attached report).
In all cases, the baby was admitted with the mother. In 75% of cases, readmission was to a midwifery led unit.
The remaining 25% were admitted to the consultant postnatal ward.
Recording of these admissions is considered important by the service for tracking of patients under our care and monitoring of bed occupancy. The coding given was considered appropriate.

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison

b) Those women coded as Z76.8 "persons encountering health services in other specified circumstances "
These were women admitted with an unwell baby to either the consultant unit or MLU. A review of free text in our electronic patient system was undertaken re reasons for admission (see attached report). The babies were admitted for a variety of reasons particularly neonatal jaundice, weight loss or feeding difficulties. The mothers received routine postnatal care as per the postnatal pathway during their inpatient stay. Recording of these admissions is considered important by the service for tracking of patients under our care and monitoring of bed occupancy. However, coding of these admissions is not a requirement as only routine postnatal care was provided.

In response to a previous CQC alert the service did explore whether well women admitted with their unwell baby could be recorded differently on the Patient Administrative System (PAS). However, this was not possible within our PAS system at that time. We propose to pursue this option further as a matter of urgency. Please find attached an improvement action plan that has been agreed in response to this alert.

Mortality

Performance normal variation within expected range - HSMR 95.77

National Clinical Audits

Audits highlighted by CQC:
National lung cancer Audit (NLCA) – 2015/16 next update due 01/18
Hip fracture audit – 2015/16 both sites
National vascular registry – 2015/16
Emergency laparotomy audit NELA (year 1/year 2) – both sites
National paediatric diabetes audit – 2014/15 to 2015/16
Severe sepsis and septic shock audit – 2013/14 to 2016/17

Detailed updates provided to CQC have been included as part of the CQC engagement template

A&E Waiting Times

Highlighted already within Trust wide and core service overview

Access & Flow – Under development by CQC

Patient Surveys

Cleanliness of room or ward	9.0 2015	9.3 2016	↑	
Cleanliness of toilets & bathrooms	8.7 2015	8.9 2016	↑	
Bothered by noise at night from hospital staff	7.6 2015	8.1 2016	↑	
Length of time on waiting list before being admitted to hospital	8.7 2015	7.8 2016	↓	
Asked to give views on quality of care	2.5 2015	1.8 2016	↓	

- **Cleanliness of room or ward & Cleanliness of toilets and bathrooms**
  The reason for the increased score for cleanliness is that we have undergone a rota review as part of workforce planning and have increased staffing levels as much as possible. The cleanliness team receive improved and continuous training which has led to higher standards of cleanliness. We have also introduced a robust cleanliness monitoring process which has helped to increase standards of cleanliness.

- **Bothered by noise at night from hospital staff**
  Quiet night sleep tight campaign which included putting posters up in ward areas to communicate with staff and introduction of comfort packs for patients.

- **Length of time on waiting list before being admitted to hospital**
  Overall waiting times for elective surgery have reduced since the 2016 survey and SaTH is now delivering the 92%

National Average	Previous Trust Performance	Latest Trust Performance	Change	National Comparison

Incomplete Standard for RTT.

- Robust waiting list management
- Additional activity at premium cost to the organisation
- Winter last year was better managed within surgery than in previous years resulting in fewer cancellations.

- **Asked to give views on quality of care**

  The Trust remains in the top 6 in the country for FFT promoter score and is above the national average. Patient Experience using RaTE (electronic monitoring tool) - 5 patients from each ward are asked a series of questions monthly. Complains, PAL's leaflets available In addition to the CQC National Patient surveys, we have our own programme of local surveys selected to target areas identified for improvement, a list is available upon request.

Staff surveys

Engagement Score

The engagement score is made up of 3 elements: motivation, advocacy and involvement.
Involvement was a key area of opportunity in which the Trust could make improvements; therefore the Trust has focused on how better to involve staff in decision making:-

- Breakfast with the Boss Campaign- a selection of staff will be invited to have breakfast with the CEO to share their good news, feedback on how it feels to work in the organisation, discuss 'if you could change one thing what would it be…….
- Refreshed Staff Survey Campaign- targeted approach by departments, myth busting and more visible campaign to encourage staff to feedback
- Transforming Care Institute/ Virginia Mason Institute- through the Values Streams, Lean for Leaders and roll out of further introductions and sharing events increased numbers of staff have been empowered to make differences within their area of work
- Leadership Conference- this included streaming to a wider audience within the Trust
- Values in Practice agreement whereby clear expectations of our leaders is articulated
- Launched the leadership academy with key modules such as Values based conversations and standard leadership behaviours

Recommend organisation

- Belong To Something Campaign- a bespoke recruitment campaign that promotes all roles within the organisation
- Workforce business partners and OD working with care group leads have asked specific questions within staff conversations re staff survey on the advocacy questions to try and ascertain why are results are not improving at a pace we would like and remained at the same level last year
- VIP Awards- these are celebrated each month with care group winners, overall Trust wide winner and culminates in an annual award ceremony in which 200 are in attendance, long service is celebrated with the full executive team in attendance
- Enhanced health and wellbeing offer with access to more subsidised exercise classes, free water bottles and staff therapies
- Recruitment Value Stream
- Implemented Trac system – more effective and efficient recruiting system
- Achieved Silver Award Recognition – Armed Forces Employer

Communication (this is however improving year on year)

- Increased presence on Social Media, including Facebook, Twitter, Instagram
- Regular Report Out Events every Friday across both PRH and RSH CEO/ Exec led
- Increase of PC access to over 4000 members of staff regularly accessing email
- Visible poster campaigns and the increased use of video clips

Bullying and Harassment (NB this is a positive result)

We recognise that our score is lower than acute average (which is positive) however, recognise this is not the employment experience we want any percentage of our staff receiving so have:

- Recruited Freedom to Speak Up Guardians across sites- our values guardians
- Across the kitchen table events hosted by our values guardians
- Values based conversations training
- Mental wellbeing as part of managing attendance and wellbeing (to start a conversation) through skills development arm of leadership academy

Table 20

Standard Operating Procedure (SOP)

SOP Title	**Safest and Kindest Quality Improvement Plan**		
SOP Number			
Care Group	Trust wide		
Version Number	10		
Effective Date	November 2017	Review Date	
Author	Angela Hughes: Quality Assurance Lead corporate Nursing and Midwifery		
Approved by			
Approval date			
Distribution			
Location			

Document Control				
Version	Date	Author	Status	Comments
1	November 2017	Angela Hughes: Quality Assurance Lead corporate Nursing and Midwifery	New SOP	To formalise the process for the Safest and Kindest Quality Improvement Plan

SOP Objectives	1. To provide guidance on the scope and remit of the Trusts' Safest and Kindest Quality Improvement Plan 2. To provide guidance on reviewing and reasonability of the CQC Insight, Intelligence tool.
Scope	Trust wide
Performance Measures	The performance of the quality improvement plan will be detailed in the quarterly report, scrutinised by the Quality and Safety Committee.

Ratification and Circulation process

Group	Purpose	Date
NMF	Ratification	16/10/2017
Quality and Safety Committee	Ratification	23/11/2017
SLT	Circulation	
CGE	Circulation	
CQRM	Circulation	

Number	Brief	Responsibility

1.0	**Context** The Safest and Kindest Quality Improvement Plan represents the hub of quality improvements. This plan collates the Trust overarching CQC action plans and other quality action plans. Its purpose is to provide assurance against internal and external reviews. Its methodology includes triangulation of themes to enable collective learning across the Trust. This SOP should be read in conjunction with Safest and Kindest Every Day Quality Improvement Strategy 2017-2018, which provides supplementary detail. The Safest and Kindest Quality Improvement Plan will evolve over the coming year in order to make a real difference to our patients, staff and the organisation.	
2.0	In order to achieve actions within the Safest and Kindest Quality Improvement Plan, it is intended that the actions within will incorporate 6 pivotal aspects: • **Leadership** :nurtures cultures that ensure the delivery of continuously improving high quality, safe and compassionate care • **Communication:** raising awareness and understanding • **Audit** - actions will be monitored through spot checks / audit • **Governance -** Instilling a robust overarching governance process • **Education** – identifying education requirements, • **Training -** provision and access to training	Care Group Directors
3.0	Accountability **Quality Assurance Lead Corporate Nursing and Midwifery** • Has responsibility for co-ordination and collating the updates for the Safest and Kindest Quality Improvement Plan. This requires monitoring its progression, critical analysis of the Trust themes / triangulation and producing quarterly assurance update reports to the Quality and Safety Committee CGE and CQRM. **Care Group Leads** • Are responsible for ensuring robust governance process are in place to be able to demonstrate timely progression of their components of the Safest and Kindest Quality Improvement Plan. In addition, the Care Groups Leads are responsible for sharing the learning and providing a quarterly synopsis to update and inform the Quarterly Quality and Safety report. **Deputy Director of Quality and Nursing** • In order to ensure the Trust remains focused on the Quality Improvements within the Safest and Kindest Quality Improvement Plan the Deputy Director of Quality, Nursing and Midwifery will undertake random bi monthly reviews with the Assurance Lead Corporate Nursing and Midwifery and provide executive support in addressing challenges and updating pivotal quality forums of its progression. **Director of Quality, Nursing and Midwifery** • Is accountable in providing Board level leadership and executive direction for the Safest and Kindest Quality Improvement Plan. This role is responsible for quantifying its progression, risk mitigation and providing assurance to the Quality and Safety Committee and the	Quality Assurance Lead Corporate Nursing and Midwifery Care Group Leads Deputy Director of Quality and Nursing Director of Quality, Nursing and Midwifery

	CEO. **Trust Board** • Is accountable for rigorously evaluating the effectiveness and the progression of the Safest and Kindest Quality Improvement Plan and determining how it supports the achievement of the organisation strategic objectives / performance.	Trust Board
4.0	**Inclusion into the Safest and Kindest Quality Improvement Plan :** The following actions plans are incorporated into the Trusts' Safest and Kindest Quality Improvement Plan Directory: • Trust CQC action plan (Must do and should do), • Care Groups Improvement plans, • CQC / Ofsted Safeguarding • West Midlands Quality Review. • The intention is to incorporate fundamental national audits such as EOLC, stoke etc.	Quality Assurance Lead Corporate Nursing and Midwifery
5.0	**Timely updates:** Appendix 1 details the expectation required for contemporaneous update of the Trusts' Safest and Kindest Quality Improvement Plan In order to enable these updates, Care Groups will be required to use existing governance frameworks and formally agenda the reviews at their Clinical Governance Boards.	Care Group Leads and the Quality Assurance Lead Corporate Nursing and Midwifery
6.0	**Robust evidence to underpin the Safest and kindness Quality Improvement Plan :** • Evidence for the Trust CQC action plan, will be collated by the Corporate nursing Team. • Evidence for the other Core Services action plans will be collated locally by the individual Care Groups and held within a central drive.	Corporate Nursing Clinical Information officer Care Group Leads
7.0	**Triangulation of themes:** The purpose of the Safest and kindness Quality Improvement Plan is to stream line and cross reference internal and external action plans, in order to draw out reoccurring themes and therefore learning.	Care Group Leads and the Quality Assurance Lead Corporate Nursing and Midwifery
8.0	**Quarterly updates:** A proforma has been devised, which identifies the information required from each Care Group, this includes an overview of the status, themes and details regarding issues which are challenging to achieve. The care group leadership team is responsible for updates and these must be returned within the specified timeframe, in order to meet the deadline for the Quarterly Quality and Safety Report and consequent escalation to Trust Board	Care Group Leads and the Quality Assurance Lead Corporate Nursing and Midwifery

9.0	**Access and reporting on the Quality improvement plan:** The overarching Safest and Kindest Quality Improvement Plan is a dynamic and "live" document updated on the Corporate Quality, Nursing and Midwifery shared drive. Care Group Leads will be given access to review it. It will be version controlled and be available on the Trust Public website following ratification to Quality and Safety Committee on a quarterly basis.	Corporate Nursing Clinical Information officer
10.0	SaTH's review and coordination of the CQC insight Intelligence tool Senior leaders within SaTH will understand and be responsive to extraordinary changes cited within the monthly CQC intelligence Tool "Insight" and will review quarterly updates circulated to Executives, SLT and Quality and Safety Meetings. The following individuals have the responsibility to receive and review a monthly Insight data. ➢ **Chief information officer** will review and validate the data on monthly basis and inform the Corporate Nursing and Midwifery Assurance Lead of any inaccuracies. ➢ **Executives-** will discussed extraordinary changes at Executive meetings and liaise with Care Group leads regarding mitigation / actions. ➢ **The Care Group** will review and significant changes to the intelligence data on a monthly basis and provide assurance to the Executives that there is mitigation / actions in place. They will also be required to liaise quarterly with the Corporate Nursing and Midwifery Assurance Lead, in order to inform the Quality improvement plan to Executives, SLT and Quality and Safety Meetings. ➢ **Corporate Nursing Team** In addition, the following members of Corporate Nursing and Midwifery Team: Deputy Director of Safety and Quality, Associate Director of Patient Safety, Associate Director of Patient Experience, Quality Assurance Lead, Patient Safety Manager will receive review and monitor significant changes on monthly basis and inform the Executives and the Corporate Nursing and Midwifery Assurance lead of mitigations in place regarding extraordinary changes.	