Cover page	
Meeting	SaTH Trust Board
Paper Title	Quality Improvement Plan (QIP) update
Date of meeting	01/08/2019
Date paper was written	22/07/2019 (Reflecting Progress made up to the 28 June 2019)
Responsible Director	Paula Clark Chief Executive
Author	Rajinder Biran, Head of Improving Care PMO

Executive Summary

Overall Risk Rating for the QIP plan remains **Amber.**
Excellent progress has been made in SCG and W&C's with transition into phase three around checking evidence of the outcomes through gemba walks and other transformational initiatives to confirm the CQC finding has been addressed. A plan is being devised to use the mid-month cycle to focus on this piece of work.
Improved Leadership of Well Led has given improved direction and leadership review of all KLOES.
USCG requires further improvement. The Executive Sponsor is actively working with corporate leads to engage support of the wider CQC findings linked to ED, Medicine and Hospital at night.

Please Refer to Appendix One for summary update.

Previously considered by	Elements of this paper have been presented at the Executive Continuous Improvement, Quality & Safety Committee, Board and through the Improvement Steering Groups, and the Safety Oversight Assurance Group.

The Board (Committee) is asked to:			
☐ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework	RR1533 We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients

risk(s)	

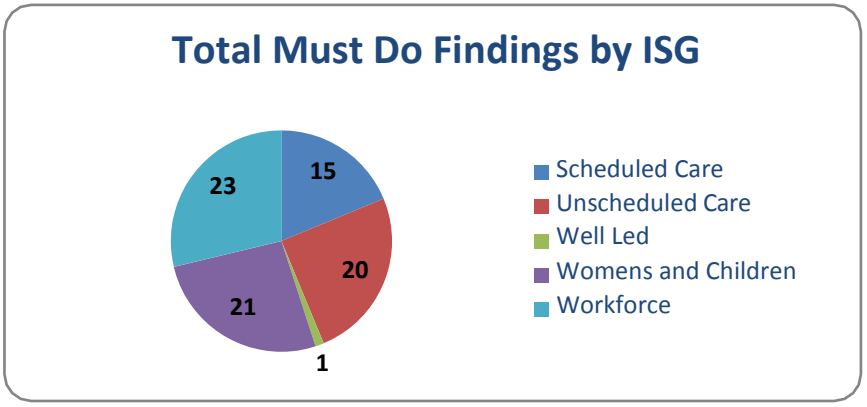
Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	

Main Paper

Situation

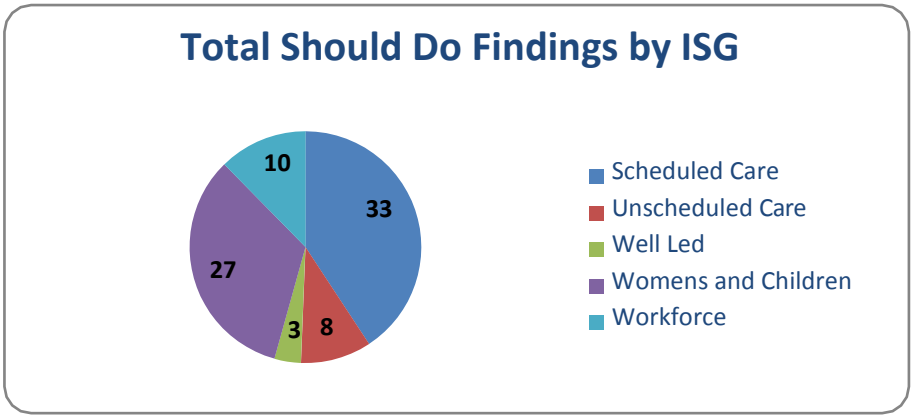
Assurance by CQC Finding

There are 79 CQC Must Do findings recording across the four Internal steering Groups (ISG's), Workforce, W&C's, USCG and SCG. There is also 1 further Must Do Finding (MD002) within the Well Led Plan, taking the total to 80 Must Do Findings.

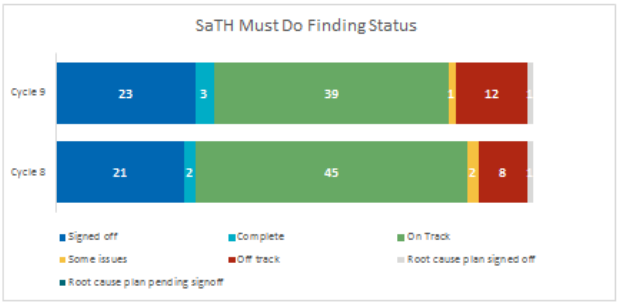


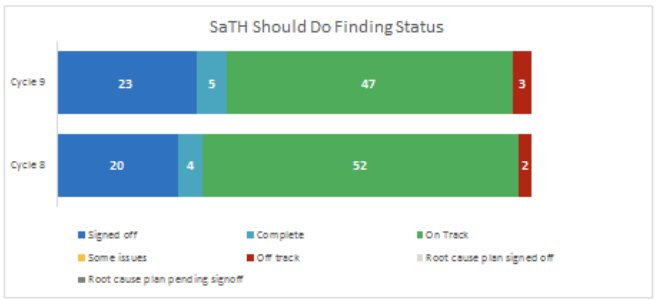
There are 78 CQC Must Do findings recorded across the four ISG's: Workforce, W&C's, USCG and SCG, with a further 3 Should Do Findings (SD001, SD002, SD003) within the Well Led Plan, taking the total to 81 Should Do Findings.

- SCG have a higher number of Should Do's than Must Do's.



Total Trust Findings



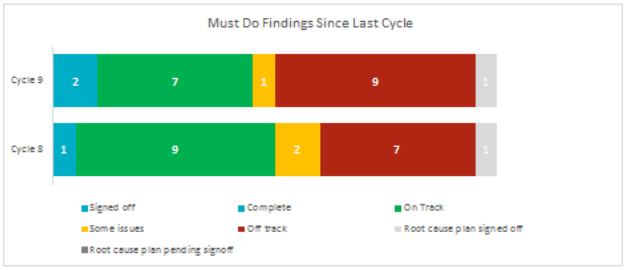


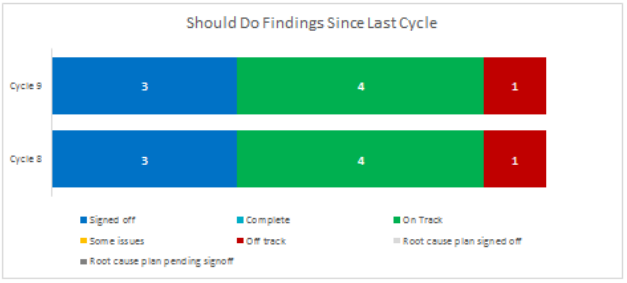
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Root cause plan signed off	Root cause plan pending signoff
Must Dos	79	23 (29%)	3 (4%)	39 (49%)	1 (1%)	12 (15%)	1 (1%)	0 (0%)
Should Dos	78	23 (29%)	5 (6%)	47 (60%)	0 (0%)	3 (4%)	0 (0%)	0 (0%)

Of the 79 Must Do's,
29% are signed off with evidence.
3% are complete, pending validation of evidence.
49% are on track and making good progress.
1% has some Issues, which means that risk has been identified which may impact completion of the action by the completion date.
15% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.

Of the 78 Should Do's,
23% are signed off with evidence.
5% are complete, pending validation of evidence.
60% are on track and making good progress.
0% has some Issues, which means that risk has been identified which may impact completion of the action by the completion date.
4% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.
Please refer below for breakdown by ISG

Unscheduled Care ISG Findings



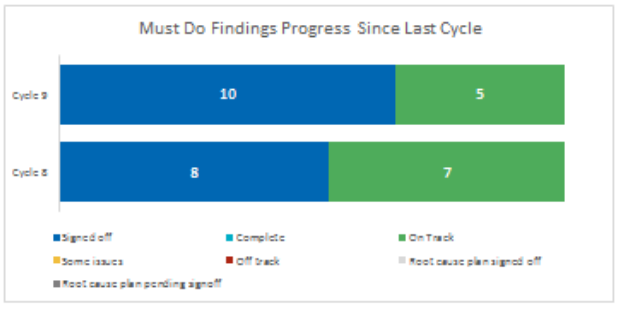


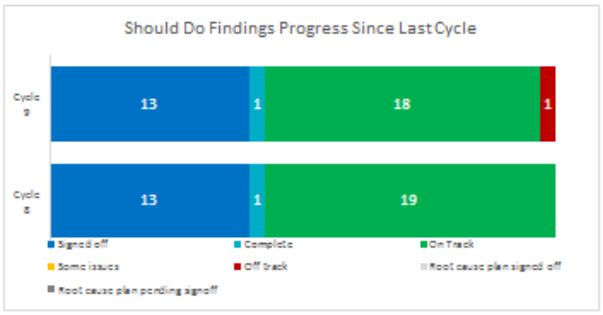
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Findings plan signed off	Findings plan pending signoff
Must Dos	20	0 (0%)	2 (10%)	7 (35%)	1 (5%)	9 (45%)	1 (5%)	0 (0%)
Should Dos	8	3 (38%)	0 (0%)	4 (50%)	0 (0%)	1 (13%)	0 (0%)	0 (0%)

Of the 20 Must Do's,
0% is signed off. The root cause analysis will demonstrate part of the Should do's are complete, however due to there being multiple root causes attached to a Must Do, it requires every single one to be completed for the Trust to demonstrate progress.
10% are complete, pending validation of evidence.
35% are on track and making good progress.
5% has some Issues, which means that risk has been identified which may impact completion of the action by the completion date.
45% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.
5% is awaiting a time frame. This has been addressed at Cycle 10. (CQC ID: MD036 - Ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm, Root cause ID: MD036.5, Lack of full knowledge over who is responsible for some equipment items - issue around the transfer of patients)

Of the 8 Should Do's,
0% is signed off. The root cause analysis will demonstrate part of the Should do's are complete, however due to there being multiple root causes attached to a Must Do, it requires every single one to be completed for the Trust to demonstrate progress.
38% are signed off with evidence.
50% are on track and making good progress.
13% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.

Scheduled Care ISG Findings





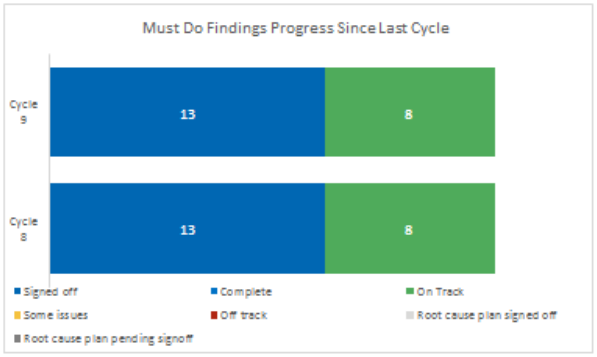
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Findings plan signed off	Findings plan pending signoff
Must Dos	15	10 (67%)	0 (0%)	5 (33%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Should Dos	33	13 (39%)	1 (3%)	18 (55%)	0 (0%)	1 (3%)	0 (0%)	0 (0%)

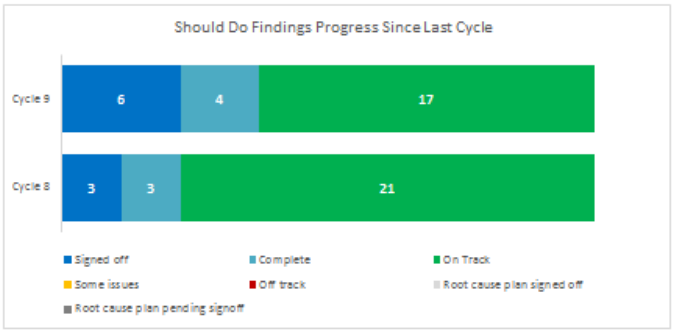
Of the 15 Must Do's,
67% are signed off with evidence. All relevant root cause actions have been completed to demonstrate this.
33% are on track and making good progress.

Of the 33 Should Do's,
39% are signed off with evidence. All relevant root cause actions have been completed to demonstrate this.

3% are complete, pending validation of evidence.
55% are on track and making good progress.
3% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.

Women and Children's ISG Findings



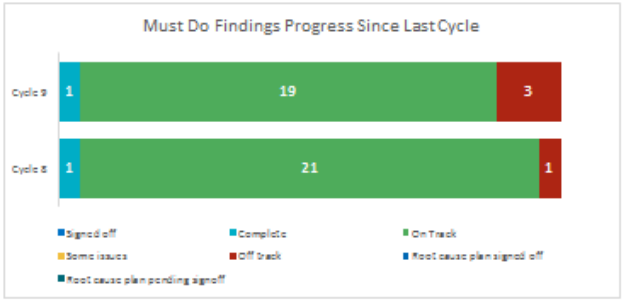


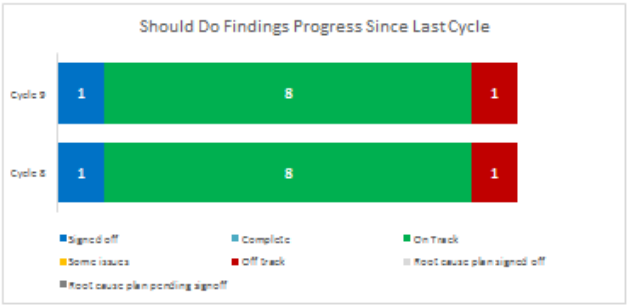
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Findings plan signed off	Findings plan pending signoff
Must Dos	21	13 (62%)	0 (0%)	8 (38%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Should Dos	27	6 (22%)	4 (15%)	17 (63%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Of the 21 Must Do's,
62% are signed off with evidence. All relevant root cause actions have been completed to demonstrate this.
38% are on track and making good progress.

Of the 27 Should Do's,
22% are signed off with evidence. All relevant root cause actions have been completed to demonstrate this.
15% are complete, pending validation of evidence.
63% are on track and making good progress.

Workforce ISG Findings





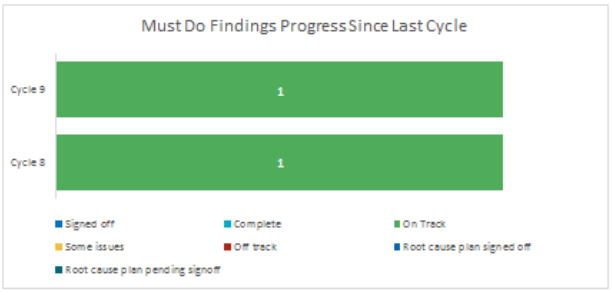
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Findings plan signed off	Findings plan pending signoff
Must Dos	23	0 (0%)	1 (4%)	19 (83%)	0 (0%)	3 (13%)	0 (0%)	0 (0%)
Should Dos	10	1 (10%)	0 (0%)	8 (80%)	0 (0%)	1 (10%)	0 (0%)	0 (0%)

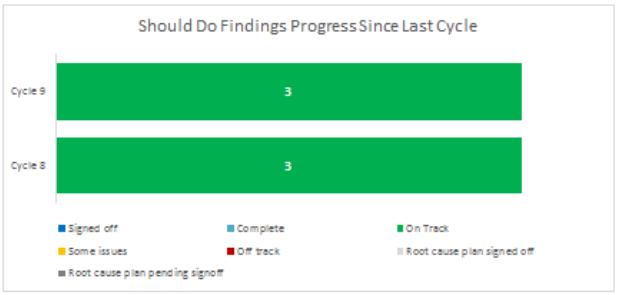
Of the 23 Must Do's,
4% are complete, pending validation of evidence. All relevant root cause actions have been completed to demonstrate this.
83% are on track and making good progress.
13% are off track, which means the actions were not completed by the planned completion date and are now pending Executive review.

Of the 10 Should Do's,
10% are signed off with evidence. All relevant root cause actions have been completed to demonstrate this.
80% are on track and making good progress.
10% are off track, which means the actions were not completed by the planned completion date and are now pending Executive

review.

Well Led ISG Findings





	Number of Findings	Signed off	Complete	On Track	Some issues	Off track	Findings plan signed off	Findings plan pending signoff
Must Dos	1	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Should Dos	3	0 (0%)	0 (0%)	3 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Of the 1 Must Do's,

100% are on track and making good progress.

Of the 3 Should Do's,
100% are on track and making good progress.

To be noted: The Well Led Plan is tracking the findings from the Delloittes review and the majority of the Well Led Findings from the CQC report sit within workforce. Please see further down.

Over 50 Must Do & Should Do Findings have been completed so far, and the Trust is continuing to increase its focus on the impact to patients.(USCG, SCG, W&C's and Workforce)

- 92% of Must Do Findings completed within the planned deadline of 30/6/19.
- 112% of Should Do Findings completed within the planned deadline of 30/6/19.
- 82% of Must Do Findings are Signed off, Complete or On Track.
- 96% of Should Do Findings are Signed off, Complete or On Track.

The above is a reference to a point in time. (Cycle up to 28 June 2019)

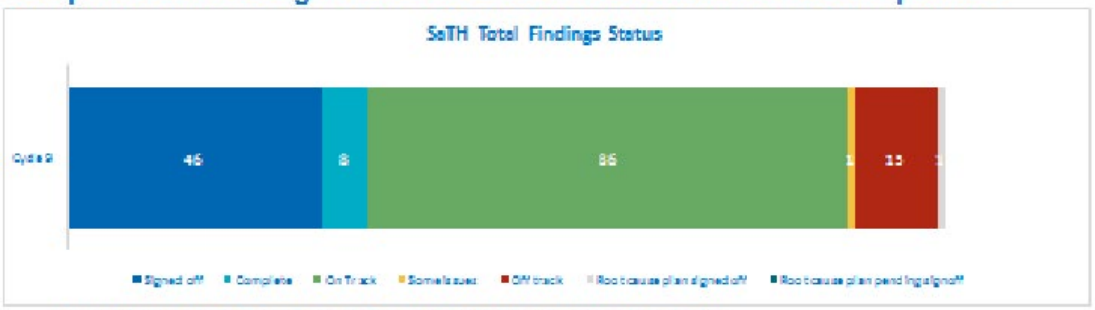
To be noted the Well Led CQC findings are referenced through the Well Led Summary.

The Trust made good progress through Cycle 9, with 54 Findings of 157 Must do and Should do Findings now complete or signed off (34%) against the full trajectory. This is above the planned trajectory of 53.

• Women and Children's have completed or signed off 23 of 48 (48%) total findings
• Scheduled Care has completed or signed off 24 of 48 (50%) total findings
• Unscheduled Care has completed or signed off 5 of 28 (17%) total findings. There are 10 off track issues and one action rated as

having some issues.
• Workforce has completed or signed off 2 of 33 (6%) total findings. There are 4 off track issues with most of the actions due for completion later than the other ISG.

The Trust is progressing in terms of the actions that have been completed and recognises there is a lot of work still to be completed.

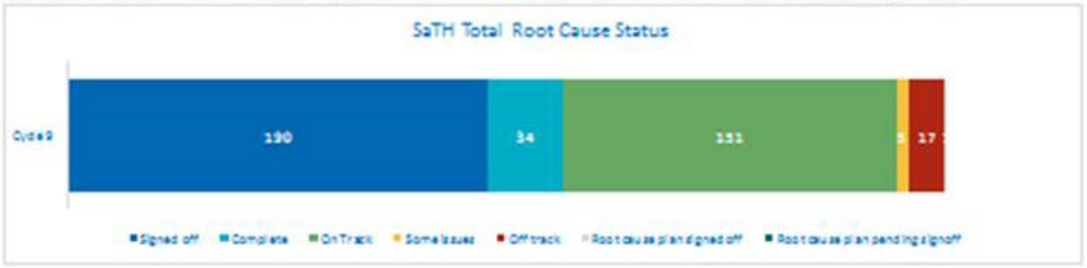


- An additional 9 Must Do and Should Do Findings due to be complete though July.
- A review of the ISG structures is taking place in July, to understand how these need to be reflected to support the progress/or lack of progress being made in the ISG's.
- 15 Findings are Off Track and continued monitoring and escalation is in place to ensure mitigation.
- Currently 86 Root Causes are marked as on track and we foresee no significant risks to delivery.

July Actions

- Re-development of key quality metrics
- Focus on recovering off track root cause actions.
- Embedded approach between Freedom to Speak up and Well Led ISG to be strengthened

The Trust is progressing in terms of the actions that have been completed and recognises there is a lot of work still to be completed.



- An additional 29 Root Causes due to be complete though July.
- 17 Root Causes are Off Track and continued monitoring and escalation is in place to ensure mitigation.
- Currently 151 Root Causes are marked as on track and we foresee no significant risks to delivery.

July Actions

- Understanding whether the root cause actions answer the CQC finding or do these need to be revised

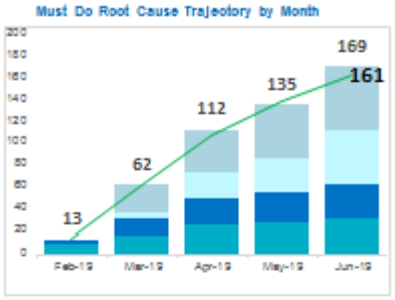
Assurance by Root Cause Action

The Trust has made progress through Cycle 9, with 224 Root Causes of 398 Must do and Should do's now complete or signed off (56%) YTD. This is ahead of the planned trajectory of 169 by 28/06/2019. There are 17 actions classified as off track.

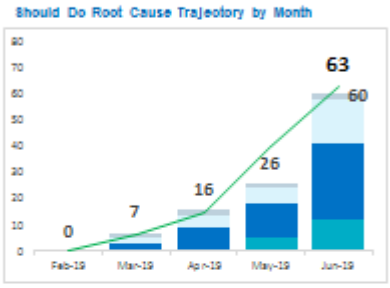
- In Women and Children's, 9 actions have been completed earlier than planned in addition to the trajectory of 34, which means 100% have been achieved within the completion date.
- In Scheduled Care, 29 actions have been completed earlier than planned in addition to the trajectory of 47, which means 100% have been achieved within the completion date.
- In Workforce, there was a shortfall of 4 out of 51, which means 92% have been achieved within the completion date. In addition 9 actions have been completed ahead of time.
- In Unscheduled Care, there was a shortfall of 12 out of 37, which means 67% have been achieved within the completion date. In addition 24 actions have been completed ahead of time.
- In Well Led, there was a shortfall of 20 out of 53, which means 62% have been achieved within the completion date.

The PMO Team continues to monitor the progress of the QIP plans through improved analytical reporting. This has supported identification of anticipated slippage and improved clarity around completion timescales. The focus must remain on ensuring quality is improved and the direction given is that in order to sign off the action, the check is does it answer the exam question – CQC recommendation.

Over 220 Root Cause actions have been completed so far, and the Trust is continuing to increase its focus on the impact to patients. (USCG, SCG, W&C's and Workforce)



- 95% of Must Do Root Causes completed within the planned deadline of 30/6/19.
- 105% of Should Do Root Causes completed within the planned deadline of 30/6/19.
- 93% of Must Do Root Causes are Signed off, Complete or On Track.



- 97% of Should Do Root Causes are Signed off, Complete or On Track.

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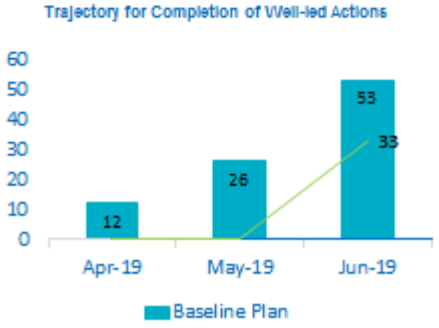
Overarching Progress Status of Well Led CQC & Deloitte Findings – June

Cumulative Year to Date Performance						
Number of Actions	Signed Off	Complete	On track	Some Issues	Off track	Not yet rated
110	23 (21%)	10 (9%)	57 (52%)	0 (0%)	20 (18%)	0 (0%)

Of the 110 KLOEs,

21% are signed off with evidence.
9% are complete, pending validation of evidence.
52% are on track and making good progress.
0% has some Issues, which means that risk has been identified which may impact completion of the action by the completion date.
18% are off track, which means the actions were not completed by the completion date and are now pending Executive review.



This section of the paper provides a more detailed analysis of the progress that has been made in completing the Root Causes and actions t within the ISG's.

The above is a reference to a point in time. (Cycle up to 28 June 2019)

To be noted the Well Led CQC findings are referenced through the Well Led Summary.

Root Cause Off Track Analysis

Overall summary of progress: Cycle 9 – 28th June 2019

- 190 Root Causes have been Signed off in total
- 34 are Complete and awaiting validation of evidence by the ISG
- 151 are On Track
- 5 have Some issues are still within time frame
- 1 are awaiting a time frame
- 17 are Off Track and past due date

Analysis for Root Causes Off Track over due

	OFF TRACK						
	CYCLE 3	CYCLE 4	CYCLE 5	CYCLE 6	CYCLE 7	CYCLE 8	CYCLE 9
Women and Children's	3	4	4	4	6	0	0
Workforce	3	5	9	4	4	2	4
Scheduled Care	2	2	3	12	3	0	1
Unscheduled Care	6	3	9	10	8	9	12
Overall	14	14	25	30	21	11	17

Analysis for Root Causes with Some Issues within date

	SOME ISSUES						
	CYCLE 3	CYCLE 4	CYCLE 5	CYCLE 6	CYCLE 7	CYCLE 8	CYCLE 9
Women and Children's	3	3	1	0	0	0	0
Workforce	0	0	0	0	0	0	0
Scheduled Care	0	0	0	0	0	0	0
Unscheduled Care	12	7	5	7	11	7	5
Overall	15	10	6	7	11	7	5

Root Cause Off Track Analysis

Analysis for Off Track Root Causes by number of Cycles

	NUMBER OF CYCLES OFF TRACK					
	1	2	3	4	5	6
Women and Children's	0	0	0	0	0	0
Workforce	2	0	0	0	0	2
Scheduled Care	1	0	0	0	0	0
Unscheduled Care	7	3	0	0	2	0
Overall	10	3	0	0	2	2

Recovery Action's

- **PMO Support and Assurance**
  BI weekly meeting with Plan Owner to discuss recovery actions for off track root causes and to formulate an action plan for delivery of upcoming actions.
- **Off Track Analysis Report**
  Circulation of Off Track Analysis Report to all ISG Triumvirate

Head of PMO has met with ISG sponsor to raise concerns for readdress where appropriate. Tailored actions by ISG agreed to address slippage noted.

Well Led ISG

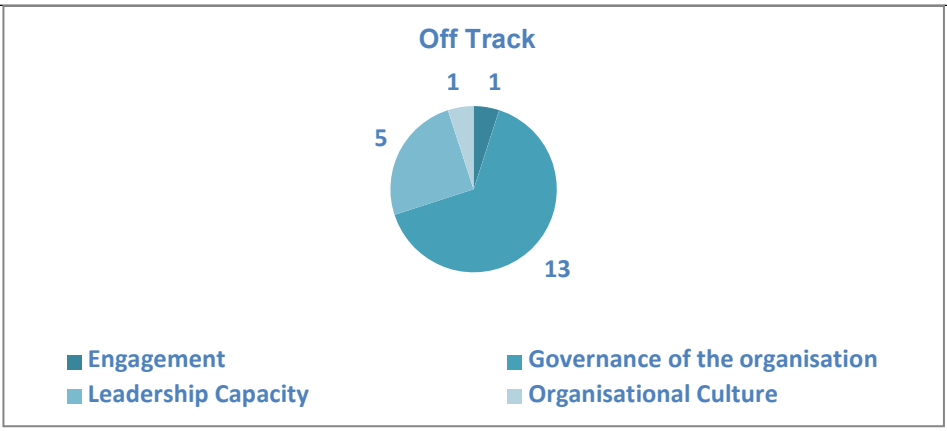
Has made progress through June, with **33** KLOEs of **110** now complete or signed off (30%) YTD. This is significantly behind of the planned trajectory of 53 by 30/06/2019. There are **20** actions classified as off track.

23 KLOEs have been Signed off in total

10 are Complete and awaiting validation of evidence by the ISG

57 are On Track

20 are Off Track and past due date



Unscheduled Care

Off Track - Unscheduled Care					
Root Cause ID	Root Cause Description	Owner	Core Service	# cycles off track	Reason it is off track
MD033.5	Lack of awareness of documentation required for tissue viability	Clare Wesley	Medicine	2	To be progressed through Corporate Nursing task and finish group.
MD034.2	Pressures on staff result in patients not being treated as individuals	Ruth Smith Gary Caton	Medicine	5	To be progressed through Corporate Nursing task and finish group. 50 bed boards ordered to be trialled on agreed prior to final design agreement and roll out
MD035.1	The Escalation Policy and Hospital Full Protocol are not consistently adhered to by staff	Deputy Chief Operating Officer	Medicine	2	Updated Hospital Full Policy to be circulated.
MD039.1	Lack of understanding when a mental capacity assessment (MCA) needs to be done and who can complete it	Helen Hampson	Medicine	1	To be progressed through Corporate Nursing task and finish group.
MD039.3	Unclear process for escalation and de-escalation of risk	Helen Hampson	Medicine	1	To be progressed through Corporate Nursing task and finish group.
MD043.2	Equipment updating should be monitored at ward level	Gary Caton Sharon Main; Renal Matron	Medicine	5	Equipment task and finish group to be set up to support completion of actions
MD045.2	The appropriate equipment and drugs are not consistently available on the ward	Medical Director KPO Sepsis Working Group	Medicine	2	Louise Brennan to confirm who is checking sheets for daily checks of sepsis box and to provide evidence of these checks
MD046.2	There is a lack of adherence of best practice for preparing, administering and storing medicines	Tracy Lloyd Emma Barber	Medicine	1	Awaiting confirmation from Safe Medicines committee to see if they think this is good (or safe) practise
MD061S.2	Staff are not aware of the Trust wide Deteriorating Patients policy	Subramanian Kumaran; Vanessa	ED	1	To be progressed through Corporate Nursing task and finish group.
MD061T.2	Staff are not aware of the Trust wide Deteriorating Patients policy	Subramanian Kumaran; Vanessa Roberts	ED	1	Policy is still to be approved.Request extension until 31/08/19
SD007.2	Staff are not aware of the Trust wide Deteriorating Patients policyand Sepsis policy	Subramanian Kumaran; Vanessa Roberts	ED	1	Awaiting Inclusion in ED SOP in agency induction folder, Requested to extend date till 31/08/19.
SD007.4	There are two systems in use for prioritising patients with sepsis (red folder and sepsis bleep) so staff (permanent and non-permanent) are unclear which system to use	Dodiy Herman (Karen Baker & Becky cc)	ED	1	Awaiting Policy update by newly appointed Sepsis Nurse.

Workforce

Off Track - Workforce					
Root Cause ID	Root Cause Description	Owner	Core Service	# cycles off track	Reason it is off track
MD017.1	The service is not supported by the level of anaesthetist recommended in national guidance	Centre Manager for theatres / Clinical Lead for anaesthetics	Maternity	1	Lack of agreement between Anaesthetitics (Scheduled Care) and Obs & Gynae (Women and Childrens)about the required level of anaesthetic support required.
MD057.1	Medics not trained specifically to undertake End of Life Conversations and adapt and record treatment plan accordingly	Medical Director	Medical Director	1	Slightly more complex than originally anticipated. Resourcing of EOLC training to be agreed and plan written up.
MD050.4	There is less EoLC team presence at PRH	Kath Preece Elin Roddy Jules Lewis	End of Life	6	More complex than originally anticipated which delayed the final version of the Scheduled Care Business Plan. Going to Workforce Committee on 15th July 2019.
SD035T.1	Physio Vacancies Lack of funding Lack of visibility of Physio	Amanda Taylor	Critical Care	6	Optimistic completion date did not anticipate delays in funding agreement. Trust Board approved on 27 June so will be complete in Cycle 10.

Scheduled Care

Off Track - Scheduled Care					
Root Cause ID	Root Cause Description	Owner	Core Service	# cycles off track	Reason it is off track
SD016.5	Loss of Theatres 10 & 11 at RSH	Nigel Lee	Surgery	1	The issue is the lack of capital and pressures on the bed stock, Escalation Form raised.

Well Led

Off Track - Well Led					
KLOE ID	Specific Changes to be Implemented	Owner	Core Service	# Months off track	Reason it is off track
WL1.1.1	*All Board Members to have up-to date job descriptions and objectives in place with an emphasis both on developing their portfolio area as well as their impact at the Board. *Implement robust appraisal process including 360 peer feedback. *Review whether to carry out 360 feedback process for NEDs	Victoria Rankin Bev Tabernacle	Well Led	1	New Executives - Portfolios to be reviewed
WL1.4.3	*Clarity over SLT accountabilities and delegated decision making. Take forward through: -Amending SLT TORs -SLT meetings without Exec present -Empower SLT as a problem solving group with a purpose (consider Ward 35) *Implement SLT development sessions *SLT development plan	Bev Tabernacle	Well Led	1	SLT Development Plan to be created
WL1.4.6	*Expedite ongoing work to develop Executive team to address perceptions around lack of cohesion and leadership styles, including: -Clearly defined operating principles, expected behaviours and values. -Arranging joint development sessions with the SLT.	Bev Tabernacle	Well Led	1	Further evidence of Development sessions
WL1.4.7	*Board development sessions to be extended to include a focus on team building and cohesion, including clarifying roles, responsibilities and impactful debate. *Develop 12 month Board Development plan	Ben Reid	Well Led	1	Await 12 month board development plan
WL1.4.10	*Review Executive team meetings to ensure there is sufficient time to air all views on significant papers and decisions prior to Board and Committee debate	Bev Tabernacle	Well Led	2	Await external NHSI review of Exec Meetings
WL2.4.1	*Following the final Future Fit Board in April, carry out internal process to agree on the new name for SSP (engage people on the development of the name). *Describe what SSP is and what it means to the organisation. Achieve this through an engagement process and identification of Follower. *Communicate the new agreed phrase to the organisation and stakeholders.	Bev Tabernacle	Well Led	1	Further communication of SSP throughout trust
WL3.5.4	*Take action to change the culture around reporting incidents through Datix: -Communicate why we Datix -Proper use of Datix (not as a threat) -Ensure process is in place to feedback on the action taken to the person who logged Datix for moderate and high harm incidents	Edwin Borman	Well Led	1	Embed culture change of Datix into organisation
WL3.7.1	*Develop a set of staff health and well-being priorities, through engagement with staff. *Implement Health and Wellbeing aspects of OD plan this will include: -Psychological safety included in the OD plan -Review how Health and Wellbeing support is signposted to Staff -Review into whether/ how Employee Assistance Programme could be rolled -Effective communication to staff	Victoria Rankin	Well Led	1	Review of Employee assistance programme is embedded into trust
WL4.1.1	*Clarify the purpose of each Board committee, including ensuring that all Terms of Reference are up to date and are supported by an effective forward plan of activities. This should include reviewing attendance at all committees to ensure that this remains appropriate.	Julia Clarke	Well Led	3	Awaiting further evidence from Exec lead
WL4.1.3	*Review Care Group governance arrangements and ensure consistent governance arrangements are implemented across the Trust.	Nigel Lee	Well Led	1	Evidence of consistency across care groups not available
WL4.1.4	*Review and implement necessary amendments from Deloitte Divisional Governance Review report. Actions taken forward should ensure: -All Care Group boards have structured agendas, which should include core components including a review of the risk register and escalation points from centres.	Nigel Lee	Well Led	1	Interdependent on WL4.1.3
WL4.1.7	*Review and update the ToR of the Waste Reduction Meeting to ensure that its roles and responsibilities and delivery against these are clearly stated. *Review the role and purpose of both the Carter Review Group and Waste Reduction Meeting (R2.1, R2.3 Deloitte Audit Report)	Nigel Lee	Well Led	1	Review amalgamation of Carter and Waste Reduction meetings

WL4.1.11	*Strengthen reporting to the Workforce Committee through both the introduction of an overarching workforce dashboard along with improvements to the quality of executive summaries and the balance between narrative and quantitative data.	Victoria Rankin	Well Led	2	Further evidence of workforce development plan
WL4.2.2	*Provide greater opportunities for interaction in SLT meetings by: adopting a more inclusive chairing style; setting a tone of respect and inclusion; enabling SLT input into the agenda-setting process; including opportunities for cross Care Group learning; and re-clarifying the role of SLT.	Bev Tabernacle	Well Led	3	Survey of SLT to be carried out to demonstrate changes to SLT meetings
WL4.2.3	*Review executive team meetings (as outlined in 1.4.2) to undertake steps to ensure that there are appropriate levels of engagement with SLT (for example to invite representatives to attend for specific agenda items, or to ensure that key decisions have been subject to SLT engagement prior as part of the options appraisal process).	Bev Tabernacle	Well Led	3	Interdependent on WL1.4.10
WL5.1.1	*Implement Deloitte audit report (review of Tier 3 Committees and Groups) finding R:2.2: -Adopt an accountability framework (in line with recommendation below) to inform the frequency and focus of Care Group Confirm and Challenge meetings.	Nigel Lee	Well Led	1	Review results of Think On Audit
WL6.7.1	*Update the Data Quality Policy and Strategy	Edwin Borman	Well Led	2	NHS Digital DSPT Improvement Plan due for completion August 19, interdependent on this
WL6.7.2	*Clarify executive responsibility and governance oversight of the Data Quality Policy and Strategy	Edwin Borman	Well Led	1	NHS Digital DSPT Improvement Plan due for completion August 19, interdependent on this
WL7.5.1	*Regular info to Contract review meetings and CQRM *Regular sharing of unvalidated information *Integrated Performance Report to bring together key performance information	Nigel Lee	Well Led	1	Awaiting further evidence from EA

Summary of Findings

Proactive intervention in SCG has improved the status of the Root Cause action each cycle.
The directive from the USCG Executive Sponsor to increase the presence of corporate functions at the ISG should improve on the outcome and delivery of Root Cause actions.
The robust structure of the W&C's ISG is demonstrated in the consistency of the cycle by cycle reporting.
There are a high volume of Root Cause Actions due for completion from June to September for Workforce ISG and they will need to keep pace to deliver these in addition to seasonal core pressures including high annual leave and Junior Doctor rotations
Well Led ISG is under new leadership and there is a commitment to driving the pace going forward, A detailed review of the kloes has identified interdependencies which need further consideration to ensure improved embedding can be demonstrated.

Background

CQC rating table by area and domain

	Safe	Effective	Caring	Responsive	Well Led	Overall
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
PRH						
Urgent and Emergency	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Medical Care	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Maternity	Inadequate	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
End of Life Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement
RSH						
Urgent and Emergency	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Maternity	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

Is it Safe?

Safeguarding and protection from abuse
Managing risks
Safe care and treatment
Medicines management
Track record
Learning when things go wrong

Is it Effective

Assessing needs and delivering evidence-based treatment
Monitoring outcomes and comparing with similar services
Staff skills and knowledge
How staff, teams and services work together
Supporting people to live healthier lives
Consent to care and treatment

Is it Caring

Kindness, respect and compassion
Involving people in decisions about their care
Privacy and dignity

Is it Responsive

Person-centred care
Taking account of the needs of different people
Timely access to care and treatment
Concerns and complaints

Is it Well Led

Leadership capacity and capability
Vision and strategy
Culture of the organisation
Governance and management
Management of risk and performance
Management of information
Engagement and involvement
Learning, improvement and innovation

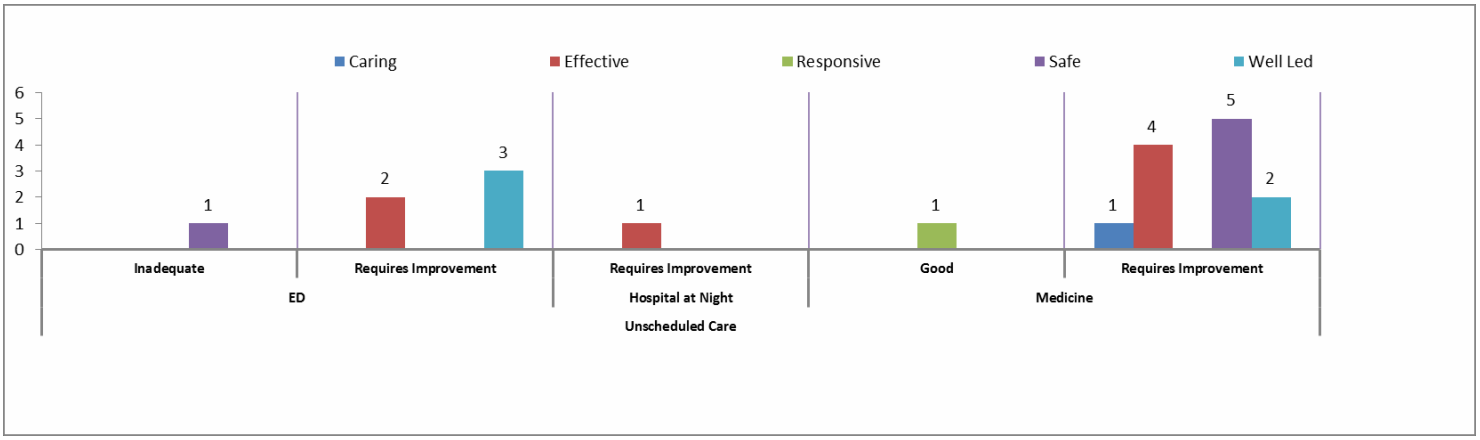
USCG

The chart below breaks down the USCG CQC domain and summary of Must do's by domain status.

The key area of focus MD064 which sits in Inadequate and will improve safe care.
To be noted, Inadequate CQC findings within the Well Led Domain within ED are tracked within the Workforce ISG.

Finding ID	Description	Overall Status
MD064	Ensure rooms allocated for use with psychiatric patients meet requirements to keep patients safe	Some issues

Progress update since cycle 9: Quote received for required building works and a draft paper is in progress for Executive review and approval of funding.

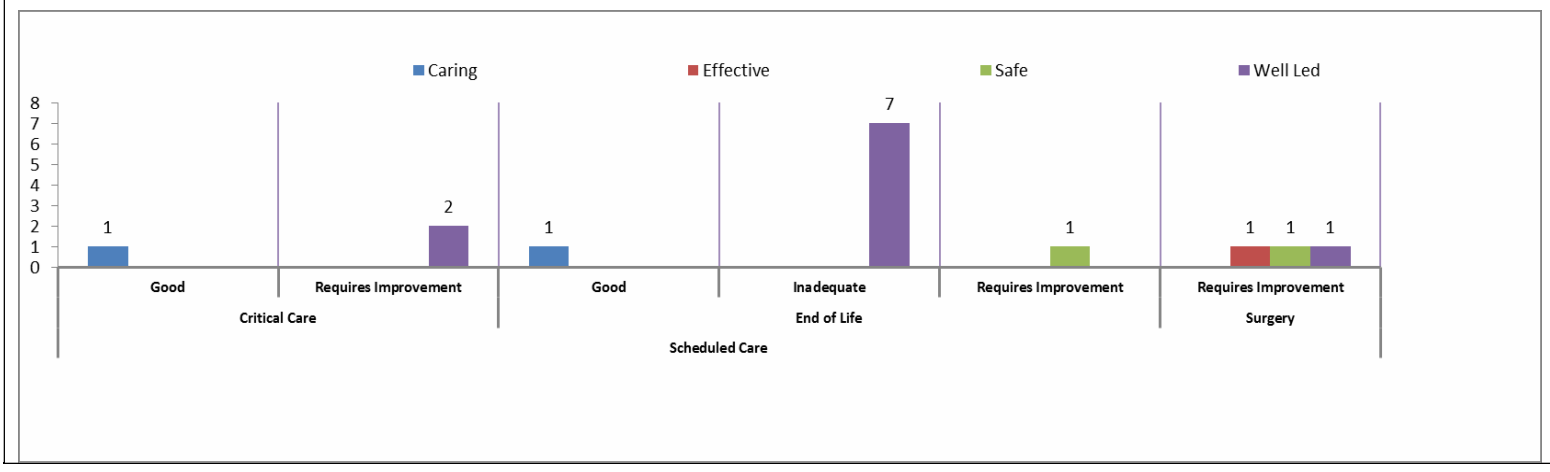


SCG

The chart below breaks down the SCG CQC domain and summary of Must do's by domain status.

The Key area of focus is MD048, MD049, MD051, MD052, MD053, MD054 and MD055 which sits in Inadequate and will improve End of Life Quality Care.

Finding ID	Description	Overall Status
MD048	Ensure that staff store patient records securely, complete the end of life plan, ensure equipment inventories for syringe drivers are up to date and that mortuary staff have access to the trust intranet, policies and procedures.	Signed off
MD049	Ensure that end of life performance measurements is part of the trusts quality dashboards and routinely audit and act on data within the end of life care service to drive improvement.	Signed off
MD051	Ensure that the end of life care team have its own dedicated risk register that reflects the risks and management of risks within the service.	Signed off
MD052	Ensure that end of life patients have appropriate access to mental health input or advice	Signed off
MD053	Ensure that equipment is stored safely and that ward areas are free from clutter.	Signed off
MD054	Ensure records are properly completed and used by appropriate staff including EOLP.	Signed off
MD055	Ensure staff are supported to report incidents.	On Track

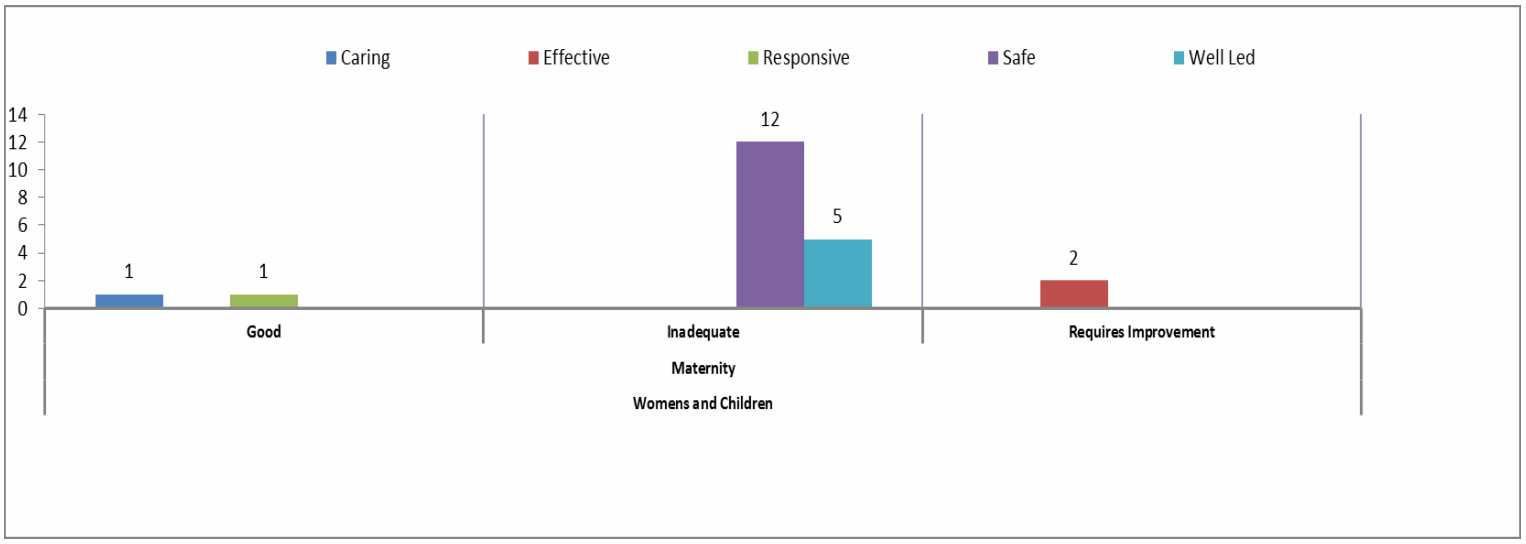


W&C's

The chart below breaks down the SCG CQC domain and summary of Must do's by domain status.

The Key area of focus are MD009S,MD009T,MD010,MD013,MD014,MD016,MD018,MD019,MD020,MD021,MD022,MD023,MD025,MD026,MD027,MD028 and MD029 which sits in Inadequate and will improve Maternity Quality Care.

Finding ID	Description	Overall Status
MD009S	Ensure that the Head of Midwifery has direct access to the board in line with better births 2016	Signed off
MD009T	Ensure that the Head of Midwifery has direct access to the board in line with better births 2016	Signed off
MD010	Ensure that the low risk midwifery pathway is robust and women access the correct pathway of care and give birth in the correct area according to their assessment of risk.	On Track
MD013	Ensure that the lone working policy is adhered to ensure staff safety	Signed off
MD014	Ensure that the women's weight is recorded on the prescription charts	Signed off
MD016	Ensure high risk women are reviewed in the appropriate environment by the correct member of staff	Signed off
MD018	Ensure that the community midwives are carrying the correct equipment to carry out their work in line with best practice	Signed off
MD019	Ensure Maternity Early Obstetric Warning Score (MEOWS) charts are fully completed	Signed off
MD020	Ensure all staff complete the cardiotocography (CTG) training defined by the service	Signed off
MD021	Ensure that prescription and observation charts are stored confidentially.	Signed off
MD022	Ensure grading of incidents reflects the level of harm	Signed off
MD023	Ensure that, in line with the 'Lone Working & Peripatetic Policy', midwives use the safety devices when working alone	On Track
MD025	Ensure that environmental risks are identified and acted on in a timely way.	On Track
MD026	Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe	On Track
MD027	Implement action plan to respond to recommendation contained Report commissioned from RCOG by SaTH in 2017 and published in February 2018	On Track
MD028	Review the processes around escalating women who are at high risk so that these women who present at the midwifery led unit/day assessment unit receive a medical review without delay.	On Track
MD029	Review the policy on reduced fetal movements so there is a clear and defined pathway for midwives and sonographers to follow	Signed off

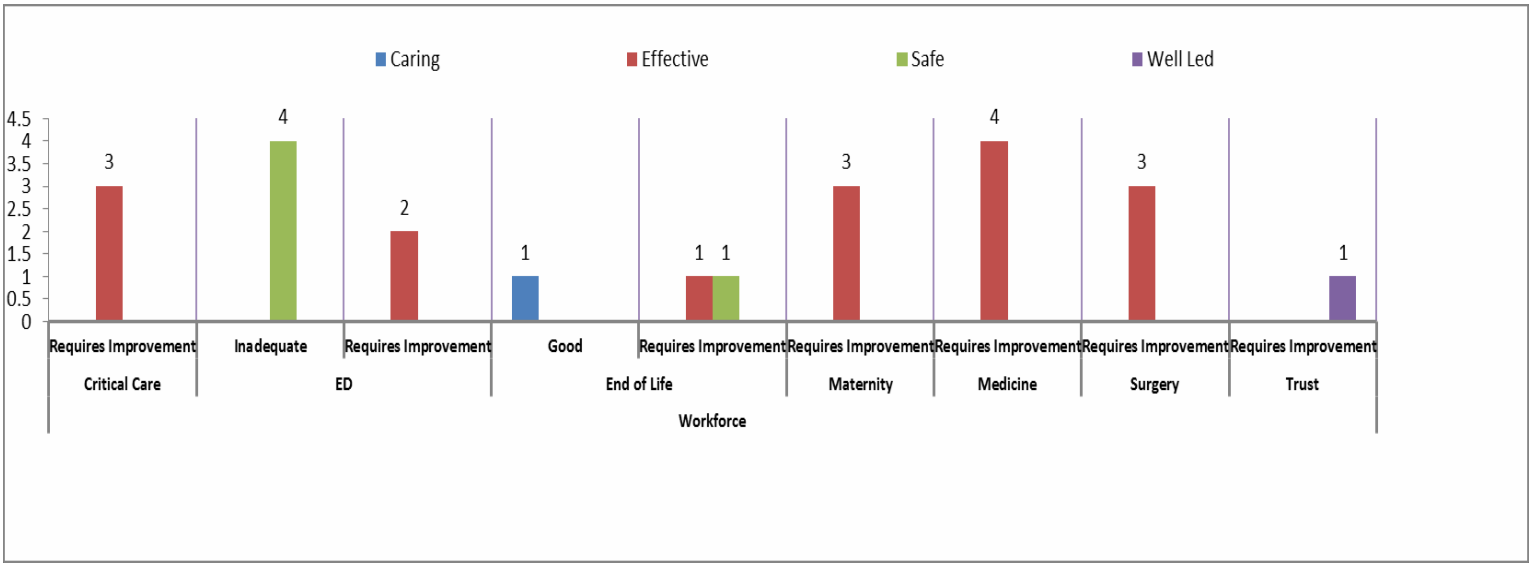


Workforce

The chart below breaks down the workforce CQC domain and summary of Must do's by domain status.

The Key areas of focus are MD059S, MD059T, MD060S and MD060T which sit in Inadequate and will improve workforce across a number of operational areas. Workforce is not a standalone ISG, it requires collaborative support from the Care groups to ensure the findings are addressed and embedded. The Business Partners assigned to each ISG are pivotal in supporting collaborative engagement to ensure Quality improves.

Finding ID	Description	Overall Status
MD059S	Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients.	On Track
MD059T	Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients.	On Track
MD060S	Ensure medical staffing is adequate to keep all patients safe, especially during nights	On Track
MD060T	Ensure medical staffing is adequate to keep all patients safe, especially during nights	On Track

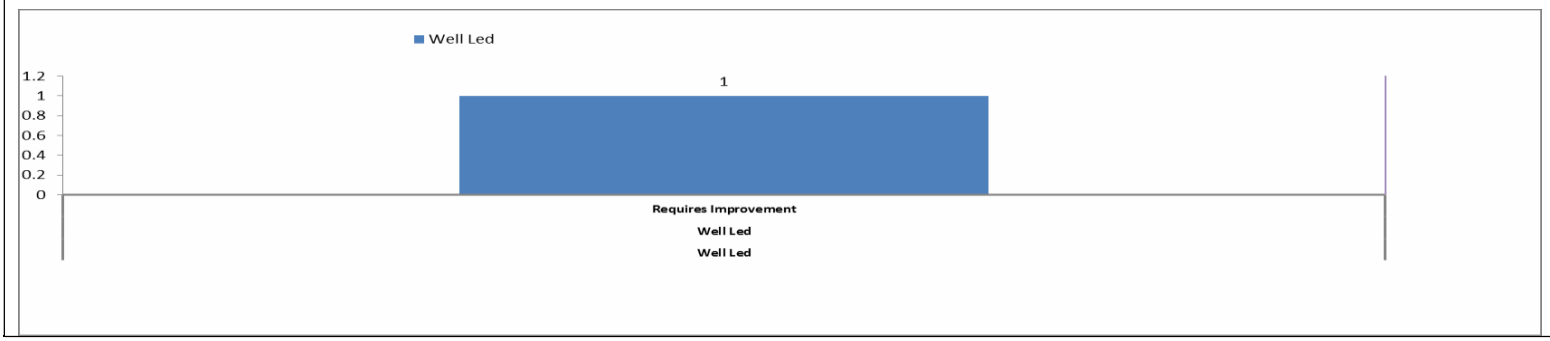


Well Led

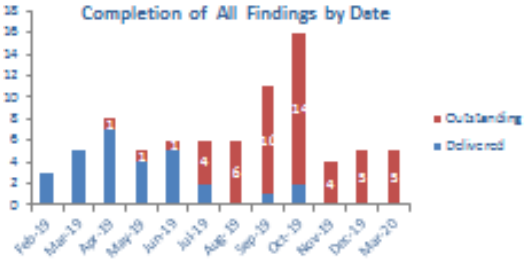
The chart below breaks down the Well Led CQC domain and summary of Must do's by domain status.

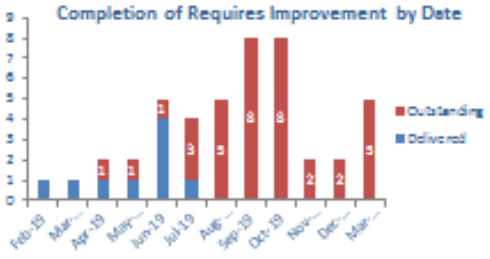
The key areas of focus is MD002 which sits in Requires improvement.
All other KLOES were derived from the Deloittes report.

Finding ID	Description	Overall Status
MD002	Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks.	On track

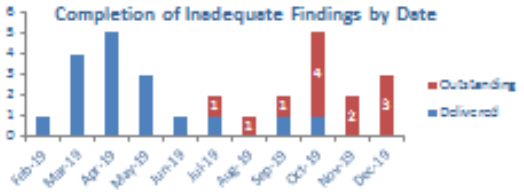


Completion of Must Do Findings

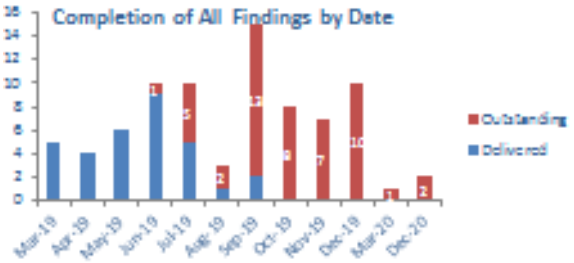


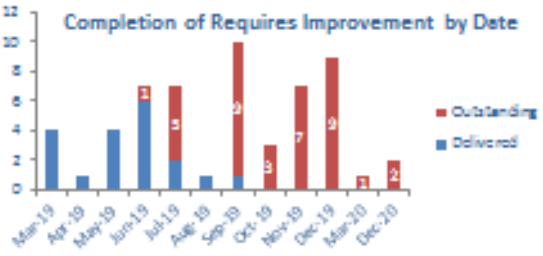


Highlights the trajectory for completion is heavily due to deliver in Q4 of 2019 with a number of actions not due for completion by Nov 19, the planned CQC re-inspection date. This is especially prominent in the Findings within areas rated as Requires Improvement but highlights priority being given to the Findings in areas found to be Inadequate.

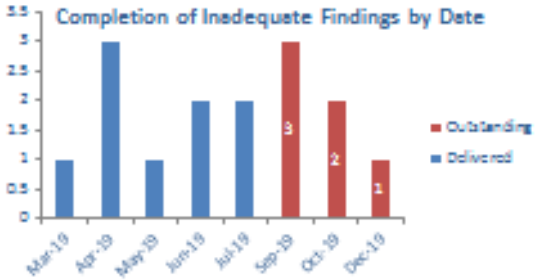


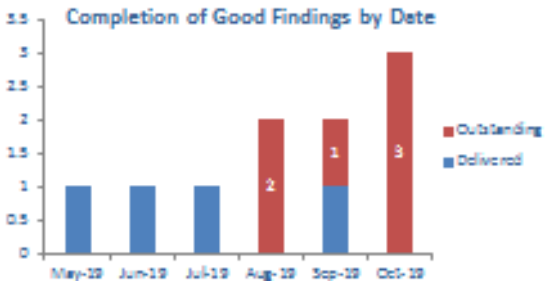
Completion of Should Do Findings





Highlights the trajectory for completion is heavily due to deliver in Q4 of 2019 with a number of actions not due for completion by Nov 19, the planned CQC re-inspection date with some Findings not due to complete until Dec 2020. This is especially prominent in the Findings within areas rated as Requires Improvement but highlights priority being given to the Findings in areas found to be Inadequate.





Assessment

Off Track Findings Analysis

Off Track Must Do Findings by ISG

SATH ISG	No of Off Track Findings
Unscheduled Care	10
Workforce	2

Total	12

USC

MD033	Ensure that patients individual needs are assessed and planned for. This includes needs that are related to any learning disabilities, pressure care, nutrition and hydration and end of life care needs.
MD034	Ensure that all patients are consistently treated with dignity and respect
MD035	Ensure that during periods of increased demand and capacity safe systems are in place to manage this.
MD039	Ensure that no patients are unlawfully detained at the hospital
MD043	Ensure that all equipment is reviewed within trust and manufacturer guidelines
MD046	Ensure best practice is followed when preparing, administering and storing medicines
MD061S	Ensure they enable staff to consistently manage and review deteriorating patients in line with national guidance. The trust Must also review their policies regarding managing deteriorating patients.
MD061T	Ensure they enable staff to consistently manage and review deteriorating patients in line with national guidance. The trust Must also review their policies regarding managing deteriorating patients.
MD062S	Review national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.
MD062T	Review national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.

Workforce

MD017	Ensure the correct number of anaesthetists are employed as recommended by the Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland 2013 guidelines for obstetric anaesthesia
MD057	Ensure doctors out of hours have the capability and confidence to review patients at the end of life, including through prescribing

Off Track Should Do Findings by ISG

Unscheduled Care	3

USC

SD007	Review all policies regarding managing deteriorating patients, especially the use of a bleep system to prioritise patients with sepsis
SD009	Perform a review of all documentation with regards to patient assessments, to provide consistency across both sites. This review Must include all early warning scores that are currently in use and any that are planned to be introduced.
SD026	Ensure the cover provided by the hospital at night team is safe

Off Track Review _The governance approach to review and approve escalations is proving to be difficult to follow. The Weekly Continuous Improvement Executive Meeting have noted taken place in a timely manner and this has resulted in a delay in escalation forms being cited and the outcome agreed which has had an adverse impact on the review of the mitigating action to be taken for the Root Causes that are Off Track and Some Issues.

ISG Review and sign off_ there are currently 34 Root Causes that are complete and waiting sign off. This evidences that Executive Leads are not signing off Root Causes without reviewing evidence, however, highlights an issue around lack of pace being made to lock down evidence. The guidance from the PMO is that no Root Cause action should be marked as complete for more than one cycle, if the evidence cannot be submitted prior to the following ISG the action must be moved to Off Track until the Executive Sponsor has received and reviewed satisfactory evidence.

Recommendation

The Trust Board is asked to:

- Note the progress that has been made in the delivery of QIPs against the previously approved trajectories by the USCG, SCG, W&C's, Workforce ISGs and Well Led throughout June.
- There are concerns around slippage to deliver the Root cause actions identified to deliver the Findings associate with USCG and Well LED against the original trajectories agreed. Each Executive Sponsor is aware of this and looking at understanding whether 1: the KLOE Action or root cause action answers the Findings or what is a more realistic timescale to complete.
- Note the approach to the development and monitoring of progress.

Appendix A – detailed below

Appendix B and C

Please refer to 16 July 2018 Safety Oversight Assurance Group (SOAG) Papers **(In Information Pack)**

Appendix One: Operational Plan performance updates (using VMI methodology)

2019/20 SaTH Operational Plan A3

19/20 Objective:
Move out of special measures (By Improving Care)

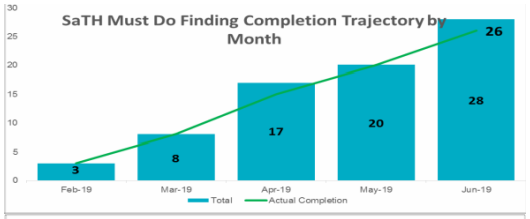
Month update:
June

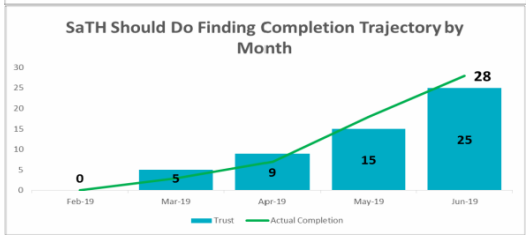
Executive Sponsor(s): Paula Clark

Operational Leader(s): Nigel Lee, Victoria Rankin, Jo Banks, Edwin Borman, Julia Clarke, Arne Rose, Barbara Beal

RAG

1. Current performance by Findings





2. Narrative update/In month actions - Findings

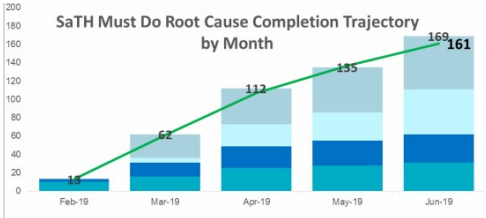
At the end of June, the latest full month for which reporting is available, 26 Must Do Findings and 28 Should Do Findings were completed, continuing to make steady progress against the trajectory. This is 92% of the forecast completion trajectory for Must Do Findings and 100% of Should Do Findings with some additional Findings completed ahead of trajectory. This progress is shown, in the charts to the left; Figure One shows progress for the Must Do Findings by month, Figure Two for the Should Do Findings by month.

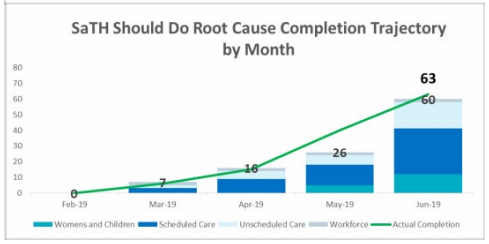
3. Trajectory

Metric: CQC Must Do Findings														
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	3	8	17	20	28	34	42	51	66	67	74	74	74	79
Actual	3	8	15	20	26									

Metric: CQC Should Do Findings														
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	0	5	9	15	25	33	36	51	59	66	75	75	75	76
Actual	0	3	7	18	28									

4. Current performance by Root Cause





5. Narrative update/In month actions – Root Cause

At the end of June, the latest full month for which reporting is available, 161 Must Do Root Causes and 63 Should Do Root Causes were completed, continuing to make steady progress against the trajectory. This is 98% of the forecast completion trajectory, a slight increase from the 95% of trajectory completion achieved at the end of May.
This progress is shown, broken down by Improvement Steering group (ISG), in the charts to the left; Figure One shows progress for the Must Do Root Causes by month, Figure Two for the Should Do Root Causes by month.

6. Trajectory

Metric: CQC Must Do Root Causes														
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	13	62	112	135	169	188	204	230	252	256	261	261	261	265
Actual	13	61	107	137	161									

Metric: CQC Should Do Root Causes														
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	0	7	16	26	60	70	74	99	107	114	128	128	128	128
Actual	0	6	15	40	63									

7. Analysis: *What is the root cause of the problem? Why does a gap exist between the plan and actual? How have we achieved target? Are there any learning points to be utilized elsewhere?*	**8. Escalation points/Positive highlights:** Which *areas require escalation? Which areas require committee/board assistance? What are we most proud of? How have we demonstrated progress towards strategic goals? How have our values been reflected?*
At the end of June there was an overall underperformance of 5. This is being significantly masked by the early completion of several Root Causes and the true underperformance is 17 against the trajectory. The PMO has analyzed the reasons for this by root cause. This has been presented to the Executive Continuous Board and recovery actions have been agreed.	The slippage within the Well Led plan is being reviewed with improved rigor provided by newly established leadership team. A full QIP update is provided to Trust Board and Quality & Safety Committee on a monthly basis. Cycle 9 dashboards attached. This includes detail behind progress being made and support required.

9. Previous months actions	**10. Next month's actions**
• Reporting cycles completed. • 30,60,90 day evaluation added to QIP. • June Safety Oversight & Assurance Group (SOAG) delivered.	• Re-development of key quality metrics. • Focus on recovering off track root cause actions. • Embedded approach between Freedom to Speak up and Well Led ISG to be strengthened. • July Safety Oversight & Assurance Group (SOAG) delivered.

Safety Oversight and Assurance Group

16 July 2019

Considered at SaTH Continuous Improvement Executive Board

Final Version …

This presentation relates to the Trust Executive's section on the overall SOAG agenda

#	Item	Lead	Paper / verbal	Time
1	Welcome, introductions and apologies:	NS	Verbal	5 mins
2	Draft minutes of previous meeting and matters arising	NS	Paper	5 mins
3	• Trust Wide Workforce Metrics • Maternity Services Overview • NHSI IPC	Trust Leads Trust Leads Trust Leads and Partners Trust Leads	Paper	65 mins

4	Feedback from stakeholders
	• Healthwatch
	  ○ Shropshire
	  ○ Telford and Wrekin
	• CQC
	• Commissioners
	• HEE
	• NMC
	• Other representatives
		All	Verbal	30 mins

5	Actions from the last meeting – by exception	All	Paper	5 mins
6	Items for August agenda & Forward Plan	All	Verbal	5 mins
7	Any other business and agreement of key headlines from meeting • Safe Today Update	NS BB/JS	Verbal	5 mins

This paper will take us through the **Trust Executive-led elements of the SOAG agenda –** agenda item 3.

The agenda shown on the following slide **refers to this agenda item only, as opposed to the full meeting.** It is not intended to replace the wider agenda, but guide this part of the agenda.

Where appropriate, the Trust Executive will invite other relevant **Trust members with relevant to share updates.**

No	Description	Lead	Timing
1	Workforce 1.1 Trust Wide Workforce Metrics 1.2 Trust Wide Here and Now 1.3 How to get to where we need to be. 1.4 Trust Wide Oversight by Medicine, Nursing,	Barbara Beal, Arne Rose, Nigel Lee & Victoria Rankin	10.10 – 10.40 30 min's
2	Maternity Services Overview 2.1 Maternity Services Overview 2.2 What good looks like 2.3 The here and now 2.4 Considerations – Areas for improvement 2.5 Outstanding – What's gone well	Jo Banks and W&C's	10:40-11:05 25 min's
3	Infection Prevention and Control Update 3.1 IPCC Visit Risks identified and action taken	Barbara Beal & Clare Wesley	11.05 – 11.15 10 mins

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SOAG Agenda Item 3 – Running order

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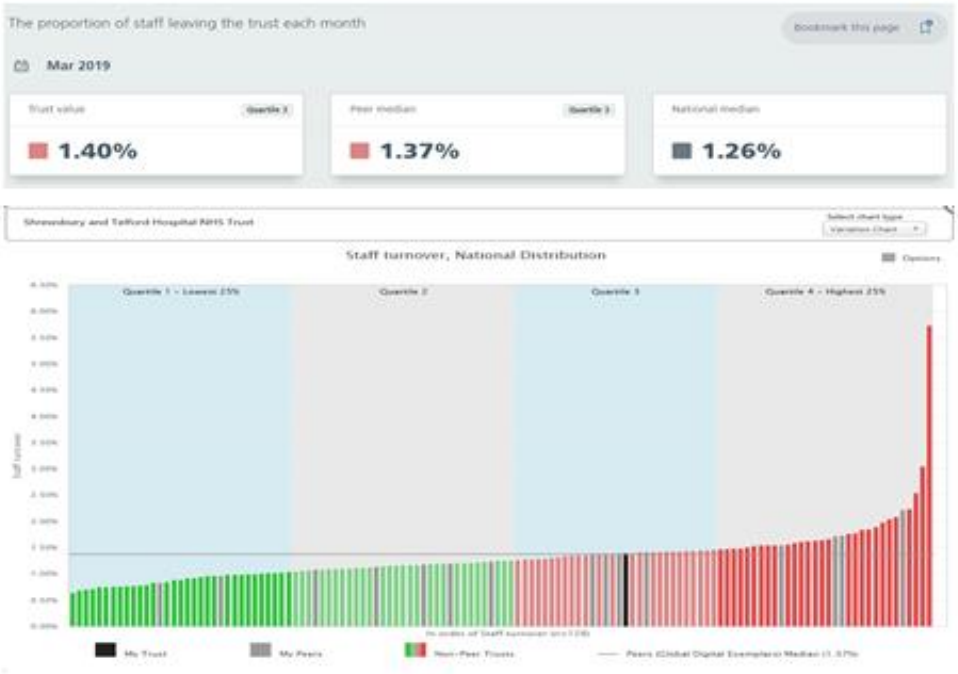
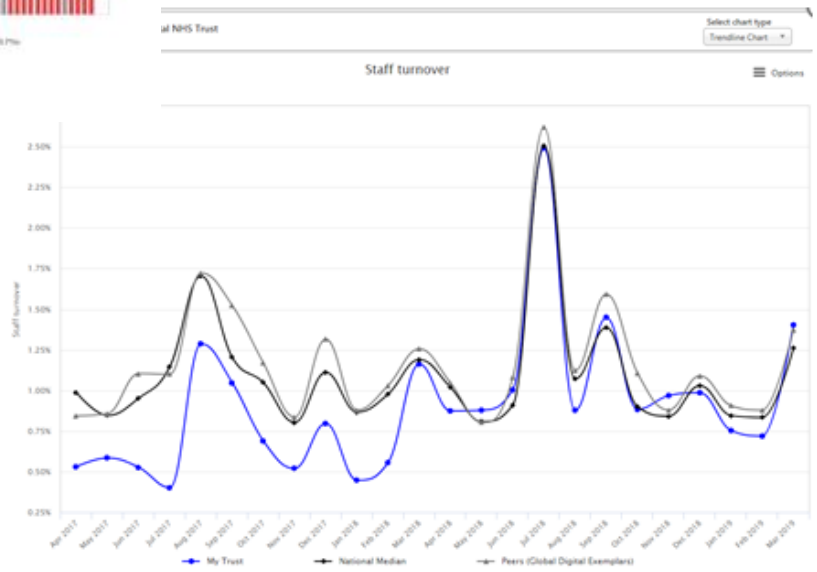
Trust wide Workforce Metrics: Turnover & Retention



During March 2019 the Trust turnover rate was 1.4%
This is slightly higher than the national average.

The Trend in turnover rate maps to the national and peer group trend.
The peaks in march and July match national trends.



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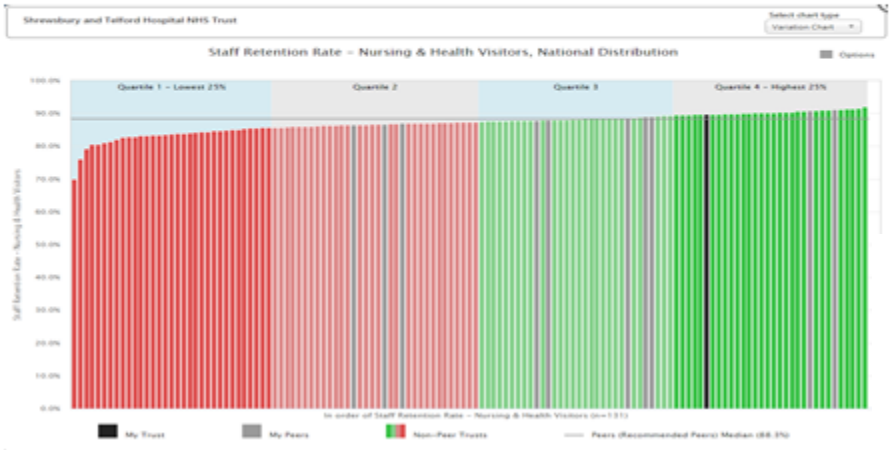
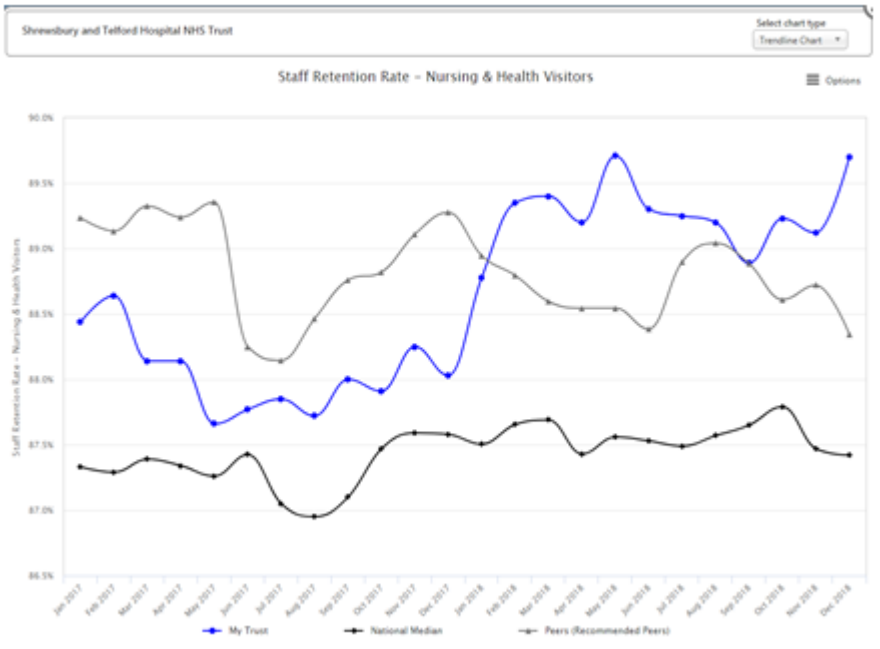
Trust wide Workforce Metrics: Turnover & Retention Nursing & Health Visitors

The retention rate for Nursing is 89.7%
which gives us a ranking of quartile 4, i.e. within the top 25%.



The trend analysis shows that our retention rate is increasing and we are above national and peer group levels.



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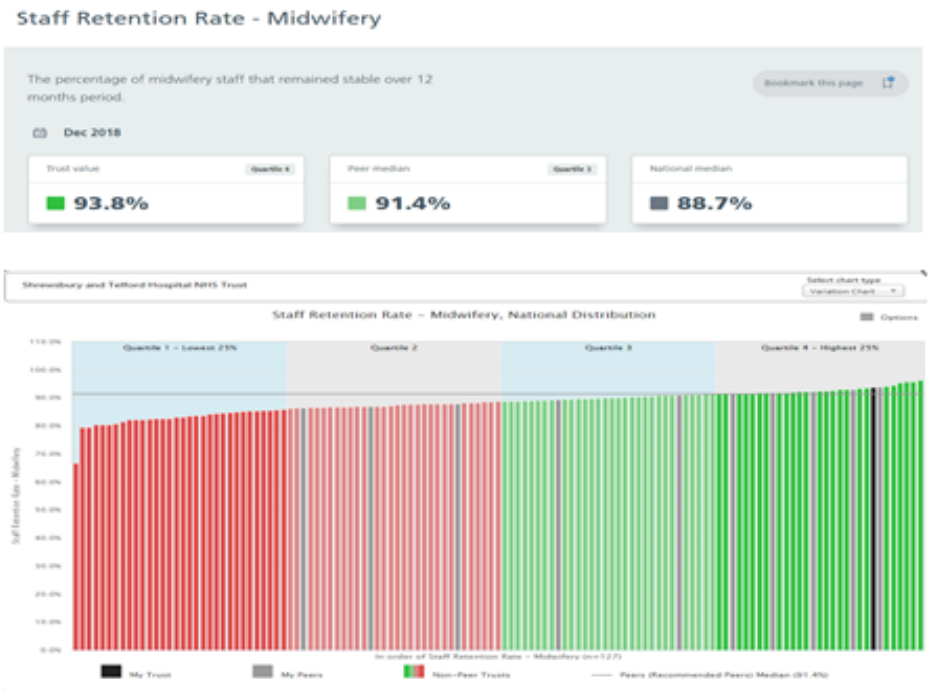
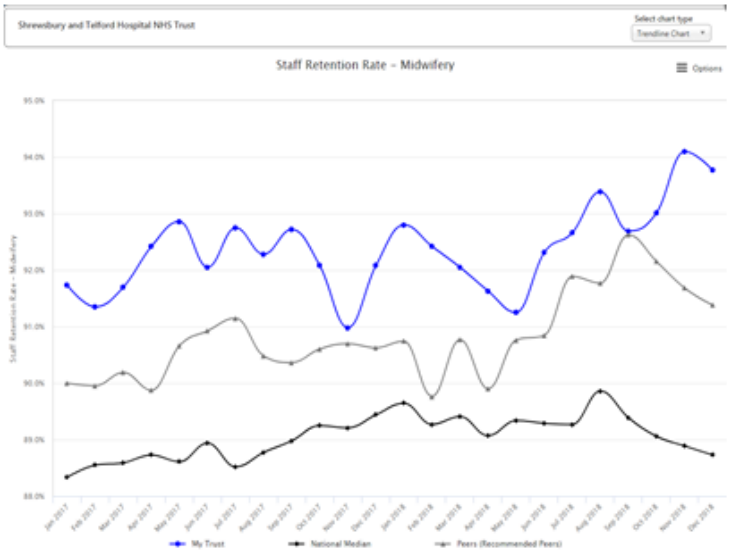
Trust wide Workforce Metrics: Turnover & Retention Midwifery



The retention rate for Midwifery is 93.8%
which gives us a ranking of quartile 4, i.e. within the top 25%.

The trend analysis shows that our retention rate is increasing and is consistently above national and peer group levels.



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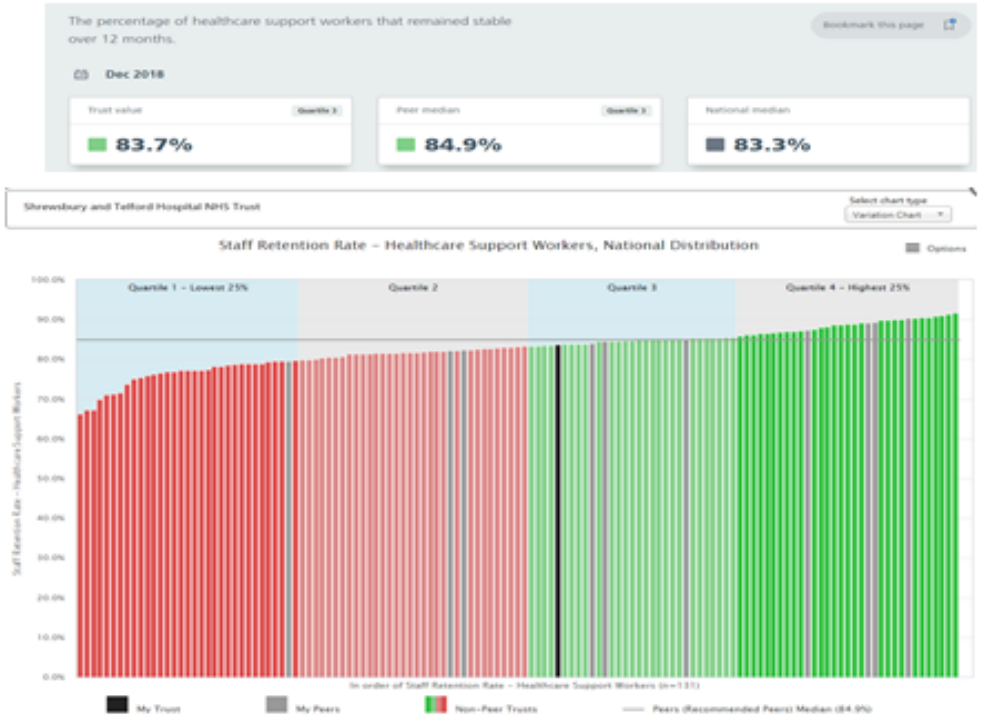
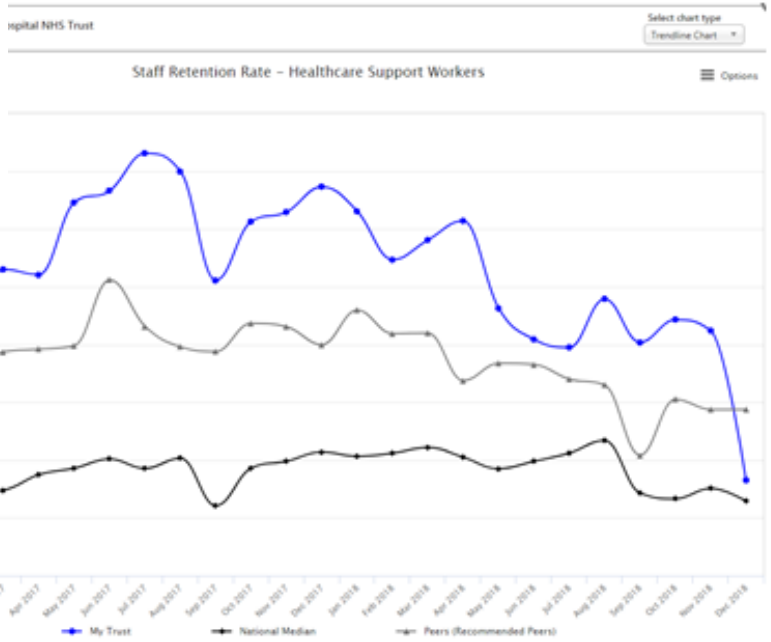
Trust wide Workforce Metrics: Healthcare Support Workers



The retention rate for healthcare support workers is 83.7% which gives is above national average and gives us a ranking of quartile 3.



The trend analysis shows that our retention rate was above national and peer group levels. However we have seen a significant reduction in the year up to December 2018.

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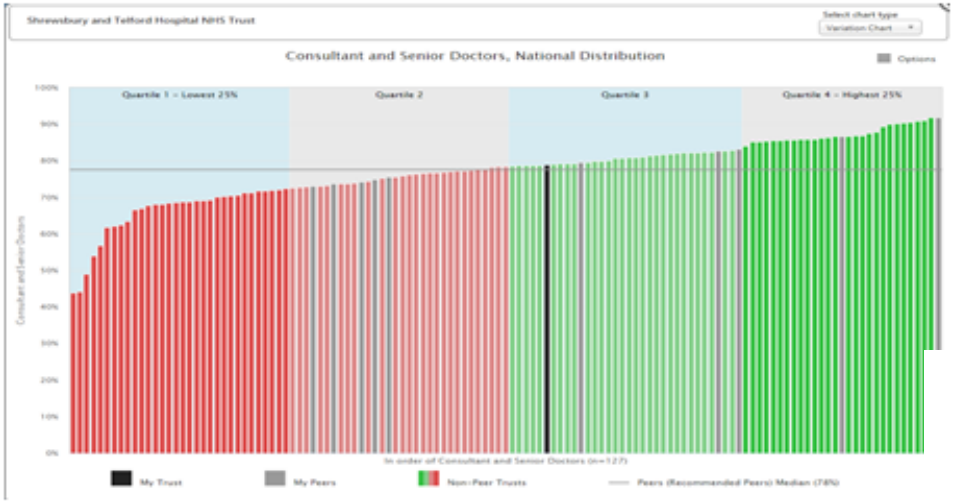
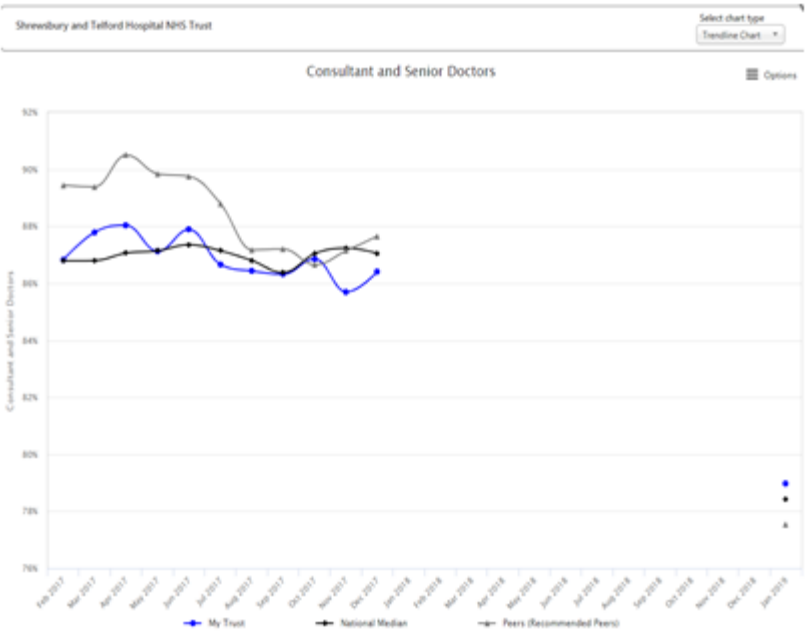
Trust wide Workforce Metrics: Consultants & Senior Doctors

The retention rate for consultants & senior doctors is 79% which gives is above national average and gives us a ranking of quartile 3.



The trend analysis shows that we are in line with national average, however there has been a deterioration around December 2017.



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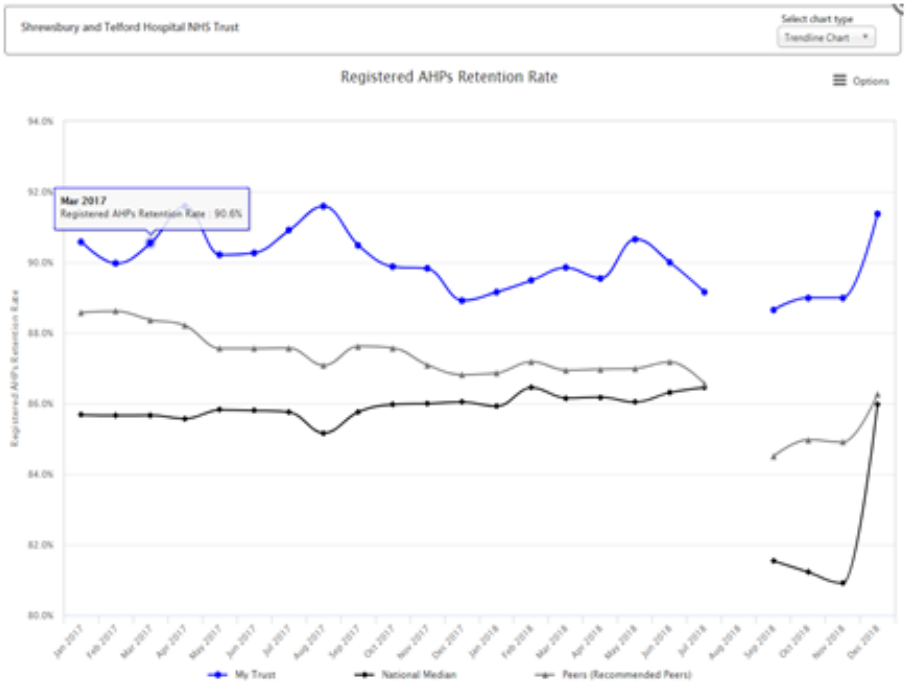
Trust wide Workforce Metrics: Allied Healthcare Professionals

The retention rate for allied Healthcare Professionals is 91.4% which is above national and peer group median and gives us a ranking of quartile 4.



The trend analysis shows that our retention rate is consistently above the national and peer group median.

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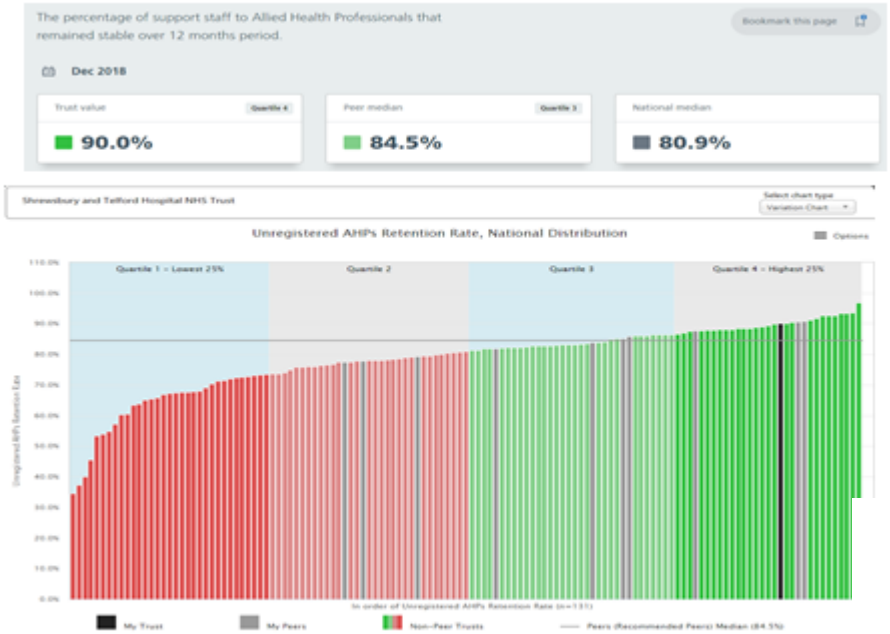
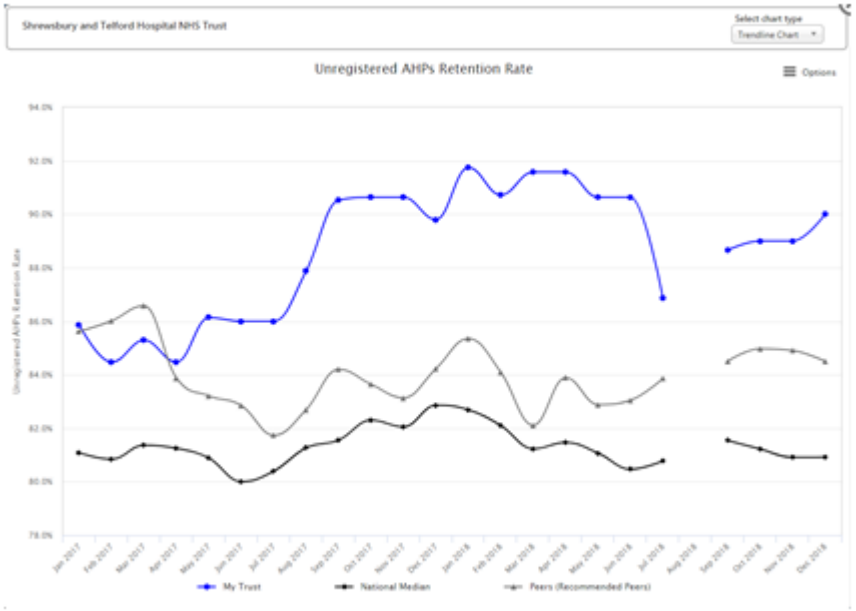
Trust wide Workforce Metrics: Unregistered Allied Healthcare Professionals



The retention rate for unregistered allied Healthcare Professionals is 90% which is above national and peer group median and gives us a ranking of quartile 4.

The trend analysis shows that our retention rate is consistently above the national and peer group median.



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Trust wide Metrics Summary

- The Trust retention rates are generally above the national and peer group median.
- The trend analysis indicates that is a recurring position.

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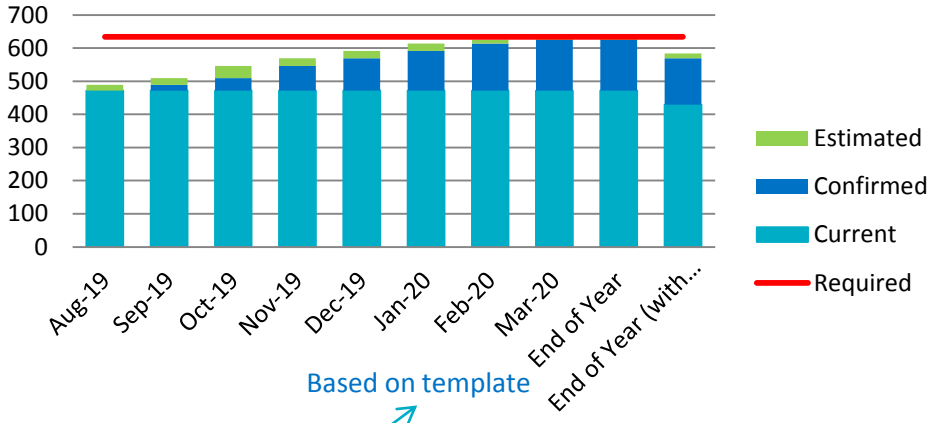
Workforce – Challenged Specialities / Departments

Specialty /Department	Vacancy rate	Action to address gap
Emergency Department	Nursing – 32% Medical - 40%	• ED Nursing business case approved. Expansion of senior nursing workforce (recruitment plan) in place. • International recruitment campaign supported by Remedium Partners. • CESR programme developed first rotation out of ED expected November.
Acute Medical Unit	Nursing – 19% Medical - 24%	• Support from ECIST in reviewing service which will result in development in business case outlining required change . • Actively recruiting Acute Physicians .
Medicine	Nursing Ward 11 – 41% Ward 27 – 100% Ward 28 – 48%	• International nursing recruitment as part of Global Learners Progarmme. 73 offers made, 43 confirmed acceptance. 2nd Phase in July 2019. • Non-consultant workforce plan in place which includes expansion of new roles (Physician Associates and ACP's) to support medical workforce gaps.
Radiology	Medical (Radiologist - 22%)	• Advanced Clinical Practice, Reporting Radiographers and Consultant Radiographer model developed to support national shortage of Radiologist. Use of locums and outsourcing
Anaesthetics	Medical – 18%	• Changed the on call rota to cover more shifts with substantive staff, using Locums and 5 Anaesthetists from Local Trusts on Bank to offer support. • Launching new recruitment campaign to attract Anaesthetist.
Surgery	Nursing – Ward 22 36% Ward 25 43% Ward 26 20%	• Specific adverts for Nursing posts to the Wards • Use of Nurse Associates on Ward 25 • International recruitment campaigns in Dublin and India • Workshops to engage staff, as Ward 25 was fully staffed a year ago, resignations cite escalation as a reason for leaving
Pharmacy	Senior Pharmacist - 19%	• Internal Secondments • Mix of bank and agency cover • Launching new recruitment campaign to attract Senior Pharmacist • NHS Transformation Board revision of Technical Services
Paediatric Nursing	Nursing – 11.7%	• Open day event

Nursing Recruitment (WTE) July 2019 Here and Now

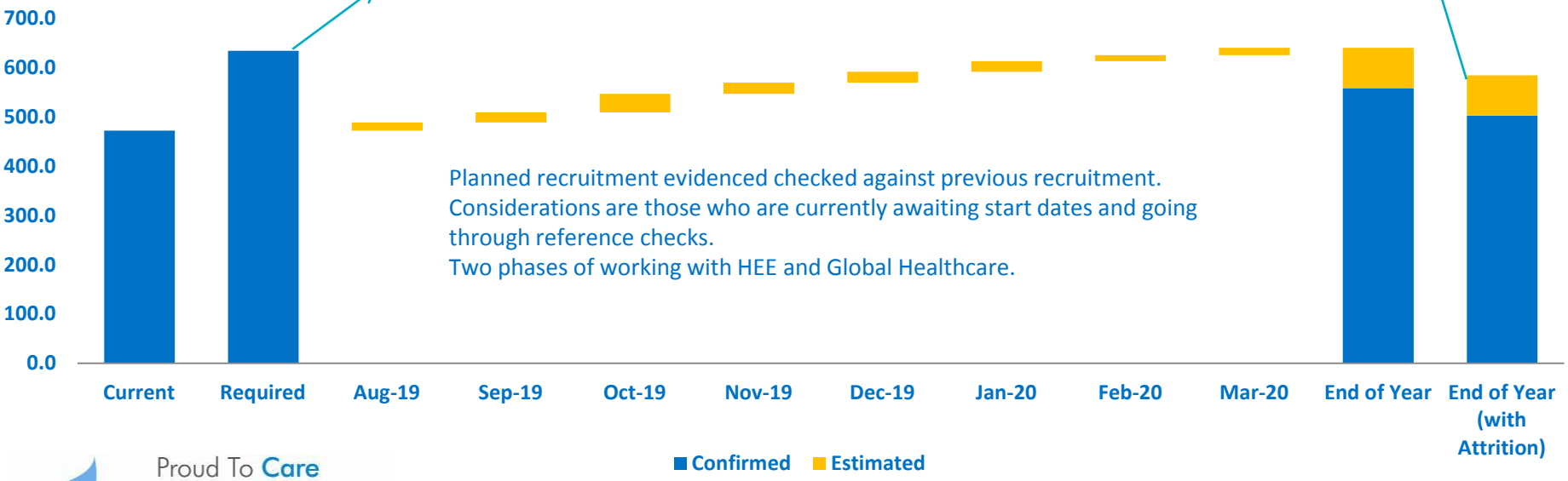
Band 5 RN Summary Nursing Recruitment within Inpatient



This excludes W&C's, Band 6, 7 and 8A recruitment.
Enabling:- Lessons learnt from previous events ,
_Workforce is working jointly with Corporate Nursing.
_On boarding, multi factorial about housing, local information,
_schools, development. What does Shropshire have to offer.
_Retired but wanting to return nurses are providing their skills and expertise to ensure mentoring and support is in place for the OSCE requirements.
_Possibility thinking on other supportive ward based enablers.
_The development of a nursing and recruitment retention lead with corporate nursing.

Based on template

Based on 10% attrition, aspirational but doable with enabling actions



Planned recruitment evidenced checked against previous recruitment.
Considerations are those who are currently awaiting start dates and going through reference checks.
Two phases of working with HEE and Global Healthcare.

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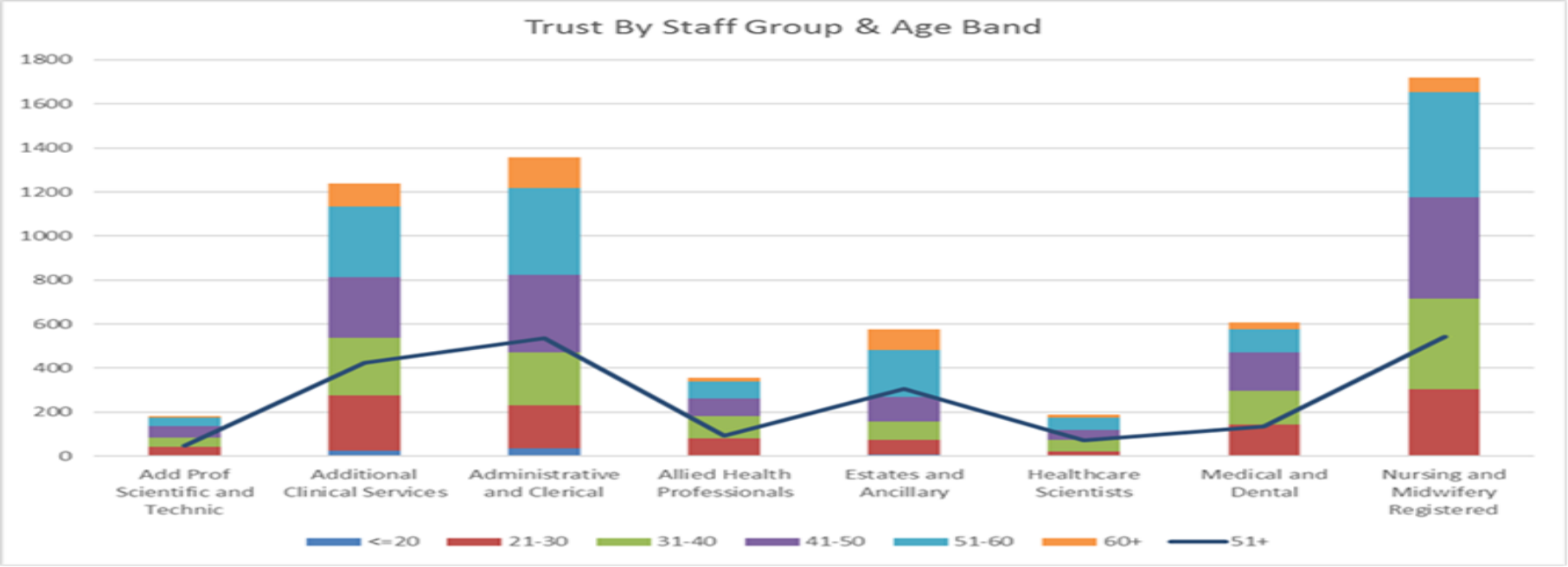
Here and Now Staff Aging Profile at July 2019



Key Risk Areas: There is an awareness in the care group and forms part of the operational workforce plans.
_Health Care Scientists,
_Estates and Ancillary.
_Nursing and Midwifery, have the ability to retire early.

Mitigation to address: -
_Apprenticeship recruitment, building in development opportunities for existing and new staff.
_2 years before retirement, an apprenticeship is recruited in to post to train and support the transition plan.
_Skills Mix
_ Personalised plans by department to address localised issues
_ Training Nurse associates (TNA), growing the numbers each year.
_Increasing student nurse placements.

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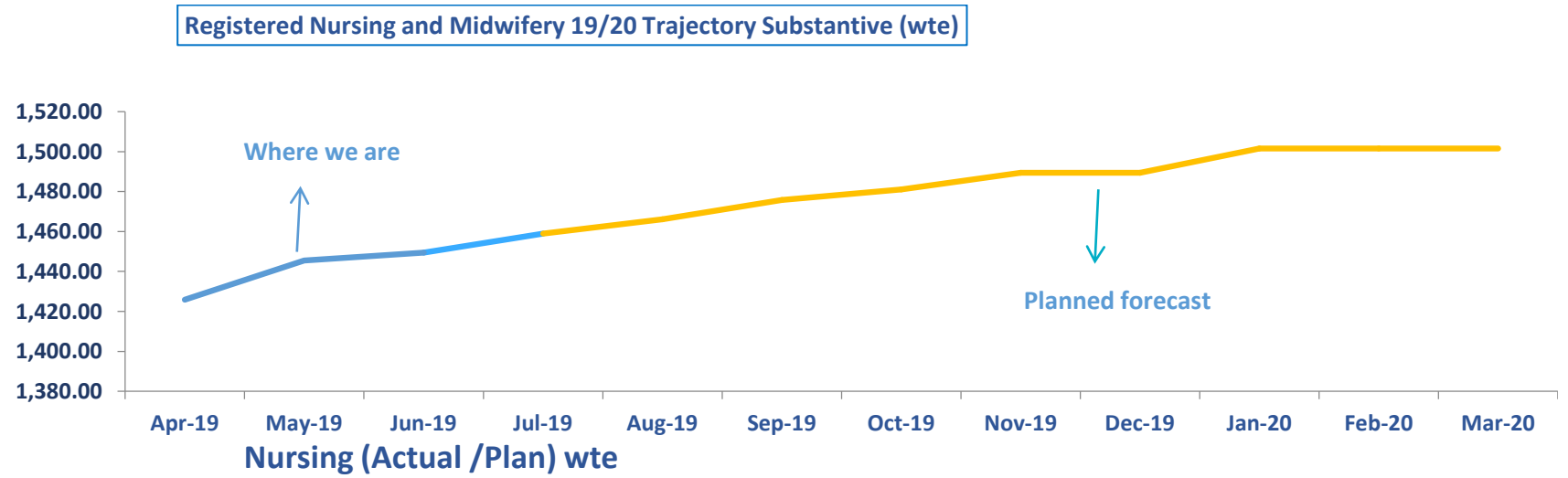
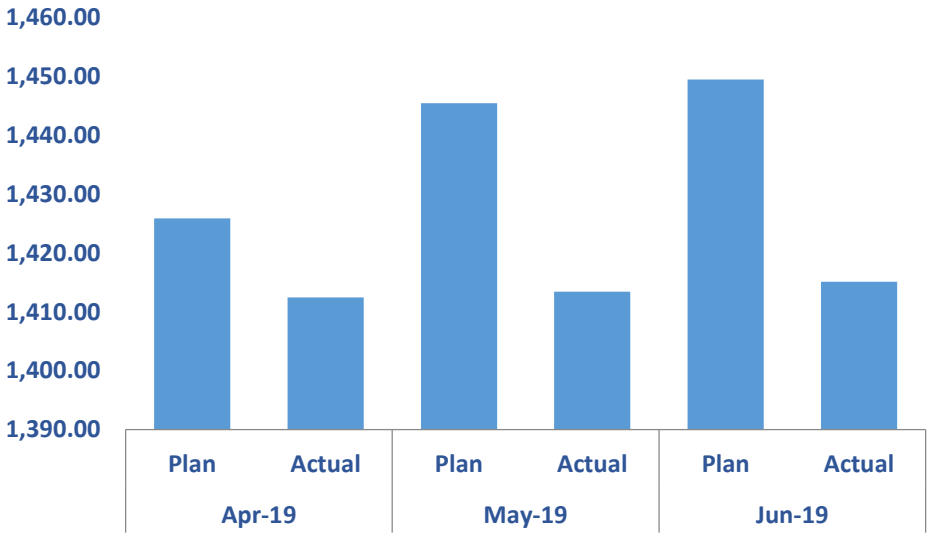
Plan Workforce Trajectory 2019/20 - Nursing





At Present

_Behind plan

Mitigation to address

_ Enhanced media coverage.

_Increased presence with universities and student engagement prior to graduation

_Catchment area widened with recruitment fairs held in Dublin

_Maximised the opportunity to work with Global Healthcare and HEE

_We are recognising why people are leaving, through the use of exit interviews to inform on boarding and retention.

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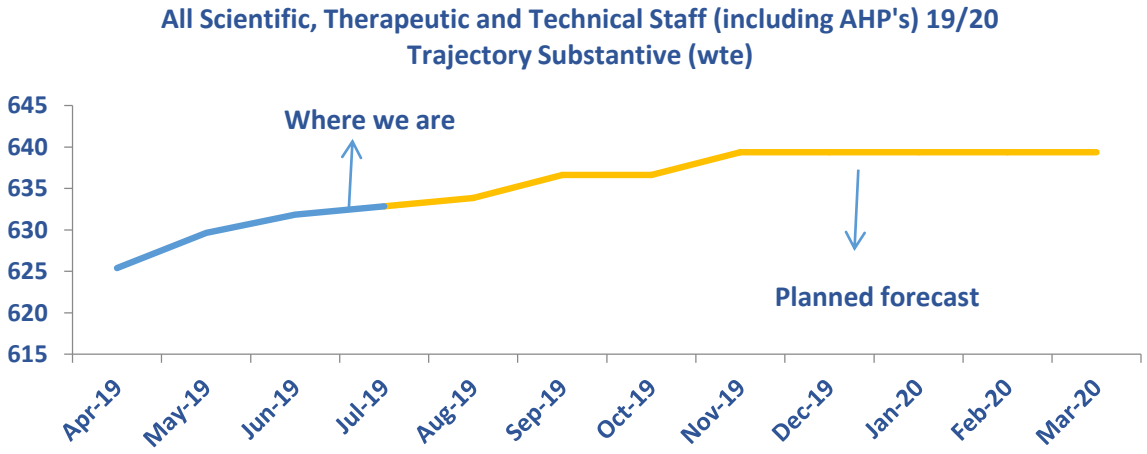
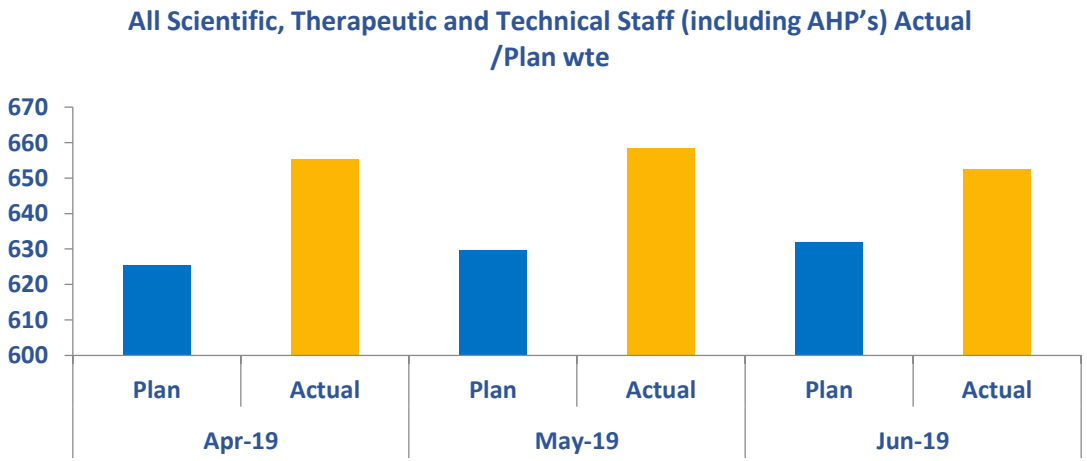
Workforce Trajectory 2019/20 – All Scientific, Therapeutic and Technical





At Present

_Over recruited Band 5 Physio and Occupational Therapists, through open days during the spring

Successful recruitment into Pharmacy Vacancy

Why

_To account for attrition

_Plan for winter pressures (Including escalation wards)

_Fill Vacancies

_Recognise that we are recruiting to meet demand and supply in advance

_Compliance with CQC findings

_This includes Pharmacists and Healthcare Scientists, and all Therapy professions.

_This represents the operational workforce plan for 2019_20

_Recruited into Pharmacy posts to fill vacancies, commencement August/September 2019.

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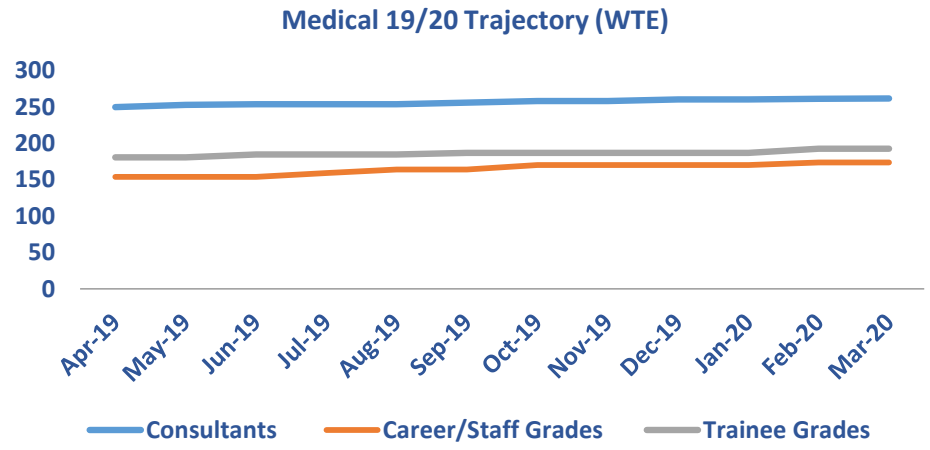
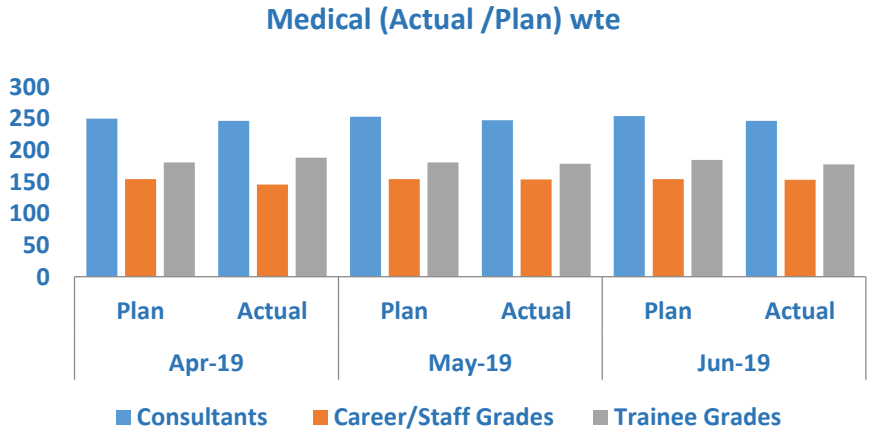
Workforce Trajectory 2019/20 - Medical





At Present

_Expansion of substantive Medics in Acute and Emergency Medicine

_In terms of Medicine Non Consultant workforce plan, the Trust is on track against year 2 of the 3 year plan. (*Available on request)*

_The Trust is behind trajectory on the Medicine Consultant workforce plan

Mitigation to address

_Continuous recruitment of Consultant roles in particular Acute Physicians

_Middle Grade ED is the Trust highest risk area. There is a plan in place to go back out to India to recruit overseas, due to the success of the first tranche. There were 12 offers made.

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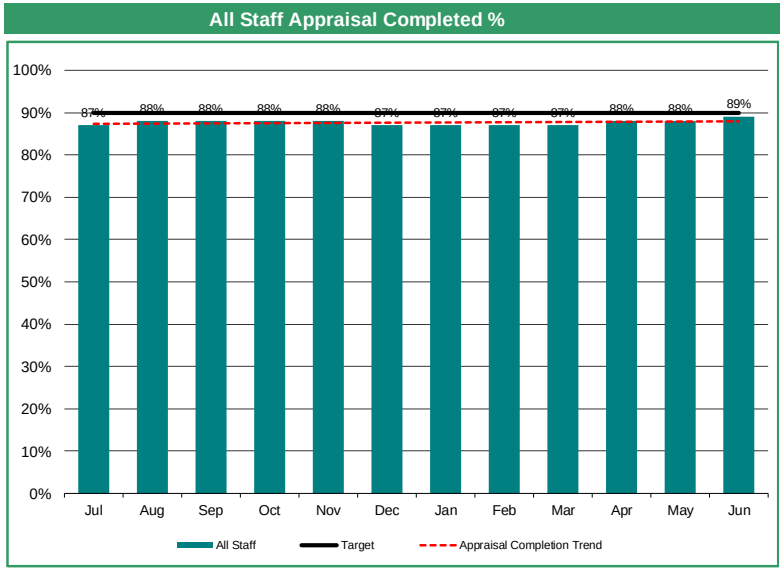
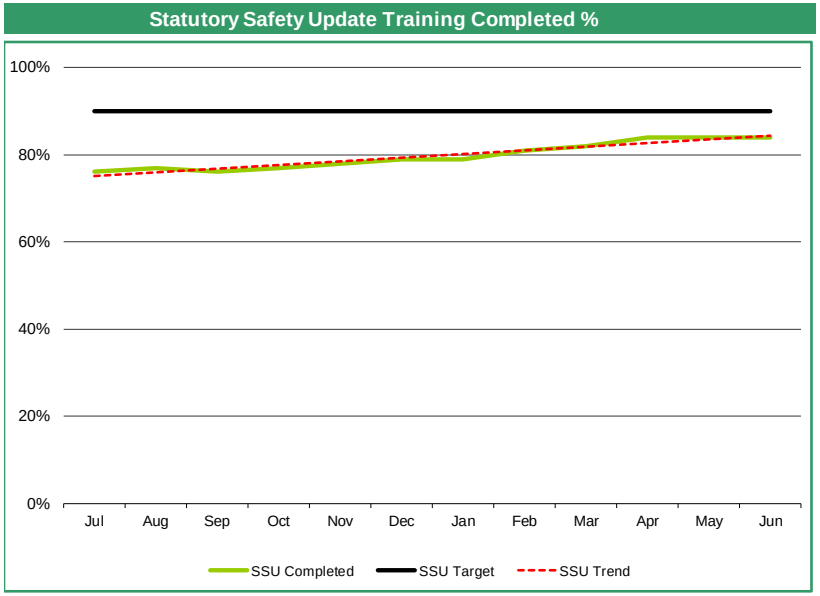
Quality Indicators: Appraisal & Statutory % completed



All Staff Appraisal Completed %

(Source: OLM)



Statutory Safety Update Training Completed %

(Source: OLM)

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The Shrewsbury and Telford Hospital NHS
NHS Trust

Women & Children's Services Care Group
Maternity Services
The Journey
Opportunities, Learning & Improving

Presentation - to Safety Oversight & Assurance Group
16th July 2019

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Context

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Maternity Services

PRH:

- Consultant Unit – Antenatal, Postnatal, Triage, Day Assessment Unit, Delivery Suite, Early Pregnancy & Assessment Service (EPAS)
- Wrekin MLU – Inpatient Midwifery Care
- Maternity Outpatients – Sonography

RSH:

- RSH MLU – Inpatient Midwifery Care
- Maternity Outpatients – Sonography
- EPAS

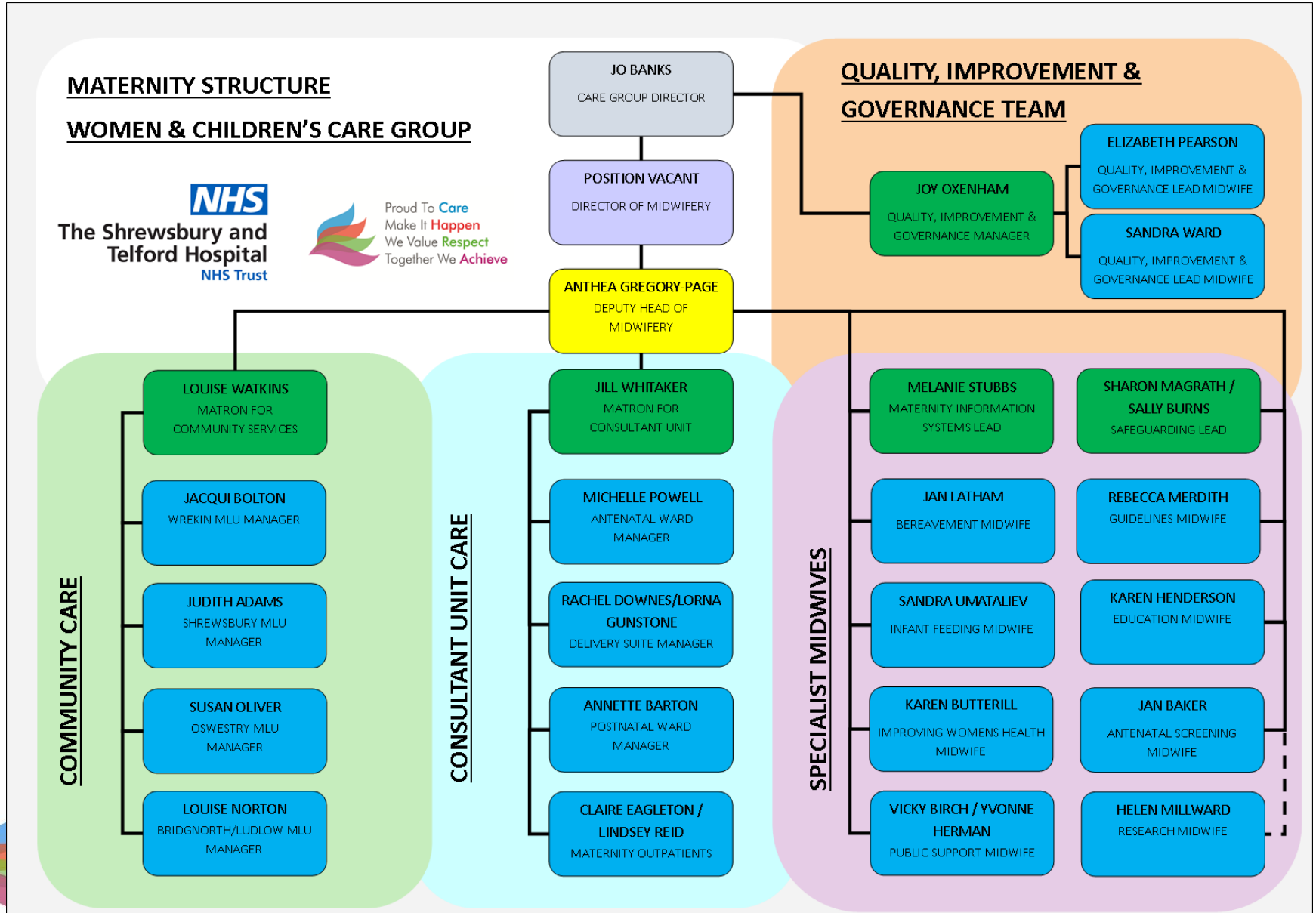
Community Services: Community Midwifery, Home Deliveries

- Market Drayton & Whitchurch

Rural MLUs:

- Ludlow
- Bridgnorth
- Oswestry

Maternity Management Structure



Birth Activity/Service Changes

Year	PRH	Bridgnorth	Ludlow	Oswestry	RSH	Wrekin	Home	BBA	Total
2016/17	4194	77	36	52	142	337	64	26	4928
2017/18	4060	26	12	15	120	351	68	3	4655
2018/19	4062	4	4	4	69	285	75	8	4511

Current Birth to Midwife ratio = 1:32

After recruitment of 29 WTE = 1:28 (in line with national recommendation “Better Births”)

Service changes timeline –

- Moved out of old Ludlow MLU into main site at Ludlow Community Hospital – November 2016
- 2016/17 intermittent inpatient service suspensions across all rural MLUs 2017 – 2018
- Temporary suspension of rural MLUs from October 2018
- Temporary suspension of RSH MLU June 2019

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Opportunities

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The Journey

Date	Review
2009-Present	Professional body referrals
Annually 2013	Mortality reports and patterns of maternity care report
October 2013	Independent Maternity Services Review
March 2014	Clinical Negligence Scheme for Trusts Level 3 Accreditation
October 2014 (published 2015)	Chief Inspector of Hospitals full Trust Inspection (including Maternity Services)
December 2014 (received January 2015)	Review of complaints from the parents of KSD.
2015 - 16	Quality and Safety Committee scrutiny
2015 - present	Trust Board oversight
Spring to Autumn 2015 (published February 2016)	Shropshire Midwifery Led Units Enter & View visit report
August 2015	Multiagency case review meeting
September 2015	Review of 2009 Supervisors of Midwives investigation conducted in relation to KSD
December 2015	Case Strategy Meeting
December 2015	National Survey of women's experiences of maternity services 2015

Date	Review
2015-16	Local Supervising Authority (LSA) reinvestigation of 2009 KSD, Supervisor of Midwives Investigation
2015-2017	Conduct Investigations
March-May 2016	Expert Midwifery support
March 2016	Table top exercise to review transfers from Midwifery Led Units to Consultant Led Unit.
March 2016 (approved by board April 2016)	Report to independently review the case of KSD (SaTH)
May 2016	Serious Incident themed Reviews
2016	Review of maternal and neonatal death Serious Incident
July 2016	Sign up to Safety review visit
2016	Local Safeguarding Authority (LSA) audit of West Midlands region Supervisor of Midwifery Investigations (including SaTH)
September 2016	New Head of Midwifery and Care Group Director for Women and Children
2016	Better Births Publication visit
2016-17	Expert Independent Midwife RCA Reviews

Date	Review
December 2016 (report due February 2017)	Birth Rate Plus Midwifery service staffing review
2016 (report due mid-January 2017)	Audit of Policy and Procedure Compliance in maternity services
Letter to SofS from SD 2016	Secretary of State (SofS) for health review.
27th June 2017	Review of maternity services 2007 – 2017 – Colin Ovington.
July 2017/April 2018	RCOG Reports
August 2018	CQC full inspection
June – Dec 18	Legacy Review – Those cases that the Trust became aware of following initial publicity.
Dec 18	NHSI "Open Book" review of data - mapping
Dec 2018 - Present	Extended review – All cases that the Trust became aware of following publicity and those cases that went directly to the independent review team.

Opportunities of learning - Maternity Review

Key themes:

- Communication
- Documentation record keeping
- Transfer of women from low risk to high risk areas
- Monitoring & escalation
- CTG interpretation
- Recognising the unwell neonate
- Holistic care of women

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So what?

- Skills drills
- Training, training, training
- Safety huddles
- Authentic leadership
- Handovers
- Triage

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CQC findings – immediate actions

- 0 CTGs performed in the MLUs
- All high risk women now seen in obstetric antenatal assessment areas
- Handovers – Delivery suite/Triage
- Escalation

In line with national guidance –

- Maternity Early Warning Score guideline updated
- Cardiotocography (CTG) guideline updated
- Reduced Fetal Movements (RFM) guideline updated
- Triage guideline updated

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Perinatal Mortality

- MBRRACE - Perinatal mortality considered higher than average. Similar to region - key issue for Telford CCG
- Figures for 2016 and 2017 have shown improved outcomes for Neonates. Possibly related to improved monitoring during labour (Qualitative/Quantitative data inconclusive)
- After a low in 2015 there has been a plateau in still birth rates.
- Extended perinatal mortality rate will not have improved from 2016 – 2017.
- 2017 – 2018 shows improving picture – reduction in still births.
- All 5 elements of saving babies lives care bundle implemented

Our people - Workforce Overview

Senior leadership

- March/April/May 2019 – Change in leadership – HOM, DoN&Q & DDoN&Q, MD, CEO
- Director of Midwifery recruitment – strong leader appointed

Workforce – Midwifery

- Sickness absence – Maternity overall = 3.62% - Stress & Musculo-skeletal
- 40% maternity staff part-time
- Birth-rate Plus assessed 2017 – implemented 2019
- Band 3 development – needs pace

Workforce – medical

- 39% of Consultants 41 - 60+ age range (average retirement age 59)
- Middle Grade and Junior Doctor recruitment risk varies based on Deanery supply

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Medical & Midwifery Recruitment Update

2 x Consultant Neonatologists recruited

1 x Consultant Obs/Gynae in progress

Band 5 Midwives

- 27 Preceptorships offered 25 Permanent roles and 10 temporary commencing July (2) and October.

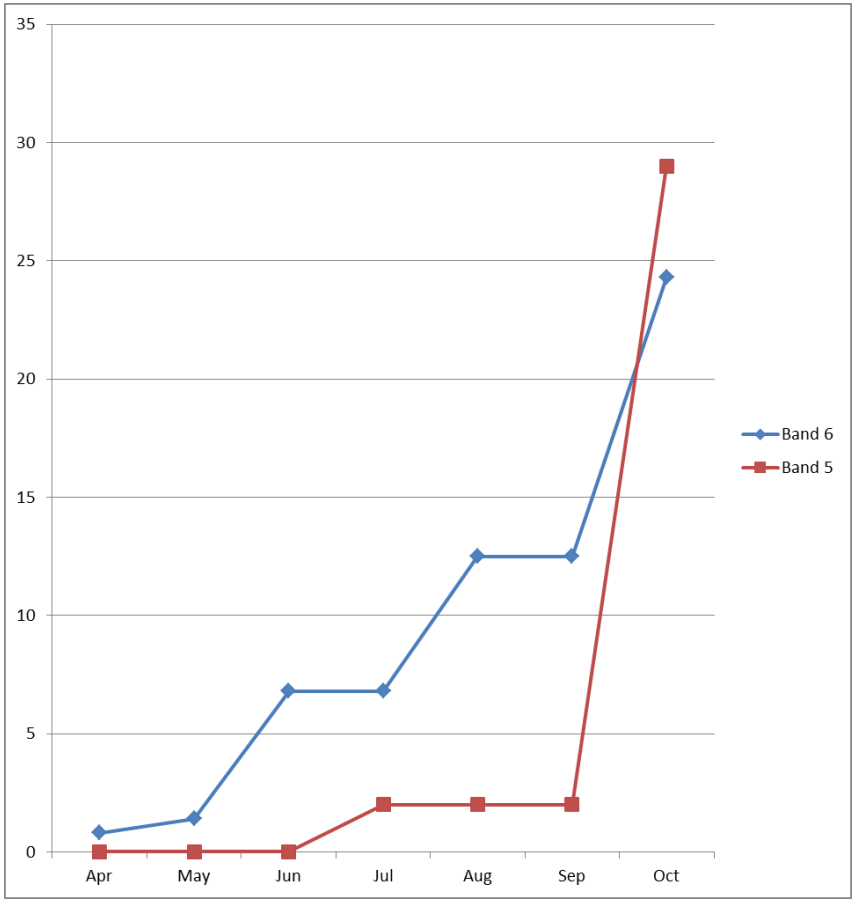
Band 6 Midwives

- 12.5 FTE starting between April and August
- 11.8 FTE Current preceptorships offered permanent contracts commencing October
- Further recruitment campaign for 8.80 FTE undertaken and interviews held (not included in graph).

Maternity Support Worker (Band 3)

- JD awaiting AfC evaluation, however recommendation made for recruitment of 20 posts to commence pending banding.

Midwifery Recruitment Plan



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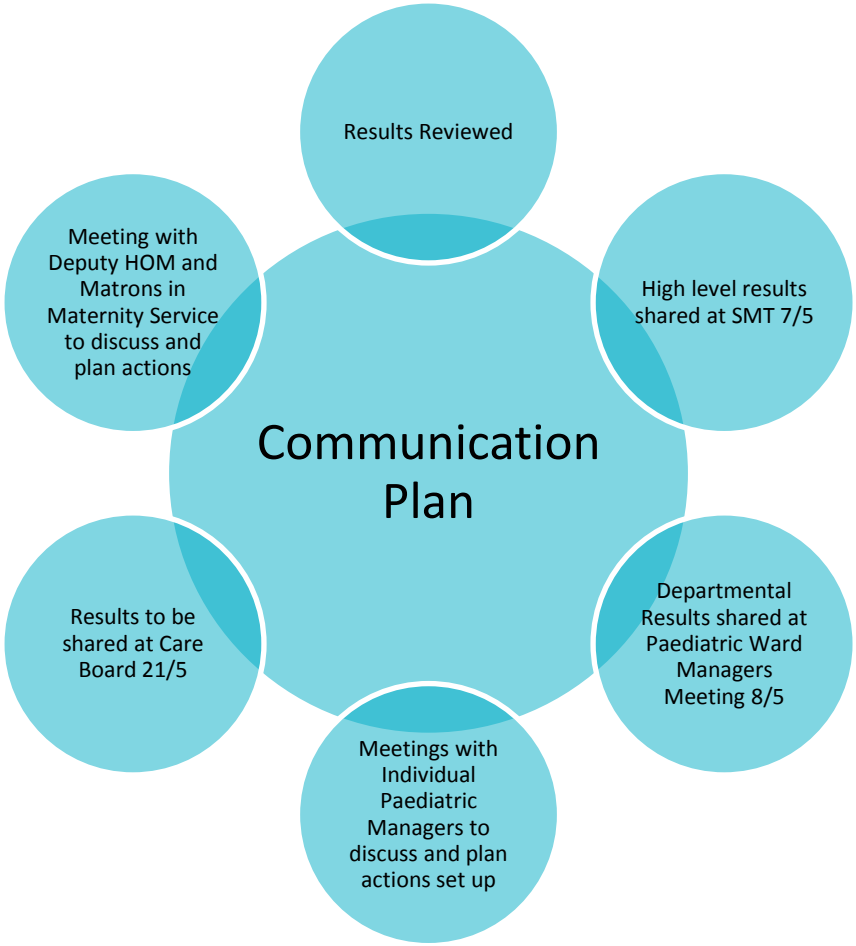
Our people - Staff Survey Results

- Care Group Results
- Response decrease by 49 from last year.
- 3 Themes saw increase year on year
  - 7 Safe Environment – Bullying and Harassment
  - 8 Safe Environment – Violence
  - 9 Safety Culture
- Neonatal Services
  - 7 of 9 themes showed an increase year on year (same number of responses)



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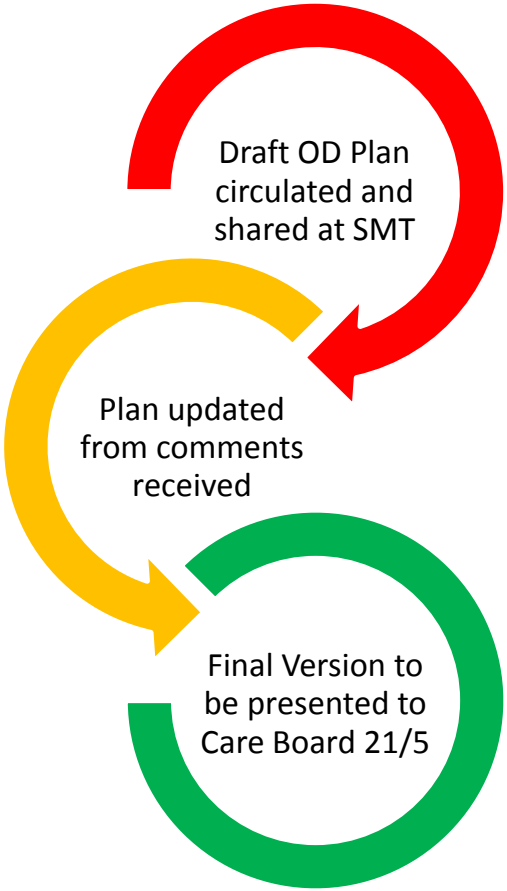
Supporting our staff - OD Plan and Activity



- Development & interventions -
  - Obs and Gynae away day
  - Motivational Interviewing Courses – well attended across the LMS community.
  - Values Based Conversations Train the Trainer
  - Mental Health Training
  - Future of Maternity Services events continue
  - Values guardians
  - Manager Visibility
  - **Chief Midwifery Officer visit 27.06.19**

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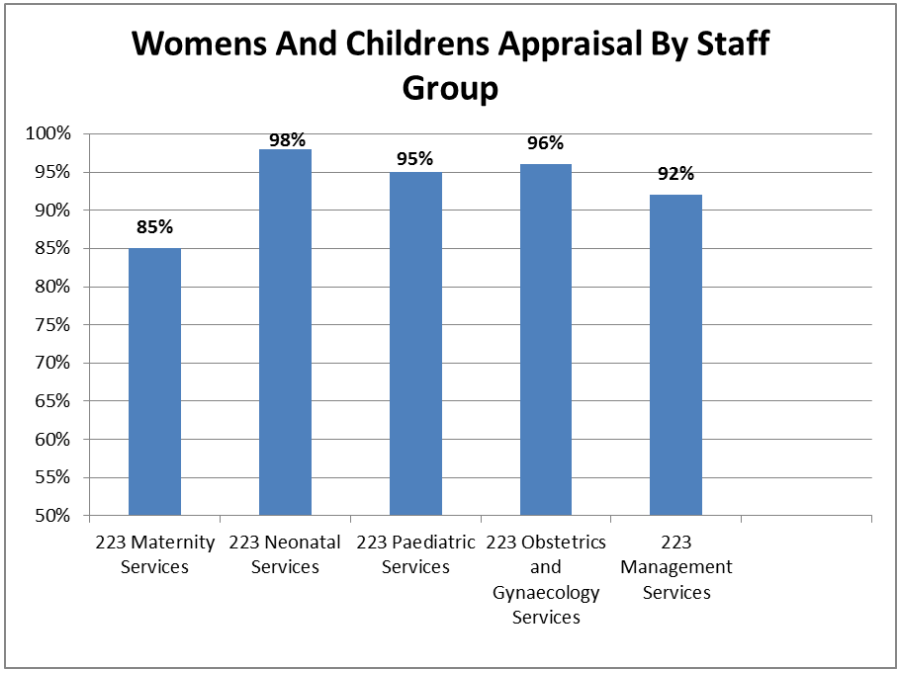
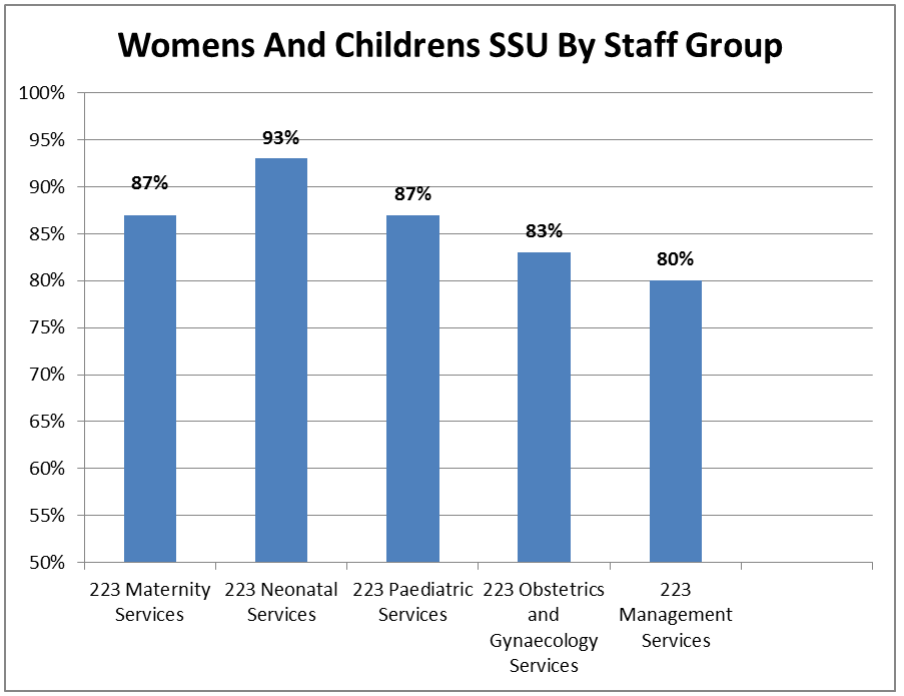
Appraisals & SSU





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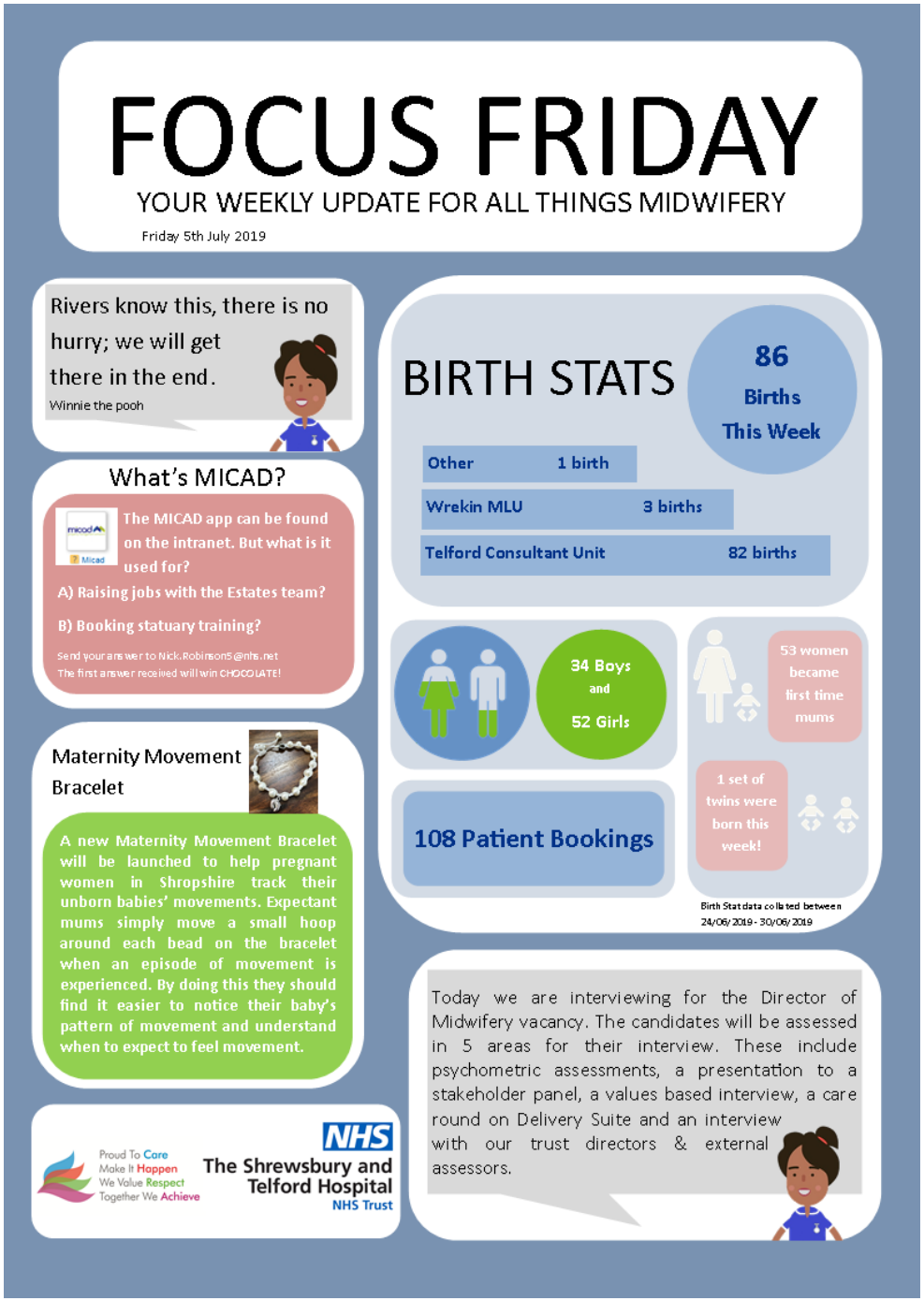
Staff involvement



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Staff involvement

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PATIENT FEEDBACK

Very attentive care, always there when needed. Friendly, funny and very supportive. Cannot thank all staff enough.

Care throughout the whole labour period has been amazing. Midwives have been very caring, understanding and brilliant. Staff were outstanding and very supportive. Loved my care during my stay here, all staff friendly.

All midwives were so thoughtful and caring.

Outstanding and exemplary care has been given to me and my son. I cannot thank you enough for all that you have done for us from cleaning staff, dinner supervisors, service assistants, midwives, doctors and specialist doctors/surgeons.

My care throughout my delivery and postnatal excellent. Everybody took the time to talk and explain what they were doing. All were extremely helpful. Thank you very much.

Lots of help with breastfeeding advice and emotional support when I was over-tired was excellent.

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PATIENT FEEDBACK

Everybody was very helpful and seemed very easy to chat to with any concerns. All of the midwives were helpful when I asked for support and didn't make me feel stupid asking questions all the time.

Staff were quick to help and friendly.

Love how welcoming and friendly all the doctors and midwives are. Always making sure you have everything you need/want and always willing to help. Can't think of any improvements that could make.

The staff were very knowledgeable and picked up on things that had gone under the radar. WSA noticed a soft patch to baby's head and before being discharged found my baby jaundice. Student midwife noticed a change in my baby's breathing.

Lovely, kind, caring staff. Made to feel very comfortable and welcoming. All staff are a real asset to SaTH, from the cleanliness, technicians, midwives, WSAs and doctors - real lovely bunch.

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Maternity Survey Jan 2018

- New mothers using our services felt that they were treated with respect and dignity, listened to and given the help they need.
- Women who raised concerns during their pregnancy or delivery had those concerns taken seriously and that they were spoken to in a way they could understand.
- Scored 8 out of 10 or higher in 42 out of the 51 categories relating to the care of mothers and babies.
- The Trust performed statistically better than most other trusts in 12 categories.

Governance – How we manage safety & risk

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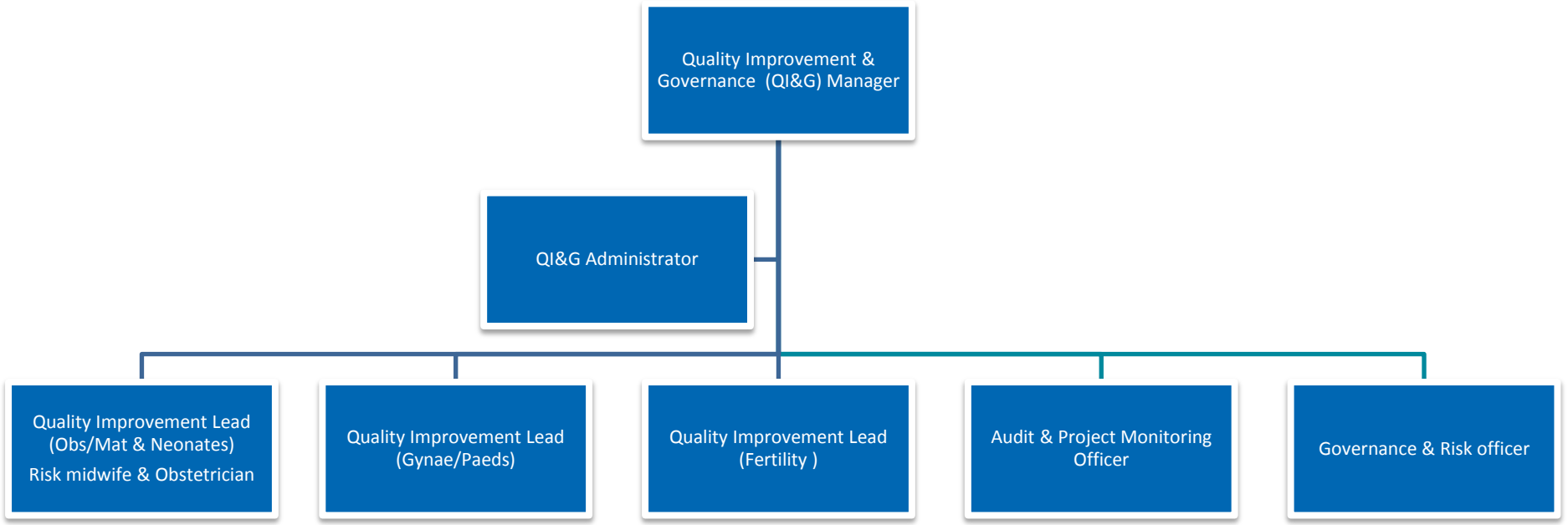
Quality Improvement & Governance Team



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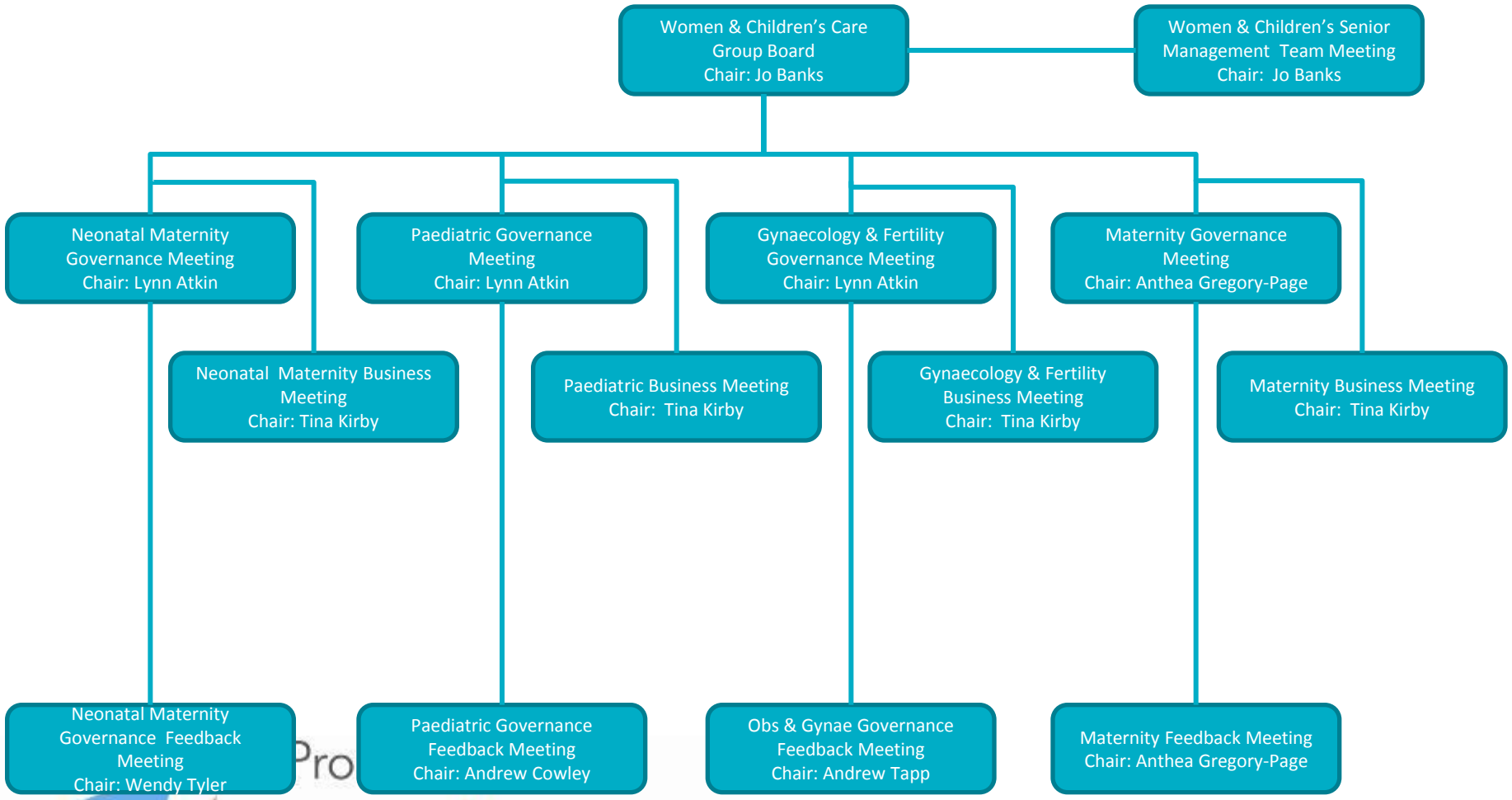
The Shrewsbury and Telford Hospital NHS
NHS Trust

Women & Children's Governance Structure Chart



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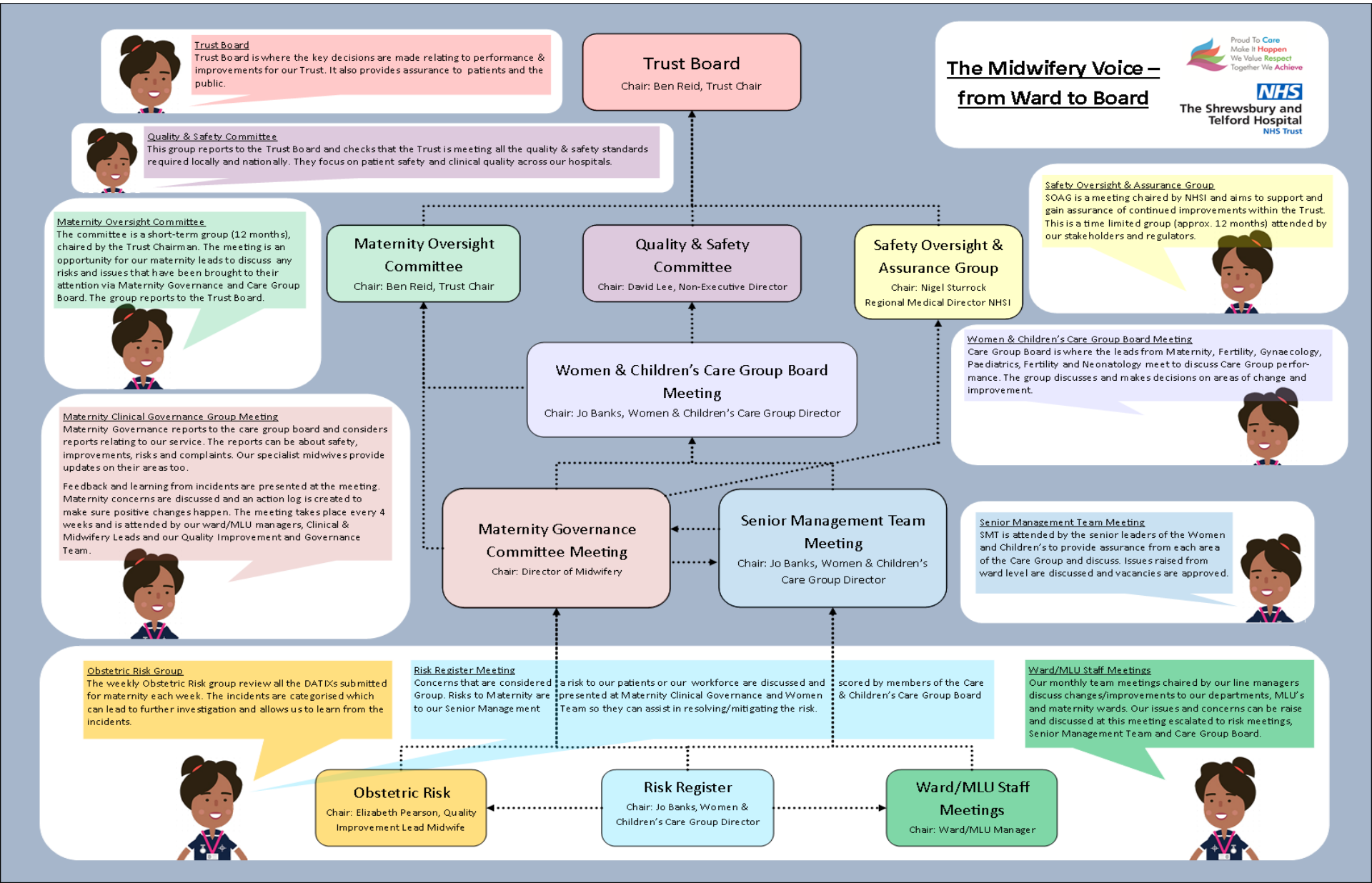
Midwifery Voice – Ward to Board



Improving quality through governance & learning

- Maternity Oversight Committee
- Revised maternity Clinical Incident Management Policy
- Culture of learning
- Oversight and scrutiny of patient safety incidents (grading & review)
- Collective & authentic leadership
- Quality Improvement & Governance team review

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Improving & Learning

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Learning & improving from incidents and complaints

Key themes:

- Communication
- Documentation
- Behaviours
- Escalation
- Monitoring & escalation
- Confidence in practice

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Examples

Importance of correct documentation in Medway

- Patient delivered baby; mother told to see GP for 6 week check and contraception. Patient attended for 6 week check and informed the GP that she had been sterilised after the birth. This information was not included in the maternal discharge summary.

Feedback from two patients via Telford & Wrekin Health Watch:

- “Postnatal, during pregnancy treatment by staff very good care, friendly, explained treatment monitored well throughout, baby born in consultant unit, labour ward amazing, antenatal wasn't great. Induced left a long time not monitored; 9:30 husband told to go home not happy with that, moved to delivery unit @ 3 am, delivery suit staff outstanding, very kind and attentive, forceps delivery, constantly monitoring throughout, after delivery moved down at 9am, at the postnatal ward, husband told to leave, other husbands on ward, I was in a bad way I needed him”

- “Explained everything to us, actually they are very good”.

Improving outcomes

- Antenatal detection of fetal growth restriction (FGR)
- Appointment of 2 further WTE sonographers
- Reduced fetal movements – updated information, social marketing/health messaging
- MatNeo Safety Collaborative project
- Improved CTG analysis - CTG masterclass, CTG telemetry, CTG MDT meetings
- Reduction in smoking - Appointment of smoking cessation midwife, CO2 monitoring
- Close collaboration within LMS
- Buddy Trust – Princess Alexander Hospital & Wolverhampton
- Professional Midwifery Advocate

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Neonates

Neonatal Peer Review 7th/8th February 2019
Immediate Actions –

- Neonatal support workers Band 4

On-going improvement

- Guidelines
- Medical workforce gaps
- Nursing – British Association of Perinatal Medicine (BAPM) standards
- Transitional care – antibiotic pathway postnatal
- Quality metrics
- IPC issues – NHSI July 2019

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LMS Transforming Maternity Services

- Transforming Midwifery Care (MLU Review) Public Consultation September 2019
- 3 - 4 Hub Model
- Continuity of Carer - Overall plan for continuity models; with timescales developed
- Implementation of competent Band 3 wSAs. - Hubs ‘staffed’ by band 3s to support flexibility and efficient use of midwives
- Improve PN capacity and support early discharge of well women and neonate
- Enhanced recovery package for CS
- Transitional care - Neonatal/paediatric pathways
- Breast feeding support
- Operational plan for MLUs around in patient time frame and discharge criteria after birth
- Single point of access- phone calls triaged centrally

Patient Feedback

*"Thank you all for all of your wonderful messages of love for **** we wish we could reply to every single one to any mum to be from Telford or Shrewsbury (or surrounding) who is apprehensive following all the bad press in the media regarding the maternity services in our area please take my word that this group of professionals are undoubtedly the best support you will ever, ever encounter within the NHS and beyond.*

*From the triage staff, the antenatal and delivery teams, consultants, paediatric doctors, anaesthetists, post natal care and any I may have missed they have **ALL - EVERY SINGLE ONE** been an absolute credit to themselves, their professions and PRH and we could not be any more grateful for their outstanding care and support from the second we walked through the door.*

So anyone from Maternity Services at SATH who may read this, never let anyone dull your sparkles. You are all AMAZING people who we will never forget and we will forever be in your debt for bringing our little girl safely into this world.

Don't always believe what's in the papers, these hero's need recognition for all the exemplary work they do. I will never be able to put into words how I truly feel so for now just a massive thank you will have to do "

Women & Children's Services

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SOAG Agenda Item 3 – Running order

No	Description	Lead	Timing
1	Workforce 1.1 Trust Wide Workforce Metrics 1.2 Trust Wide Here and Now 1.3 How to get to where we need to be. 1.4 Trust Wide Oversight by Medicine, Nursing,	Barbara Beal, Arne Rose, Nigel Lee & Victoria Rankin	10.10 – 10.40 30 min's
2	Maternity Services Overview 2.1 Maternity Services Overview 2.2 What good looks like 2.3 The here and now 2.4 Considerations – Areas for improvement 2.5 Outstanding – What's gone well	Jo Banks and W&C's	10:40-11:05 25 min's
3	Infection Prevention and Control Update 3.1 IPCC Visit Risks identified and action taken	Barbara Beal & Clare Wesley	11.05 – 11.15 10 mins

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Infection Prevention and Control Update

- NHSE/I visited the Trust on 20th June 2019 to undertake a review – the fourth in 18 months and we were Red RAG rated. The team were supported by the CCG IPC lead at the request of the Trust to ensure openness and transparency.
- A briefing paper went to Trust Board on 27th June 2019, in line with requirements detailing immediate actions taken following verbal and draft report feedback. It was noted that the initial observation was of a palpable energy to address issues not noted previously and the IPC nurses were met were engaged, knowledgeable and had a positive attitude to addressing the concerns identified. A number of required immediate actions related to the neonatal unit were flagged with assurance that these were dealt with on the day of the visit.
- The formal report was received on 7th July 2019 following the opportunity for factual accuracy checking by the Trust.
- Seven clinical areas were visited across RSH and PRH sites including: ED; Wards 26 and 28; ED; Wards 8 & 9; Neonatal Unit

- Key messages:
  - good practice associated with documentation, including VIP scores and environmental cleanliness.

Risks Identified and Actions Taken

Risks Identified:	Actions Taken
Failure to use green is clean stickers	Immediate re-instatement of green clean stickers across the Trust and decontamination label
Failure to use decontamination label	
Expired BNF	BNFs removed and replaced
Failure to undertake terminal cleaning post infection -Checked with Ward Manager and this was undertaken although the staff on duty were unable to advise you	Review of documentation post outbreak to ensure all staff aware of dates of terminal cleans
Failure to ensure expressed breast milk (EBM) fridge is monitored; Inappropriate storage of formula milk under U bend of sink and next to bleach and antifungal products; Failure to ensure baby linen is laundered appropriately	Formal review of Neonatal Unit following immediate remedial action taken, on Monday 8th July.
Failure to ensure SOP is agreed via appropriate governance mechanisms	All SOPs to be agreed through Trust governance processes
Failure to introduce appropriate MRSA skin decolonisation after being alerted to the risk in April 2019	Immediate review of recommendation regarding skin decolonisation to occur at IPCC on 8th July and discussions with wider local health economy.
Staff were not compliant with dress code e.g. bare below elbows, rings, bangles, long hair not tied up off collars	Communications plan in development to ensure Trust wide understanding of compliance with dress code/ uniform policy by all staff groups.

Generic Actions Taken

Feedback Sessions with Ward managers and Matrons by DoN/ DIPC and Associate DoN
Noted confirm and challenge meetings will occur
System/ trust wide issues to be addressed to support sustainable approaches to IPC regarding storage and cleaning and tele-tracking
IPC team allocated to ward areas to develop relationships and support teams, with specific improvement plans for the areas visited

Tissue Viability
Current update future plans for SaTH

Clare Wesley (Lead Tissue Viability Nurse) bleep 905

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Tissue Viability Update-Changes since December 2018

Appointment of a Lead TVN after 9 months without one.

- Introduction of quarterly tissue viability newsletter with latest updates-First issued Jan 2019
- Recording monthly database of patients seen in order to determine capacity v's demand and highlight problem areas.
- Conducting SNAP audit to direct education in the right area and change current practice.
- Reinvention tissue viability intranet page so it's easier for staff to access
- Updating and creating policies in line with NHSi June 2018 recommendations
- All patients referred has specialist review within 3 days-often usually the same day
- Introduction of TV link worker competency booklets and a 4 day training programme across SaTH
- Visibility of team-posters in every clinical area with our details
- PICO in MSK as prophylaxis for orthopaedic patients –post evaluation approval, plan to implement in W&C for post C-section wounds
- New training dates for RGNs and HCAs to training diary
- Secured slots on HCA and RGN induction training
- Attending staff meetings to deliver categorisation training-

Future planning:-

-Submitting an abstract to Wounds UK Harrogate for potential poster to recognise our competency training in SaTH-Potential for nurse led outpatient clinic to prevent re-admission with wounds

-Developing and launching new documentation for wound care management across SaTH

-Developing wound-care passport for community and hospital use to forge stronger links with community

-Aim for zero tolerance culture for pressure ulcers

-Thematic review currently being undertaken due for completion in October

Recent SI hospital acquired cat 4 ulcer

Learning from SI

Recent hospital acquired category 4 pressure ulcer on medical ward.

81 yr old female admitted 3/3/19 with intact pressure areas-recent fractured humerus.

Seen by TVN 11/3/19 following referral and found to have a cat 4 pressure ulcer on her sacrum.

Root causes identified

- Deteriorating patient condition (found to have metastatic disease)
- Occasional lack of compliance-patient sometimes combative
- Lack of early referral to TVN
- Not having skin assessment on transfer to ward
- Delay in transferring onto suitable mattress despite being high risk
- Not following treatment plan advised by TVN on 2 occasions
- Lack of documentation regarding pt non-compliance
- Lack of documentation regarding frequency of documentation
- Not referring to dietician in a timely manner
- Staffing issues

Actions

- Ward manager has informed staff of this incident via safety brief
- Ward manager intends to present the case at NMF to share learning
- Documentation education provided by ward manager
- Ward manager to ensure staff complete online tissue viability modules
- Additional training days provided by TVN on training diary
- Staff issues on risk register
- TVN page more easy to navigate making it more accessible for staff.
- Ward manager to continue education of documenting when there is non-compliance with a patient

Suggested Actions

- -Ensuring agency staff have an induction when new to the ward to ensure understanding of how to document in SaTH paperwork.
- TVN to attend staff meeting to educate-awaiting dates from manager.

NHSi Recommendations June 2018 and SaTH compliance

Recommendation

1. We should use the term 'Pressure Ulcer'
2. Record device related PU's individually
3. The NPUAP definition of device related Pu's to be used
4. EOL skin changes (SCALE)/Kennedy ulcers no longer be used
5. Follow current systems NPUAP/EPUAP/PPPIA including deep tissue injury and unstageable PU's
6. Definition of PU on admission should be observed during the skin assessment on admission to the service
7. The DoH definition of avoidable/unavoidable Pu's should not be used
8. Definition of new PU within a setting is first observed within current episode of care
9. Use the term 'category' instead of grade
10. The 72 hour rule should be abandoned
11. Reporting of POA should be incorporated into local monitoring systems
12. Reporting of Cat 2 and above Pus should be incorporated into local monitoring systems
13. Reporting DTIs should be incorporated into local monitoring systems
14. Moisture associated skin damage should be counted and reported in addition to PUs

SaTH Progress

1. SaTH has long used this term and will continue
2. Addition of device related category on datix
3. No change to current practice
4. Option removed from datix, treated the same way as other PU's
5. No change to current practice info available on TVN site
6. No change to current process, reported consistently since 2011
7. Moving away since 2018, wards advised and paperwork amended to reflect lessons learnt-fully implemented by April 19
8. SaTH has managed Pu's in this way for some time
9. All datix, policies and guidance amended to reflect change
10. SaTH adopted this approach in the main, where there is exemplary care but there was existing lower level damage, the TVN team make a judgement call as to whether a PU can be classed as POA
11. The category POA is on datix to ensure availability more precise local monitoring
12. This has been in place at SaTH for some time
13. They have been for some time, steps are in place to include into local governance reporting systems
14. MASD has long been part of monitoring system at SaTH but not routinely counted, plans in place to ensure info more widely included

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Safeguarding

- New safeguarding lead appointed
- Working collaboratively with TVN team.
- TVN will report all hospital acquired pressure ulcers to safeguarding team and generate safeguarding decision score.
- TVN will identify any themes such as nursing homes/certain district nursing areas/hospital wards to safeguarding lead to ensure appropriate investigation

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NHS
The Shrewsbury and Telford Hospital
NHS Trust

Improving Together

Issue #4 - July, 2019

MY SaTH APP LAUNCHED

New staff app now available to download

GETTING IT RIGHT FIRST TIME (GIRFT)

Making improvements through this national clinically-led programme

Caring | Well-Led | Responsive | Effective | Safer

This regular newsletter demonstrates the steps we are taking to improve against the five CQC domains

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CareQuality Commission

Exemplar
WARD PROGRAMME

TRANSFORMING CARE INSTITUTE

AS A RESULT OF STAFF SURVEY FEEDBACK

Six major changes to our board

We have announced six major changes to our board of directors recently – including that of Paula Clark as our new Chief Executive.

Paula, who has been working in the NHS in the West Midlands since 2005, came out of retirement to join SaTH on Monday 1 July having most recently held the role of Chief Executive at University Hospitals of North Midlands (UHNM).

She said: "I understand the challenges facing our Trust and other healthcare providers across Shropshire, Telford & Wrekin and Mid Wales. These are similar to those facing the NHS nationally, but for rural trusts such as ours they are even more acute.

"As an interim appointment, it means that I'm not going to be with the Trust in the long-term. However, even though I won't be with you for a long time, I'm committed to working with you all to ensure that we develop a plan for a better winter performance. In addition, I will be working with my new executive team colleagues to tackle many of the long-standing issues that face you all.

"I will spend as much time as I can out with you in the services to hear first-hand what you've got to say and what you think needs to be done to make things better. As the people delivering and supporting services you are best placed to help with that endeavour, so please be open with me."

Pictured: Paula Clark
Iterim Chief Executive

Pictured: Arne Rose
Medical Director

Other major changes in recent weeks:

- Dr Arne Rose – Medical Director
- Barbara Beal – Interim Director of Nursing, Midwifery and Quality
- Bev Tabernacle – Interim Deputy Chief Executive
- James Drury – Interim Finance Director
- Dr Edwin Borman - Director of Clinical Effectiveness

Other member of our Executive team are: Nigel Lee (Chief Operating Officer), Victoria Rankin (Workforce Director) and Julia Clarke (Director of Corporate Governance). We are still advertising for a Director of Strategy and Transformation.

Dr Arne Rose said: "I have been really impressed with the people at SaTH – both clinical and non-clinical— for their energy, enthusiasm and their commitment.

"I recognise that there are lots of problems – we are not in special measures for no reason – and there are clinical worries that we need to address, but my feeling is that people are up for that challenge.

# of directors

"It is not just about coming out of special measures, it is about being confident in our services. It is going to be hard, and it is going to be a long journey but I am confident that we can get through it together—and that's because we have got great people here."

Barbara Beal, the former Chief Nurse at London North West Health Care Integrated Teaching Hospital NHS Trust, said: "In my short time at SaTH I have already met with lots of talented and committed people who, like me, are committed to improving the quality, safety, delivery and assurance of standards of clinical care.

"We know there is work to be done but we have a clear vision of how we can improve and enhance patient experience, as well as the clinical and service outcomes experienced by patients, carers and their families."

The Nursing Directorate has been further strengthen by the appointment of Maggie Bailey and Rose Goodwin as Associate Directors of Nursing.

Bev Tabernacle, who joins us on secondment from her role as Director of Nursing and Deputy Chief Executive at The Robert Jones and Agnes Hunt (RJAH) Orthopaedic Hospital NHS Foundation Trust, brings with her a wealth of experience.

She said: "I have been here just over a month and am keen to raise awareness of all the good things that are happening in the Trust as well as looking to address the challenges that it is facing too. Only the other day, while on a genba walk, I heard a great 'stop the line' from Peter Warren, Ward 23 Manager. I have shared this with our Communications Team to spread far and wide and will continue to help push these positive messages.

"I have also been involved in a lot of improvement work during my NHS career, and I also bring with me the experience of helping to take RJAH from a 'requires improvement' CQC rating to 'good' over the last three years."

James Drury said: "We all know the financial pressures facing the NHS as a whole and we at SaTH are no different. What I have seen is a real determination from our teams to make sure we are as efficient as we can be, without impacting on the care we provide to our patients and their families."

Other senior appointments in recent weeks include: Rhia Boyode (Deputy Workforce Director), Obi Hasan (Financial Improvement Director) and Janet Budd (Sustainable Services Programme Director). We also have Sheila Adam is also working at SaTH as Improvement Director from NHSE&I.

Pictured: Babara Beal - Interim Director of Nursing, Midwifery and Quality

Pictured: Bev Tabernacle – Interim Deputy Chief Executive

Pictured: James Drury – Interim Finance Director

Our Quality **Improvement Plan**

CQC "must do actions"

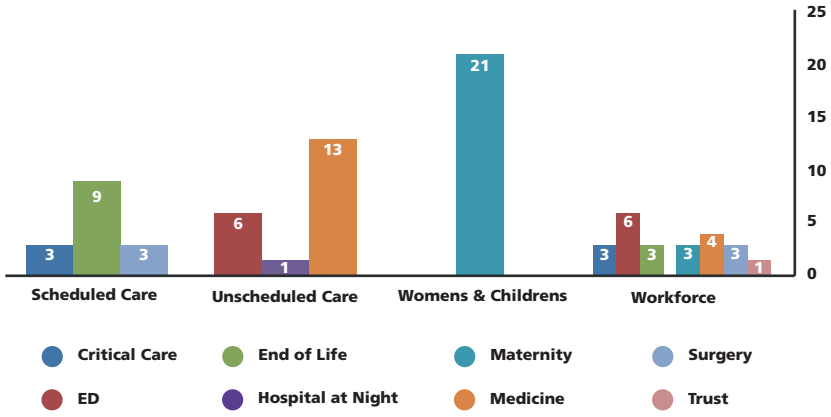
A total of 79 "must do" findings were found at the last CQC inspection – 15 in Scheduled Care, 20 in Unscheduled Care, 21 in Women and Children's and 23 in Workforce.

Following the CQC inspections, action plans were developed with a resolution dates set.

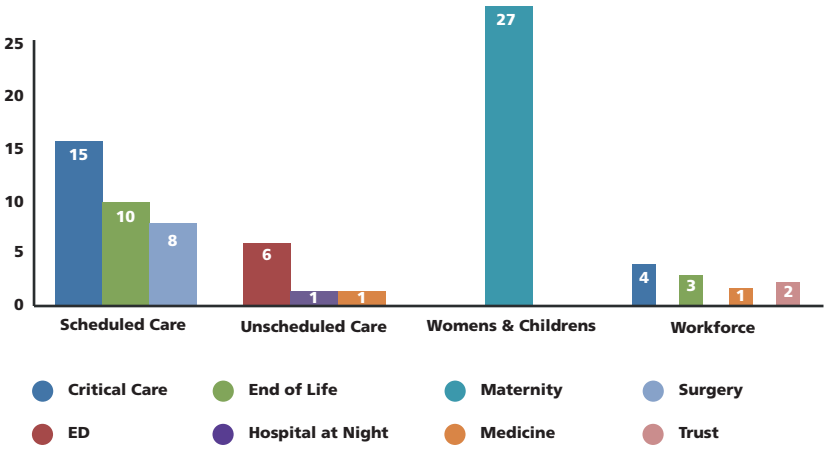
Of the 79 "must do" actions, 23 have been signed off with evidence. A further three are complete but require sign off, while 39 are on track.

Our investigations revealed 266 root causes relating to the 79 "must do" findings, with the majority having multiple root causes to address. Of these, 136 (51%) are either signed off with evidence or complete and awaiting sign off.

"Must Dos" grouped by Improvement Steering Groups (ISGs) and core service



"Should Dos" grouped by Improvement Steering Groups (ISGs) and core service



CQC "should do" actions

A total of 78 "should do" actions were also found at the last CQC inspection – 33 in Scheduled Care, 8 in Unscheduled Care, 27 in Women and Children's and 10 in Workforce.

23 of these have been signed off, while five more have been completed awaiting sign off. 47 are on track.

Our investigations revealed 131 root causes relating to the 78 "should do" findings, with the majority having multiple root causes to address. Of these, 54 (41%) are either signed off with evidence or complete and awaiting sign off.

Next steps

Regular reports will continue be produced to measure progress and our Executive team will support services with any challenges along the way

Improvements this month

Unscheduled Care

Following concerns raised by the CQC about the environment in our A&E Departments – resuscitation doors and medication drawers being kept unlocked, cluttered corridors and agency staff receiving no induction – an action plan has been developed to ensure staff are engaged and the issues are identified. The action plan has resulted in:

- An induction pack being created for agency nurses
- Regular Matron spot checks being carried out
- Executive walkabouts to identify urgent maintenance work
- Electronic monitoring through RATE, with twice daily checks

The improvements have been embedded through regular staff meetings, development days and senior nursing forums. All staff are involved in conducting and analysing audits, while the RATE results are on show in staff rooms.

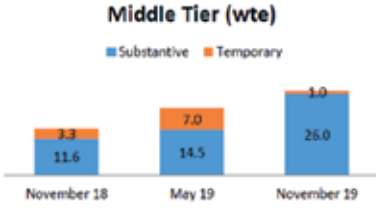
Scheduled Care

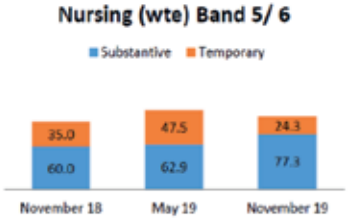
- The pre-operative checklist has been completed and is being launched today (15 July 2019) on both sites. The Five Steps to Safer Surgery has also been completed and is being launched today
- The Never Event Task Group meeting will continue in theatres. This is a monthly meeting looking at actions around the Never Events, alongside actions from the theatre safety day. There is also a monthly theatre safety meeting

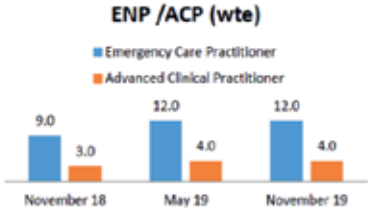
- One of the Root Causes identified a lack of storage on the wards for End of Life Care, but this has been resolved as a dedicated storage cupboard has been created using 5S methodology. Compliance, following audit, is now at 100%

Workforce

- There has been a 74% increase (4 WTE to 6.95 WTE) in substantive Consultants in our Emergency Departments since November 2018. The plan is to employ another substantive consultant by November of this year
- There has been a 25% increase in substantive (11.6 WTE to 14.5 WTE) middle tier doctors in our Emergency Departments since November 2018. We have aspirations to almost double this by the end of the year
- We are participating in the Health Education Global Learners Programme, and already 100 nurses have been recruited ready for placement in Shropshire and Staffordshire STPs







*** A&E Workforce (current and forecast)**

Women and Children's

One of the Root Causes identified, when looking at the CQC actions, was that there was no consistent awareness regarding which clinical events should be reported. To ensure incidents are accurately graded to reflect level of harm, the following has been done:

- A weekly multi-disciplinary review of patient safety incidents has been introduced
- Each clinical incident is now reviewed, logged and evidenced within the Datix system
- Staff receive regular feedback through ward and safety huddles
- The grading of every incident is now reviewed by members of the multi-disciplinary Obstetric Risk Meeting

An app has been launched to transform the way we communicate and engage with you.

The 'My SaTH' app was launched today (15 July) with the aim of improving staff engagement, which was identified as an issue in the 2018 NHS Staff Survey. More than 2,000 people completed the survey and only 28% said they felt that communication between senior management and staff was effective.

The app allows staff to read the latest news and updates and access rotas, while also providing important links to staff development opportunities and the latest benefits and discounts available. It also has a section entitled 'Help for Staff' which has links to Freedom To Speak up Guardians, Health and Wellbeing offers and the Guardian for Safe Working.

Julia Clarke, Director of Corporate Governance at SaTH, said: "My SaTH is about investing in and engaging with you.

"Listening to and engaging with our staff is fundamental to embedding our culture of quality improvement and the My SaTH app is a simple and extremely effective way for us to do just that.

"As use in the app grows over time, you can make suggestions for change and local improvement. These will be fed back to our Communications Team to implement so our teams can see their own ideas being the basis for local change."

The app has been developed by the Trust's Communications Team, in partnership with technology experts Ark, at absolutely zero cost to SaTH. The launch of the App follows the news that more than 100 people have signed up to become Engagement Champions at SaTH - a new role introduced as a result of the disappointing NHS Staff Survey feedback.

AS A RESULT OF STAFF SURVEY FEEDBACK

Download our F

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Mobile

- Read the latest ne
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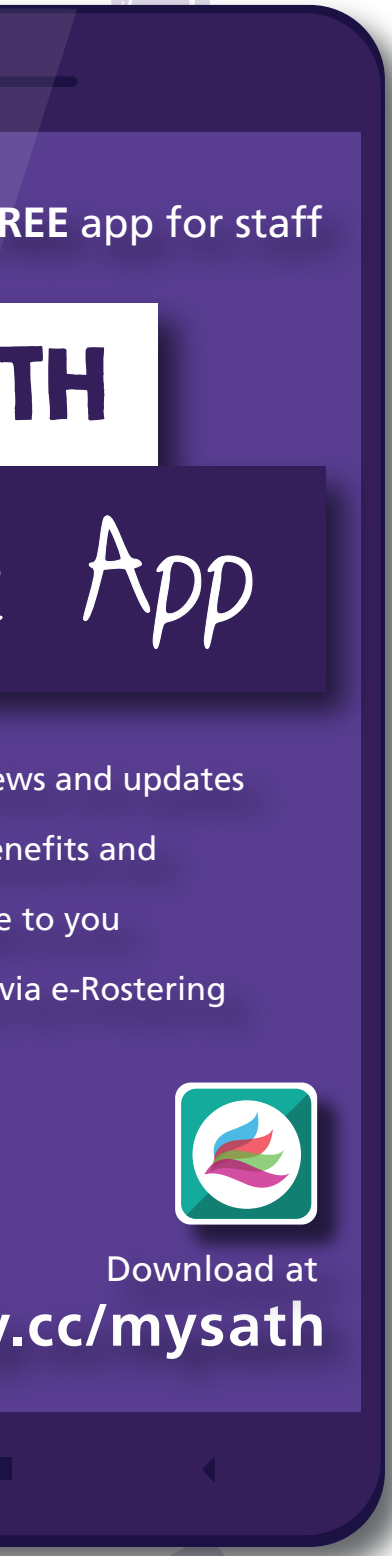
- Help for staff
- Latest jobs

http://tiny

Available for Android and Apple devices



apple

1) Open your internet browser and go to http://tiny.cc/mysath

2) Click the button to install the App. One you do this return to your phone's home page where the App will be installing.

3) When you go to open the App you will get the following message:

AS YOUR EMPLOYER WE CAN CONFIRM THE APP IS SAFE TO DOWNLOAD

4) To 'trust' the App so you can download it you need to go into your phone's settings and do the following:

Go to 'General'
Click on 'Device Management' or 'Profile'
Click on Chapelcroft Limited
Select Trust Chapelcroft

5) You can now open the App. When doing so we recommend you allow push notifications to reduce your chance of missing important messages.

android

1) Open your internet browser and go to http://tiny.cc/mysath

2) A pop-up will appear asking if you want to download the file. This is a trusted app and will not harm your phone. Click 'Download' to proceed.

3) The App download will show up in your notification centre—click on this.

4) When you open the App it you will get the following message: "For security reasons your phone is not allowed to install unknown apps from this source"

5) Click 'Settings'. You get this message because it has not been downloaded through the traditional App store method.

AS YOUR EMPLOYER WE CAN CONFIRM THE APP IS SAFE TO DOWNLOAD

6) Once in Settings turn on 'Allow from this source'

7) Your phone will ask if you want to install the App—click 'install'.

8) You can now open the App. When doing so we recommend you allow push notifications to reduce your chance of missing important messages.

FOR MORE INFORMATION PLEASE VISIT THE
STAFF INTRANET AND SEARCH FOR "APP"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News in Brief

Sepsis Nurse appointed

We have appointed our first Sepsis Nurse Practitioner to strengthen and implement the advancements that have already been made in Sepsis care.

Angela Windsor, who takes on the role following her work at the Trust as a Resuscitation Officer, will facilitate a push forward in the way we detect and treats Sepsis and ensure that this work is sustainable.

She said: "I am passionate about ensuring the best possible care for our most vulnerable patients and I am also privileged to have worked with so many staff who share my passion and are equally dedicated.

"I believe that we can bring about demonstrable improvements in the quality of care for patients with sepsis and improve patient outcomes by making small changes.

"There is excellent work that has already begun within the trust and in departments to further enhance sepsis care provision and I hope to be able to work alongside all of the teams to build on this and ensure that these improvements are sustained and stand the test of time."

Learning Disability Workshops

We held a workshop recently to educate staff about patients with learning disabilities.

The workshop, which was held during Learning Disability Week (17-23 June), was an information sharing event based around discussion and the telling of personal stories. Discussion centred around 'what values do you think are important when working with a learning disability?' while also highlighting the importance of 'The Patient Passport' and a 'one page profile' - both of which give hospital staff important information about individual patients.

Karen Breese, Dementia Clinical Nurse Specialist at SaTH who organised the event through her passion of helping people with cognitive impairments, said: "This was an excellent opportunity for us to have really important conversations, and to ensure we all understand what it means to have a learning disability."

Start of Change Weeks

We have carried out two Acute Medicine Start of Change Weeks at RSH and PRH to improve our urgent and emergency care.

The redesign work, carried out across a fortnight with The Emergency Care Intensive Support Team (ECIST), aimed for patients to be seen by the right senior clinician for their needs more quickly and to be cared for in a better environment.

Pressure was relieved on our busy A&E departments, allowing them to stream patients more efficiently and Acute Medical Unit (AMU) ward staff benefitted from receiving appropriate patients with less delay.

Acute Medicine Start of Change Weeks innovations included:

- A revised Acute Medical Model with a mix of beds and Acute Medical Assessment trolleys to assess patients 'at the front door'
- Protected ward areas for emergency patients
- An enhanced skill mix of staff with extended hours of service and increased weekend cover across acute medicine and improved systems and processes
- Our AMU, Short-stay and Same Day Emergency Care teams will continue to develop the successful changes that were introduced across the Acute Medicine Start of Change Weeks.

Small things make a big difference fund

Following a blazing hot summer of 2018, we have ordered 250 bladed fans Small Things Make a Big Difference Fund to keep its staff cool this summer.

What else was awarded last month?

- New kit for the PRH pharmacy team's rounders club
- Paint and shelves to improve the Endoscopy team's office surroundings
- New cutlery for the physiotherapy and occupational therapy teams to use during lunch breaks
- Microwave for the staff room on Ward 25
- Fridge for the staff working in Medical Records

For more information about the Fund – including how to make an application – please visit http://intranet.sath.nhs.uk/hr/smallthings.asp

Exemplar

Getting It Right First Time (GIRFT)

GETTING IT RIGHT FIRST TIME

As part of our quality improvement work, the Getting It Right First Time (GIRFT) programme has been a big focus over the last 12 months.

The GIRFT programme looks at unwarranted variation in the way services are delivered and the outcomes they achieve. 12 of our departments have already welcomed the GIRFT team, with three more visits already booked for the coming months.

The visits have highlighted a number of areas of good practice, such as:

- In paediatrics, where any child who is admitted after presenting at the Emergency Department is allocated a named paediatrician to co-ordinate their care
- The orthopaedic department has also been praised for reducing its loan kit spend by reviewing and re-negotiating contracts

Other departments are also making good progress against their GIRFT actions:

- The Renal team were commended for good practice in a range of areas including: Definitive access, infection control, low bacteraemia and peritonitis, low hospitalisation of prevalent Haemodialysis cohort, home therapies service, low amputation rates and data returns.
- The clinical coding team is meeting regularly with surgical colleagues to share information and review coding practices, with particular success in oral and maxillofacial surgery, where a dedicated specialty coder has been assigned to validate work
- In orthopaedics, we are undergoing a significant redesign of services, which has seen 14 ring-fenced beds secured for elective and emergency surgery
- The anaesthetic list for orthopaedics has also been standardised and consultants are now using a cemented prosthesis, as recommended, for hip replacements
- In obstetrics and gynaecology, three consultants are offering laparoscopic hysterectomy, moving away from open surgery which carries both a greater risk and longer recovery time. In some cases, this surgery is now being offered as a day case

We'll continue to share updates on the programme and our progress but if you'd like to know more in the meantime, please contact SaTH GIRFT lead and Senior PMO Manager Keith Roberts – keith.roberts5@nhs.net.

Exemplar

WARD PROGRAMME

All wards have received at least one Exemplar baseline assessment to highlight quality standards which are performing well and those which require further work.

The 11 Quality standards we measure against are: Environment, Infection Prevention and Control, Documentation, Tissue Viability, Falls, Nutrition and Hydration, Communications, Professional Standards, Care and Compassion and Medicines Management.

Meanwhile, nursing documentation has been reviewed to identify and remove waste or duplication. The new documentation is now being trialled on three wards during June and will be rolled out trust-wide in September.

Learning from complaints

Complaint: Patient unhappy about cancelled appointment

Cause: Information given at the time of the cancellation was not accurate

Action taken: Staff in bookings have script to ensure that they provide the correct information for short-notice cancellations

Complaint: Delays in transport

Cause: Confusion over transport requirements

Action taken: Trust and Falck working together to review the bookings process

Complaint: Interpreter not present at appointment

Cause: Problems with booking system

Action taken: Bookings to be logged on PAS and confirmation details filed with the referral ready for the appointment

Freedom to Speak Up

Two new Freedom to Speak Up Guardians have been appointed, bring the total number at SaTH to three.

Teresa Carrington and Chan Kaur have join Kate Adney to strengthen the team, which will cover the entire Trust.

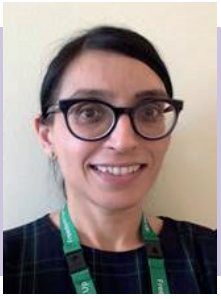
Kate said: "Chan is already a familiar face as a SATH2Home Co-ordinator based at PRH, and Teresa has worked at the Trust for many years, most recently as a Day Surgery Ward Manager at RSH.

"We are all looking forward to strengthening the profile and presence of the important work we do across the Trust, and are pleased to report that Medical Director, Dr Arne Rose, is now in place at the Executive Lead for Freedom to Speak Up."

Freedom to Speak up Guardians exist in all NHS Trusts. They act in an independent capacity to make our hospitals safer for patients and staff by encouraging a more honest environment where raising concerns is common practice.

In addition to our three Freedom to Speak Up Guardians, we also have a network of 24 Freedom to Speak up Advocates across both hospital sites. Advocates help to raise the profile of Freedom to Speak Up and provide informal and confidential guidance in their areas of work.

The role of Freedom to Speak Up Advocate is voluntary. If you are interested in becoming an Advocate we would be delighted to hear from you. Please email ftsu.sath@nhs.net



Chan Kaur
Freedom to Speak Up Guardian

Kate Adney
Freedom to Speak Up Guardian

Teresa Carrington
Freedom to Speak Up Guardian

Leadership Academy

More than 80 people took part in a new programme last week aimed at providing staff with skills and tools to enhance their thinking.

The ThinkON People Manager Workshop has previously been delivered to the Board of Directors and the Senior Leadership Team, but is now being rolled out across the organisation with the first of the courses being held at Shrewsbury Town Football Club on Thursday 11 July.

Two more courses – both to be held in Telford – are available to book online through the Training Diary on the Intranet, while more dates will be made available soon. The course is being run through our Leadership Academy.

A new Maternity Movement Bracelet has been launched

Pictured: Maternity Movement bracelet

Pictured: Louise Macleod

A new Maternity Movement Bracelet has been launched to help pregnant women under our care to track the movements of their unborn baby.

Funded and supported by The Local Maternity System (LMS) in Shropshire and Telford & Wrekin, the Maternity Movement Bracelet will be given to expectant mums at 24 weeks of pregnancy.

The Maternity Movement Bracelet has 14 beads with a Tiger Eye bead, known for releasing fear and anxiety, to mark the start of the day. Expectant mums then simply move a small hoop around each bead on the bracelet when an episode of movement is experienced. By doing this they should find it easier to notice their baby's pattern of movement and understand when to expect to feel movement.

The Maternity Movement Bracelet was developed by Louise Macleod who also works for the LMS. Louise said: "I came up with the idea of the bracelet when I was pregnant but couldn't find anything to help me monitor my baby's movements.

"I created a beaded bracelet using craft supplies and wore it from 25 weeks onwards. I found it particularly reassuring on busy days when I couldn't concentrate on my baby's movements as I normally would, and it helped me notice patterns of movement I don't think I would have otherwise have found. "Once my son arrived and I was breastfeeding, I used the bracelet to remind me which side I needed to feed on next by swapping it from wrist to wrist, and it was great at the beginning to help me monitor how many times he had fed each day."

Anthea Gregory-Page, Deputy Head of Midwifery at SaTH, said: "By using the bracelet we hope that any changes to a baby's movements will be noticed at the earliest opportunity and encourage expectant mothers to contact their midwife if they have any concerns. The bracelet comes with instructions on how to use it and information on who to contact should any changes or reduced movement be experienced."

Fiona Ellis, Programme Manager for Shropshire and Telford & Wrekin LMS said: "The aim of the Maternity Movement Bracelet is to encourage women to monitor their baby's movements and know what to do if they are worried. Feeling your baby move is a sign they are well, so it is really important if you notice your baby isn't moving as much as usual or there has been a change in the movement patterns that you call 01952 565948/01952 565712 immediately."

The launch of the Maternity Movement Bracelet forms part of a wider campaign launched earlier this year to raise awareness of the importance of monitoring baby movements.

To find out more about the Maternity Movement Bracelet, please contact louise.macleod5@nhs.net or speak to your midwife.

Transforming Care

The hospital trusts working in partnership with the USA's 'Hospital of the Decade' came together to share the improvements they have made through 'lean' working.

The NHS partnership with Virginia Mason Institute (VMI) was launched in 2015 and on 26 June the five Trusts gathered at SaTH to share how they have developed a lean culture of continuous improvement which puts patients first.

- The team from Surrey and Sussex Healthcare NHS Trust gave a presentation on the work they have done to become ranked in the top 20% of hospitals nationally as a place to work and receive treatment in the most recent national NHS Staff Survey.
- The team at University Hospitals Coventry and Warwickshire NHS Trust gave a presentation on the work they have done that saw them winning a 2018 HSJ Patient Safety Award.
- Leeds Teaching Hospitals NHS Trust gave a presentation on the work they have done that resulted in them being named Finance Team of the Year at the National Healthcare Finance Awards after they delivered the largest surplus in its 20-year history in 2017/18.
- Barking, Havering and Redbridge University Hospitals NHS Trust's gave a presentation on the work they have done to introduce cultural change and improve engagement levels with executive and divisional directors.
- Four teams from SaTH gave short presentations. They included the work done throughout the Respiratory Value Stream, which includes a two-day reduction in length of stay, and our Procurement Team who were nominated for a HSJ Value Award after they made a £1.8m saving.

Mr Tony Fox, Vascular Consultant and the medical lead for SaTH's improvement work in partnership with VMI, said: "To hear so many positive examples of how hospitals across the UK are changing the way they deliver healthcare is incredibly powerful.

"Sometimes we can think we're alone in the challenges we face but when you listen to stories from other organisations you realise everyone is overcoming issues through really innovative ideas that are being driven from the bottom up.

"By working collaboratively like this we all learn from one another. The challenge going forward is for those of us at the event to engage with the rest of the organisation and spread the messages we heard."

He added: "Our Transforming Care Production System (TCPS) is here to stay. This is the way we now do things at SaTH and how we will improve."

Representatives from 14 different trusts attended the Sharing Event, organised by SaTH's Kaizen Promotion Office (KPO) Team.

Mother-of-four Julie Southcombe, who has worked closely with us to improve ophthalmology services also spoke at the conference, providing a patient's voice.

She said: "I was sceptical and dubious of SaTH's Transforming Care work when I was first asked to get involved. I wanted to have a voice but had concerns it would not be heard amongst doctors and nurses, but I am so pleased and excited I got involved, as having a patient's voice is of huge value to the Trust and the staff here really appreciate my contribution.

"I would recommend the process to anyone wanting to get involved. What we have done, and what we hope to achieve in the future, is rewarding, exciting and very constructive. By having different voices from different backgrounds you make sound decisions. It is also ok to fail because there is no blame culture within the Transforming Care Institute, and by eliminating blame you promote creativity so you can try new ideas in a safe environment."

Genba Walk

Executive team buy-in is vital for the success of our Transforming Care Production System (TCPS) to be a success.

During the Sharing Event, Dr Edwin Borman, Director for Clinical Effectiveness, joined our new Sepsis Nurse, Angela Windsor, on a genba walk on the Emergency Department at RSH, Ward 25 and the Pathology Department to learn more about the improvements being made to ensure sepsis is recognised and treated as quickly as possible.

In A&E he was told about plans to make the department's Sepsis Trolley more accessible by having it in 'pit stop'. On Ward 25, Ward Manager Mandie Esp demonstrated their improvement work, which included easy access to a fully stocked sepsis cabinet, box and stand.

In the Pathology laboratory, Alan Jackson, Head Biomedical Scientist, explained how they have streamlined their work to ensure patients are given the most effective antibiotics at the earliest opportunity.

Date and Time	Event Type
Every Friday (12.30pm)	Staff Kaizen Huddle
18 July and 15 August	**Guiding Team – Transforming Care Accountability Wall**
19 July	Production Board training session
19 July and 16 August	**Transforming Care Production System Training**
26 July (12.30pm)	Lung Cancer pathway Kaizen Event#2 Report out
29 July and 28 August	**Two Day 5S Training**

Spotlight on...

A new model of care has been launched at SaTH to improve outcomes and reduce the length of stay in hospital for patients undergoing hip and knee replacements.

It follows a successful year-long pilot of an Enhanced Recovery programme at the Princess Royal Hospital (PRH) in Telford for those having elective surgery for joint replacements.

This new approach aims to improve the patient's experience and recovery and halve the amount of time they spend in hospital by making them active in their own recovery, and helping to ensure that they are better prepared to manage when back at home. The MSK (musculoskeletal) team at SaTH is behind the launch of the project.

It involves a multidisciplinary team - including orthopaedic consultants, specialist nurses and therapists – working together to ensure a patient is discharged from hospital following their joint replacement as quickly and as safely as possible. The aim is to reduce a patient's length of stay in hospital from an average of 6.3 days to 3 days.

Under the programme, the new model of care has:

- A new orthopaedic ring-fenced bedded ward (Ward 8) at PRH dedicated to Enhanced Recovery for hip and knee replacement patients
- A new Joint School which will educate patients and prepare them for their surgery and rehabilitation at home. They, and their 'buddy' (a relative, carer or friend, will also be able to meet the team involved in their treatment
- New protocol written for anaesthetic pathways to aid recovery
- New booklet developed to guide patients through their pathway

Nigel Lee, Chief Operating Officer at SaTH, said: "This will be of great benefit to all of our patients who need hip and knee replacement surgery. Not only will it improve clinical outcomes, it will streamline and improve their experience at what can be a stressful time and enable them to get home, where they want to be, much quicker. "This is a real success story for SaTH."

Contact Us:

Please send your feedback and story ideas to:
sath.communications@nhs.net