The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	SaTH Trust Board
Paper Title	Transforming Care/ Improvement Plan Update
Date of meeting	28/11/2019
Date paper was written	18 November 2019
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Author	Bev Tabernacle-Pennington, Director of Transformation and Strategy Rajinder Biran, Head of Improving Care PMO Louise Brennon, Head of KPO

Executive Summary

This paper describes the process undertaken to map and merge the Improvement work streams across the organisation since July 2019. This included the development of a central improvement PMO, utilising the current resource, alongside the investment to fully support the CIP delivery plan across the Care Group/ Corporate structures.

In July 2019 we undertook an initial mapping of the Quality Improvement initiatives which are currently in place across the organisation: The aims and objectives for this work are set out below.

Aim

The aim of the event is to bring together for an open discussion the people who are involved in the various initiatives across the organisation in relation to improving our services.

Objectives

- To develop an understanding of the various areas supporting quality improvement currently in place
- Identify areas of overlap and look for solutions to overcome or work with this
- To start discussions about how we can prioritise work streams to be supporting the overall Trust vision and objectives
- To allow open discussions about possible changes required moving forward

Alongside this work we have also received input from the Doelloite work who recommends the development of an internal PMO structure to support the financial improvement plan going forward.

This month's report sets out how we will now report jointly on the organisations improvement work as we move into phase 2 to develop our Improvement priorities and support delivery of these through the PMO function.

The Board are asked to:

To formally receive and discuss a report and approve its recommendations.

Previously considered by	

The Board 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 risk(s)	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

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

Introduction

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To allow open discussions about possible changes required moving forward Numerous improvement streams were identified. One of the main discussion points in the meeting was the lack of priority setting in order to understand fully what we are trying to achieve, alongside the overlap and lack of understanding about the many work streams and how these currently work to address the Quality deficits identified to date. Member of the workshop acknowledged the need for a 'Golden Thread' through our work to understand what we are setting out to achieve.

The discussion also acknowledged the work that needs to be undertaken to ensure the work completed across these schemes has a focus on transformation, sustainability and financial improvement.

A workshop was held with the leads for each element invited to contribute. When they were unable to attend an individual 1:1 meeting was held to understand and discuss this work. The area covered were;

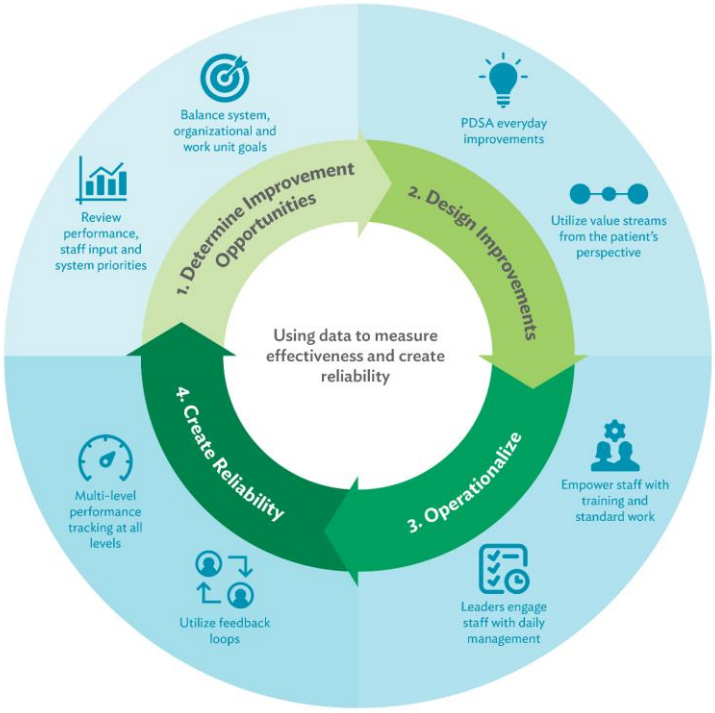
Each of the core work streams were mapped to understand where the focus of work was, progress made, resource to support and then any gaps identified. The main elements for discussion were;

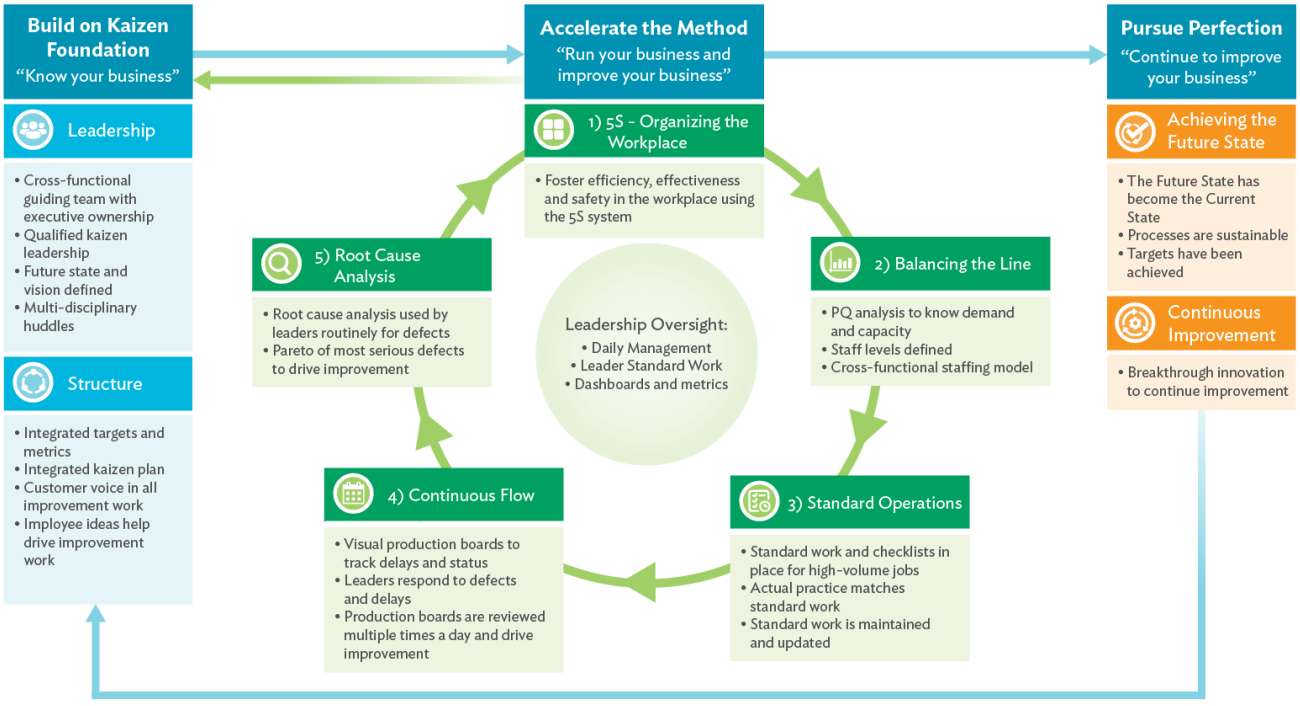
- Think about how collaboration can occur and what is needed to support this?
- Think about how you currently work within the departments across the Trust and how you feel this may be conducted in a more efficient manner?
- Think about what your priorities are within your area, so that we can then think about how these become more focused across the many schemes?

The Outputs from the discussions for each scheme is outlined in **Appendix 1.**

Since the workshop discussions we have enabled more collaboration between the improvement streams with a particular emphasis on the KPO team working more collaboratively to support the QIP plans in place. The improvement methodology has been utilised to test the sustainability of the plans put in place by the ISG's for example the use of Genba walks.

Through this work we want to be able to build a systematic approach to improvement building on the work to date:





At the beginning of October the Associate Director for Transformation and Strategy commenced in post and has now started to bring the teams together in order to progress the development of the PMO and bring into this the whole improvement process including the financial CIP delivery.

The latter will need approval of a business case for the posts to support the team implementing the recommendations from the dolloite work. This is currently under development and once approved by the executive team will come to Trust Board for approval.

Current Situation Update

Kaizen Promotion Office (KPO) Activity

Rapid Process Improvement Week (RPIW)

The latest Surgical Pathway Value Stream RPIW was held 4 - 8 November 2019. The scope of the RPIW was to explore the planning for Radiographer and equipment allocation in theatres.

The RPIW looked at resolving one of our biggest logistical challenges in theatres - the clashes that we see between specialities for using the limited radiology resources (equipment and people) in Theatres. By looking at how we make changes to the planning of lists, and how we accommodate emergency demands, the team were able to arrive at a plan that is less frustrating for all the staff involved, enables less downtime, enables us to treat patients more quickly, and reduces the likelihood of delays leading to list overruns and cancellations. Whilst many of these processes are invisible to patients, effective planning in this area will absolutely have a positive impact on the quality and safety of care that we are able to provide.

Kaizen Event

The next Kaizen event is taking place 18 - 20 November 2019 for the Lung Cancer Pathway Value Stream and will be supported by the KPO Team and Paula Davies (Head of Procurement and Advance Lean Trained Graduate). The boundaries are, From when a patients X-Ray report is reported as a suspicion of lung cancer, To when the patients CT report is completed.

The purpose of this kaizen event is to review and improve the lung cancer pathway, to ensure compliance with the National Optimal Lung Cancer Pathway (NOLCP). This event will focus on the early part of the pathway (NOLCP day -3 to 0) from when a patient has a chest x-ray that is reported as suspicious for lung cancer to when a CT scan is reported for this patient. This is an opportunity to test out an alert system for chest x-rays with suspicion of lung cancer and to create standard work for the future.

Training

During October and November 2019, the KPO Team, with support from Tony Fox (Vascular Consultant and Advanced Lean Graduate) have delivered Session #3 of the Lean for Leaders training programme to 3 cohorts.

The candidates reported out their practical application, and in session learnt:

- How to use 5S to visually manage a space
- How to use setup reduction to reduce lead time
- How to use the four elements of mistake-proofing to address defects
- Understand how to promote innovation and core creativity concepts
- Practice directed creativity techniques

Trust Value Streams Update and Progress

The SaTH Guiding Team is going through a period of transition. The meeting is now called the Transforming Care Partnership Board (TCPB). The terms of reference of the TCPB remains the same but with a plan to be more inclusive of other internal and external partners.

The focus of the TCPB is to ensure there is alignment of the organisational priorities and goals to the current value streams. We have undertaken a review of the current value streams and will be making a number of changes to the ones currently supported. We have agreed to move a number to standard work. New value streams are in development and these include:

- Acute Medicine
- Frailty

- A review of the current A/E work stream will occur to ensure re focus on the areas which need support

Stroke Care will also be an area of focus supported by L4L.

The TCPB team received the Virginia Mason Institute Transformation Journey Quarterly Report at the October 2019 meeting.

The following recommendations have guided the actions and outcomes for the team:

- Direct the excitement and momentum surrounding 'TCPS' to communicate constantly and regularly in live venues, on paper, genba walks, etc
- Support more intentional targeting of untapped leaders who have declined multiple L4L invitations. Plan for level of accountability and disciplined use of TCPS at SLT level. Linkage of training to existing operational challenges/initiatives could be key. Follow through on June 2019 commitment to Band 7 declaration.
- Development of a true organisational strategic plan will improve and empower the executive team and SLT to clearly delineate the highest priorities for SaTH and direct those to utilise TCPS.
- Identify standard work to onboard new TCPB members and communicate the importance of thinking of their work within the context of TCPS, instead of separate/extra, to ensure better alignment and cleaner messaging.
- Recommend that the TCPB discuss and decide on their roles in overseeing/monitoring the value streams after they have transitioned to operations.
- "Think with your hands" – PDSA the BRAG Board on EGRs to assess TCPS where L4L presence exists; find themes where strengths and gaps lie in the system's reaction to TCPS.
- Celebrate those leaders who are effectively using Daily Management. Identify and share through Trust-wide Comms their simple, but powerful behaviours and actions that exemplify TCPS.

Quality Improvement Plan

We are now moving into Phase 2 of our improvement plan, the planning for this has commenced and we have been looking across organisations to explore how this has been undertaken elsewhere. We are keen to set out our improvement methodology and processes in our Improvement strategy with some key areas for improvement clearly articulated and time frames and measures in place to support this. The review and re prioritisation of the value streams is a key element of this work as will be the CQC initial findings and final report. However we still have our active QIP in place and it remains important to update on the progress to date. Please find attached appendix for information and assurance:

Appendix 2 Quality and People Report – This provides an update to board on the measures and assurance given to the SOAG meeting which occur monthly with NHSi, CQC and numerous other partners

Appendix Three_20191101 SaTH QIP Dashboard Cycle 18 Findings – This provides an overview by CQC finding by Internal Steering Group (ISG) and a consolidated Trust view.

Appendix Four_20191101 SaTH QIP Dashboard Cycle 18 Root Cause - This provides an overview by Trust root causes identified by CQC findings, by Internal Steering Group (ISG) and a consolidated Trust view.

Appendix Five_QIP CQC Finding Dashboard Cycle 18 – This provides an overview dashboard by Finding, mapped back to domain status. In summary, Workforce and USCG have Quality Improvement plans remaining open to be addressed.

Time Period: Cycle 18 is up to the 01 November 2019.

Summary Review:

The Trust has made progress through Cycle 18, with 117 Findings of 157 Must Do and Should Do Findings now complete or signed off (75%). This is behind the planned trajectory of 125 by the end of October.

There are currently 11 Findings that are complete and waiting sign off at the Cycle 19 ISG.
90% of all Findings rated as on track, complete or signed off. However, 15 Findings were identified as being off track with some Findings completed ahead of trajectory.
• Women and Children's are rated **Green** at Cycle 18 with 43 of 48 Findings now Complete or Signed Off (90%) and the remaining 5 Findings On Track.
• Scheduled Care continues to be rated as **Green** with 40 of 48 Findings now Complete or Signed off (83%) and the remaining 8 Findings On Track.
• Unscheduled Care RAG status remains **Amber** with 22 of 28 (79%) of all actions are now either signed off or complete.

There are 5 off track issues listed below :
MD041 - Corporate - Mental Health - Implementation of ReSPECT form is being driven by local health economy. Root Cause requires post implementation audit so will not be completed at this point.
MD036 - Corporate - Equipment task & finish group set up. There are plans in hand to ensure completion and closure of all equipment related actions.
MD047- Corporate - One minute brief to be created and circulated.
MD034 - Corporate - On going work to identify protected Meal Times and to review capacity issues.
MD045 - Corporate. Assurance of progress being sought from Sepsis Working Group/Sepsis Nurse Practitioner.
• Workforce RAG Status is **Amber**, with 12 of 33 (36%) of all actions are now either signed off or complete, with 10 Finding Off Track.
Most of the actions due for completion later than the other ISG's, with the majority of actions due for completion by March 2020 with one final action due for December 2020.

Off Track item listed below :
MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6). There are plans in hand to recruit from internal sources and support the retention of current staff.
MDTRAIN01.9 The Trust must ensure staff complete mandatory training in line with the Trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9)
MD067.21.Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision. This is a wider health economy concern with integrated support required.

Conclusion

Progress is being made on supporting the improvement structures within the Trust to be more aligned and supportive of one another and some of the areas which are in need of improvement support.

A refocus on the value streams will enable the capacity within the team to be released from standard work in order to concentrate their efforts on more urgent matters.

A business case for further support to the team will be developed whilst looking at the current resource and ensuring all roles are working in the most effective and efficient way.

Recommendation

The Trust Board are asked to note:

- VMI Transformational Sensei Melissa Lin will undertake her quarterly visit to SaTH on 16-20 December 2019 and she is keen to spend time with the Executive and Non-Executive Teams.
- The next Rapid Process Improvement Week (RPIW) report out will be on Friday 6 December 2019, for the Surgical Pathway Value Stream RPIW #6 at 12:30 hours in the Dinwoodie Lecture Theatre, SECC, RSH or via video link to the Education Centre, PRH.
- The Trust Board is asked to note the development and emerging changes to Service Transformation within the Trust. Improved structure and realignment of roles is in hand. To

strengthen delivery and ensure Quality, Finance, Performance and Workforce are all balanced through a central structured transformation approach.

- The Phase II QIP Plans will be developed in conjunction with service transformation with enhanced delivery support from the KPO team. The current approach is looking at realigning the findings to Value streams to ensure themes are identified and owned Trust wide, rather than in pockets where the finding is identified.
- Development of a centralised PMO will continue with a business plan to be supported by executives and approved by Board in December 2019.

Appendix 1 Workshop Discussion and Output

Discussion

There has been a full consensus that the current work streams can and should work more collaboratively in order to ensure that they are driving improvement in the right places. However in order to do this some key priorities need to be clearly set out and agreed across both the Executive Group and also the Senior leadership Teams.

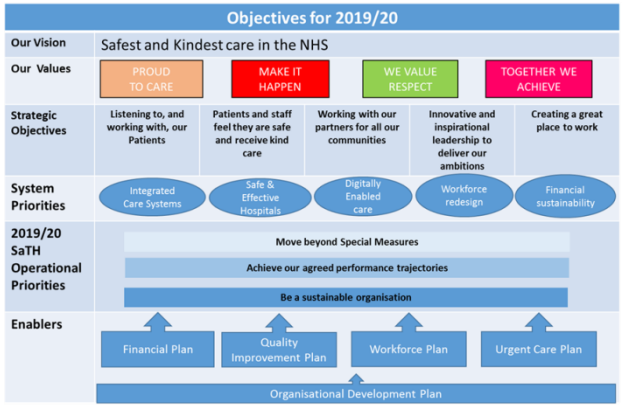
There was a can do attitude expressed about how we can do this moving forward, and how the overlap and support each scheme offers could work positively in the future.

There was another element identified in relation to ensuring the work was focusing on SATH's key areas of risk. An additional piece of work is to be completed to ensure that when the priorities are identified that the Risk register/ High Risks are assessed to ensure that the priorities identified link to improvement required in these areas.

The Trust currently doesn't have a clinical strategy. There is an opportunity to develop this quickly in order to support this work more fully setting out our clinical service direction as we move into the implementation phase of our Transforming Hospitals Programme (THP).

There was also discussion around the Trusts current Strategy and Vision. Attendees were not clear on these, and could not articulate the main drivers for our strategy work. This needs further testing from Ward to Board to ensure this assumption is correct. The Diagram below outlines the current Trust Vision and Strategy.

Out of the discussions there were some key overlapping areas. Workforce discussions were included for every element; the THP was a key priority for 2 reasons: firstly the current need to get the OBC/SOC completed, and secondly the impact of this programme on workforce, clinical services, estate, collaborative working to name a few. We also discussed how patients are involved in our schemes and this was minimal. Therefore the following areas are suggested to frame discussions going forward.



Suggested areas for focus were:

- Working collaboratively to ensure that the Hospital Transformation programme is implemented
- Enabling our workforce to have the right skills, behaviours and culture to provide outstanding care across all services
- Co-producing our services with our patients and partners
- Ensuring we care for our finances

We would then be able to map our key priority areas/ indicators against these. We also discussed some gaps in relation to the enablers needed to support. These were:

- Trust Quality Strategy
- Trust Clinical Strategy
- Patient Experience Strategy
- Workforce and OD strategy
- IT Strategy

Conclusion

The meeting had a positive outcome in relation to developing the awareness of schemes for improvement across the organisation. It also supported the hypothesis that there is more opportunity for collaboration to be explored and agreed. There were some quick wins identified in the meeting to move this work forward for example the Exemplar programme incorporating the Genba process from KPO and support for action and improvement.

This work has also assisted in assessing whether our strategic intent should be revisited or indeed developed. The lack of a clinical strategy particularly influences the schemes development of a core purpose, and should be addressed immediately.

In order to further develop a collaborative improvement process it is recommended that we develop a **Transforming Care Partnership Board** to bring together all of the necessary elements. Within the VMI Programme we have the Guiding team meetings already in place, in order to further build on this and ensure that we have linkage and golden thread of improvement being driven in areas of priority it is proposed that this group becomes the Transforming Care Partnership Board and the agenda participation is widened. This will ensure we are keeping to our pledge of not putting another meeting in without review the purpose of current meetings in place. This will be initiated at the meeting arranged for August and the Board will run from there on a monthly basis.

This Board will enable all the work streams to be brought together in one place to work in partnership. Further work will be undertaken alongside the meetings review to ensure this has a fit into the Trust Governance processes.

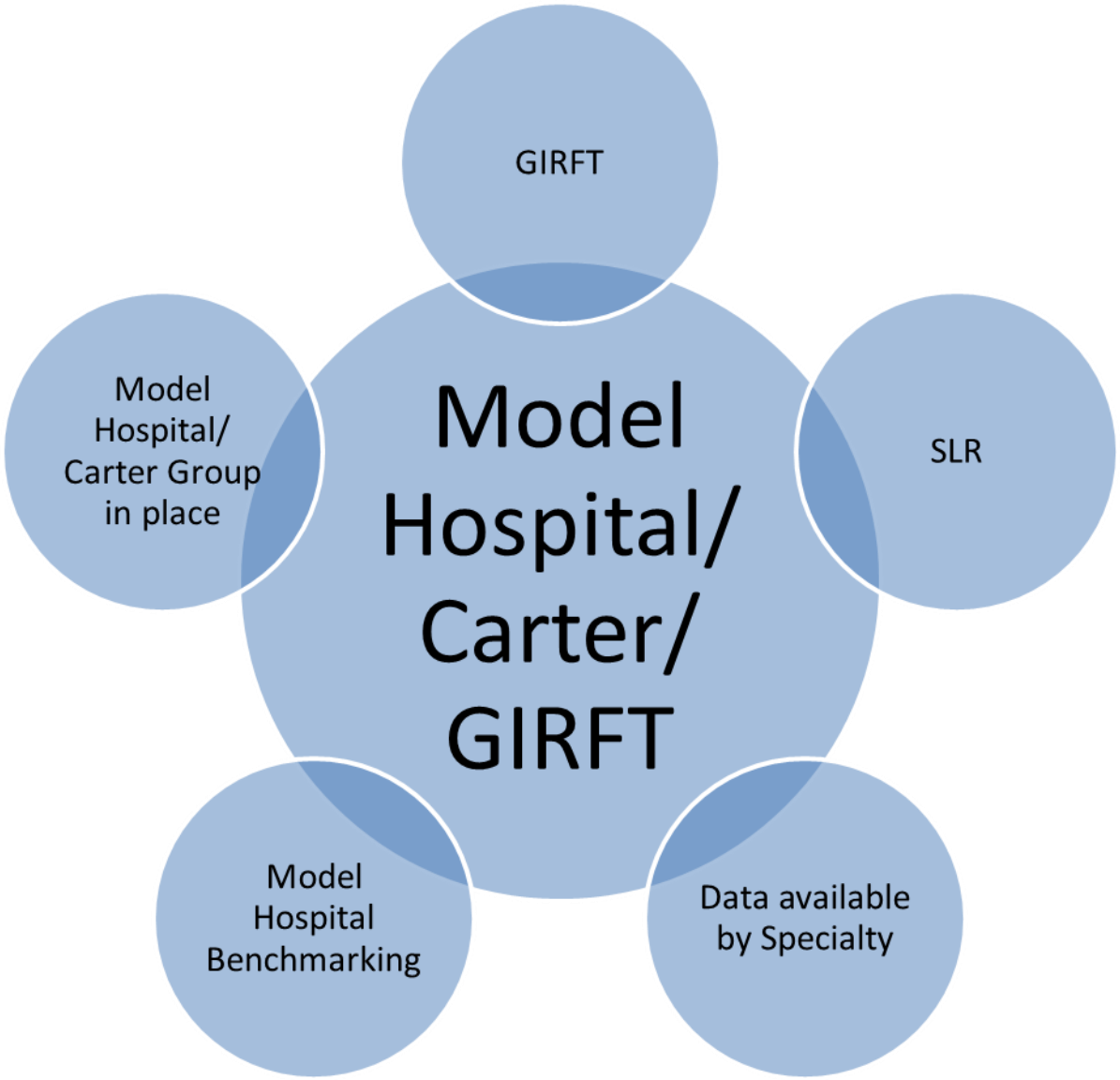
This will also open opportunities for us to be structured in relation to influencing and contributing to the wider quality initiatives across the Shropshire System work which is currently emerging.

The Executive portfolios have subsequently been agreed and the Deputy Chief Executive portfolio will include QIP, THP, KPO, STP/ Partnerships and Model Hospital et al. This will help to align the improvement and transformation work going forward.

1. Sepsis – on-going for 2.5 years
2. Outpatients – ophthalmology – looking to transfer and roll out this to other specialities
3. Recruitment – non medical recruitment process – has been handed back to the recruitment team – started to look at medical recruitment
4. Radiology – colorectal patients – has been handed back
5. ED – whole pathway – majors / minors, documentation
6. Surgical – 8 months old. Tested with one speciality – not looking at – safety in theatre, prepared, list start on time.
7. Patient Safety is 5th value stream in TCPS
8. Respiratory discharge – this has transitioned back. Has handed over 12 months

Resource:
4 Advanced Lean Trainers, 2 B4 Facilitators, Band 2 Admin. KPO Lead. 2 PA Clinical Lead Procurement provide support

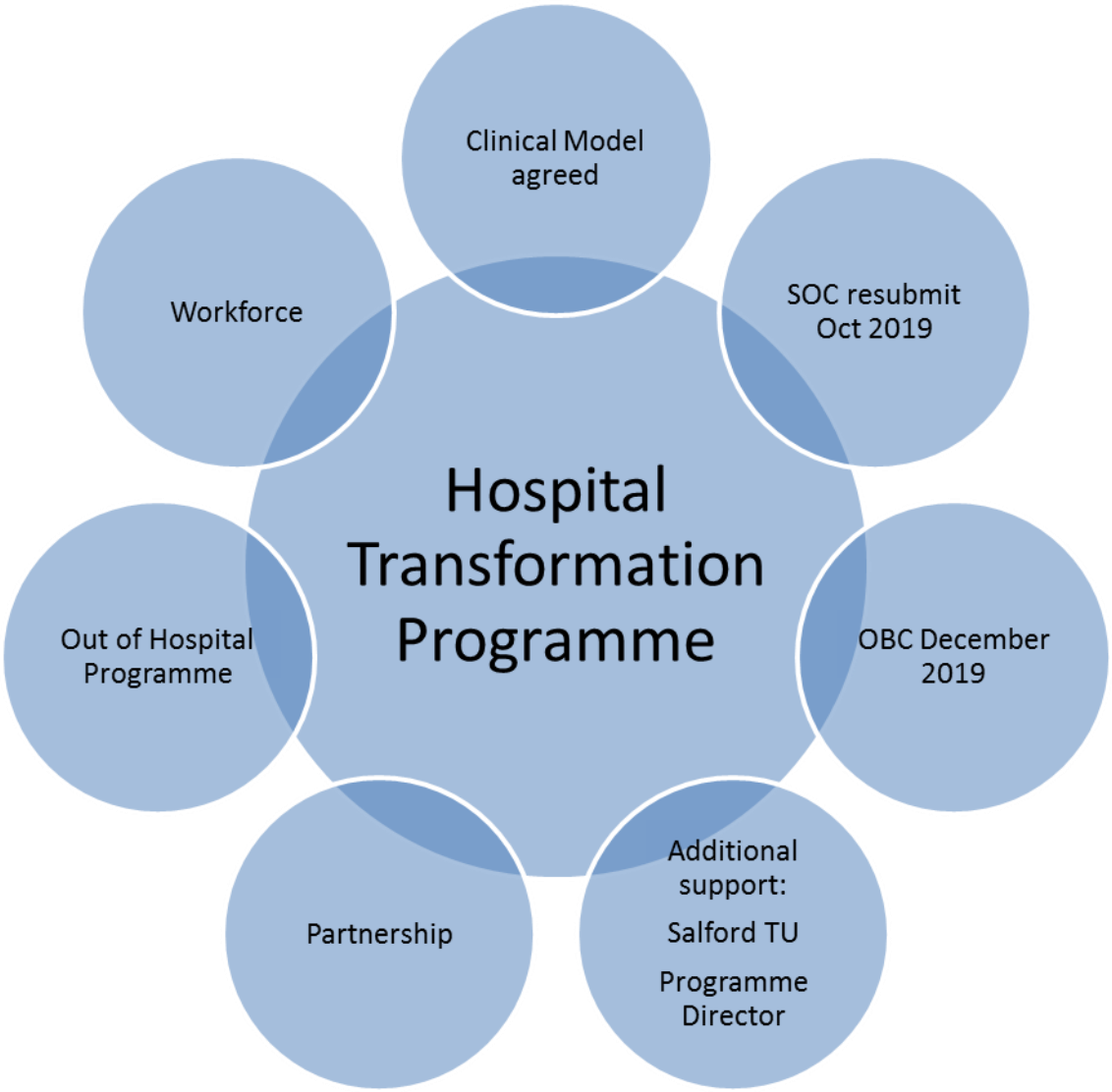
Gaps:
1. Programme priority areas are not clear
2. KPI process not integrated
3. Do we focus on our 'Wicked issues'?
4. Are we clear this is the SATH Way?



1. Data packs available for the care groups in each speciality.
2. Group in place, but not driving involvement in data decision making for service improvement/ transformation
3. Improving use of GIRFT data, utilising site expert visits to provide assurance.

Resource:
X1 8c Manager

Gaps:
1. SLR Data not utilised for care group service decision making/ Service improvement / transformation
2. Data available however clinical engagement is minimal
3. Minimal support offer to Care Groups to develop understanding and awareness
4. Data not driving clinical decision making and development of clinical strategy
5. Lack of financial measures in GIRFT
6. Business Planning performed at Care Group level and not at a speciality level



1. Timeline for OBC / Programme delivery updated
2. Update to TB in August 2019
3. Recruitment to key support for delivery
4. IRP process complete (Awaiting outcome)
5. Partnership work strengthened
6. Should be organisation Key priority

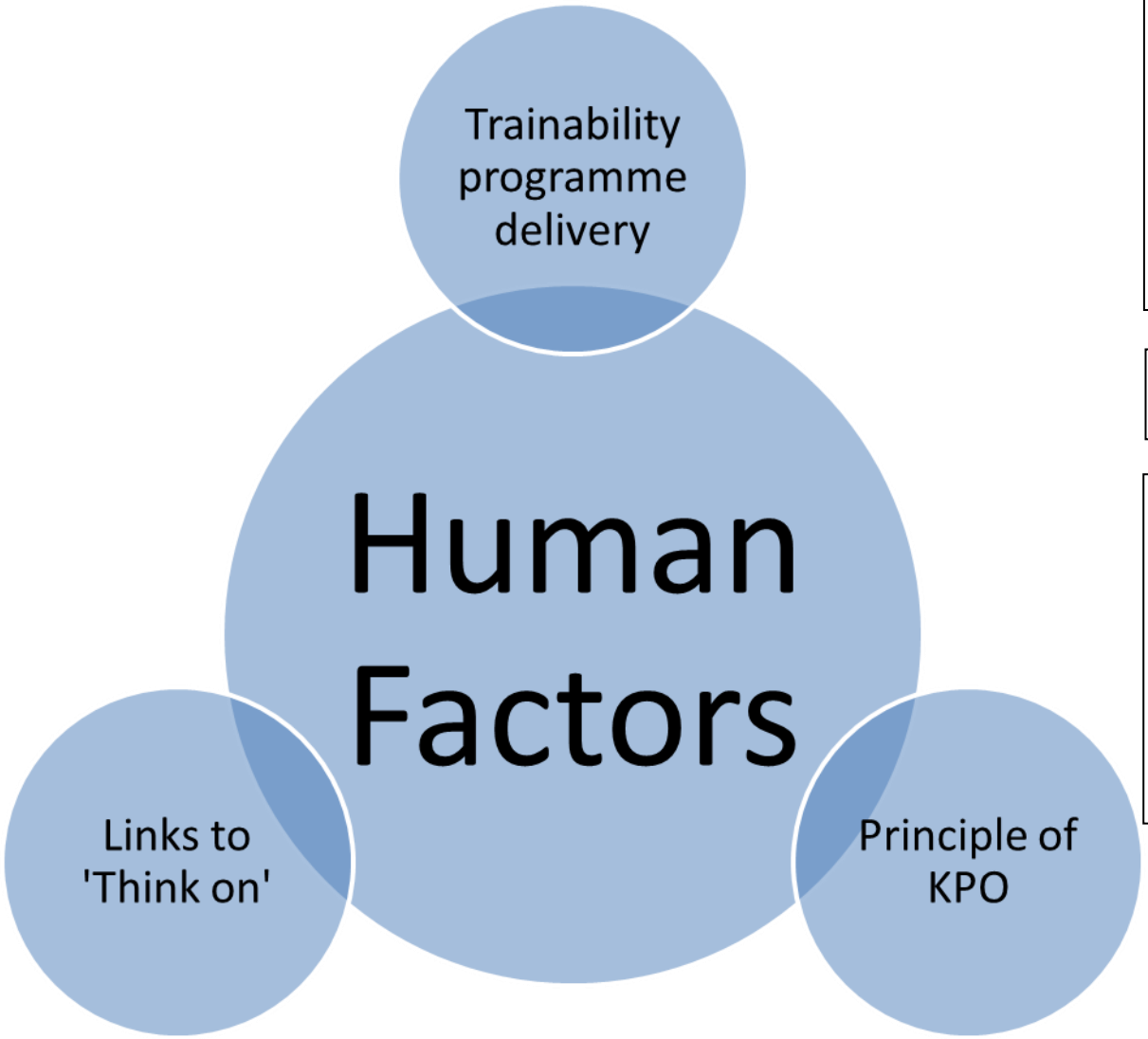
Resource:
Programme delivery support will need review once Programme Director in place/ assessing the need for additional resource.

Gaps:
1. Clinical Strategy work not completed to drive the clinical model for the future.
2. User Reference group not in place.
3. Unclear how the OBC delivery delay will impact on the 5 year STP plan completion.
4. Workforce Modelling
5. Is the Out of Hospital Programme going to deliver the required support both at the beginning and end of the transformation?
6. Financial modelling piece yet to be completed

1. CIP Target identified
2. Minimal programme assurance within care groups.
3. Minimal mitigation schemes in place.
4. Deloitte engaged to provide additional support and drive to form plans and advise on PMO establishment for a period of six weeks

Resource:
No financial PMO in place to support ongoing delivery of CIP target.
Improvement Director in place

Gaps:
1. Limited linkage to KPO/ QIP/ HTP
2. PMO Support
3. Usage of data to inform CIP programme



1. Trainability have provided ad hoc session in relation to human factor specific training
2. The KPO programme has an underpinning ethos in relation to HF
3. Lean for leaders inclusion but not explicit human factor reference
4. Included in the OD work for the Trust through 'Think on' but again not explicit

Resource:
A number of enthusiastic individuals.

Gaps:
1. Not included in the Trust strategy/ or a focus on impact to patient safety
2. No strategy for engagement and roll out
3. Opportunities for collaboration or system wide support not examined
4. Impact on organisation culture not well understood`

The leadership Academy aims to enable the organisation to respond to the future challenges and opportunities which SATH faces.
The Leadership Academy has recently been refreshed due to several factors: -

- Individuals who previously accessed the training may not have been those that needed it.
- Training may not have been applied
- What the Trust need now from leaders is different
- There is an inconsistency of leaders across the organisation
- There is a skills deficit in some core fundamentals

The new programme of work has broken down leaders into 5 levels of leadership.

The focus of the next tranche of work will be Level 3 – team leader level band 6-8a

200 Level 3 managers will go through a self-assessment with their line managers to identify development needs and will have a personalised programme in place by Oct.

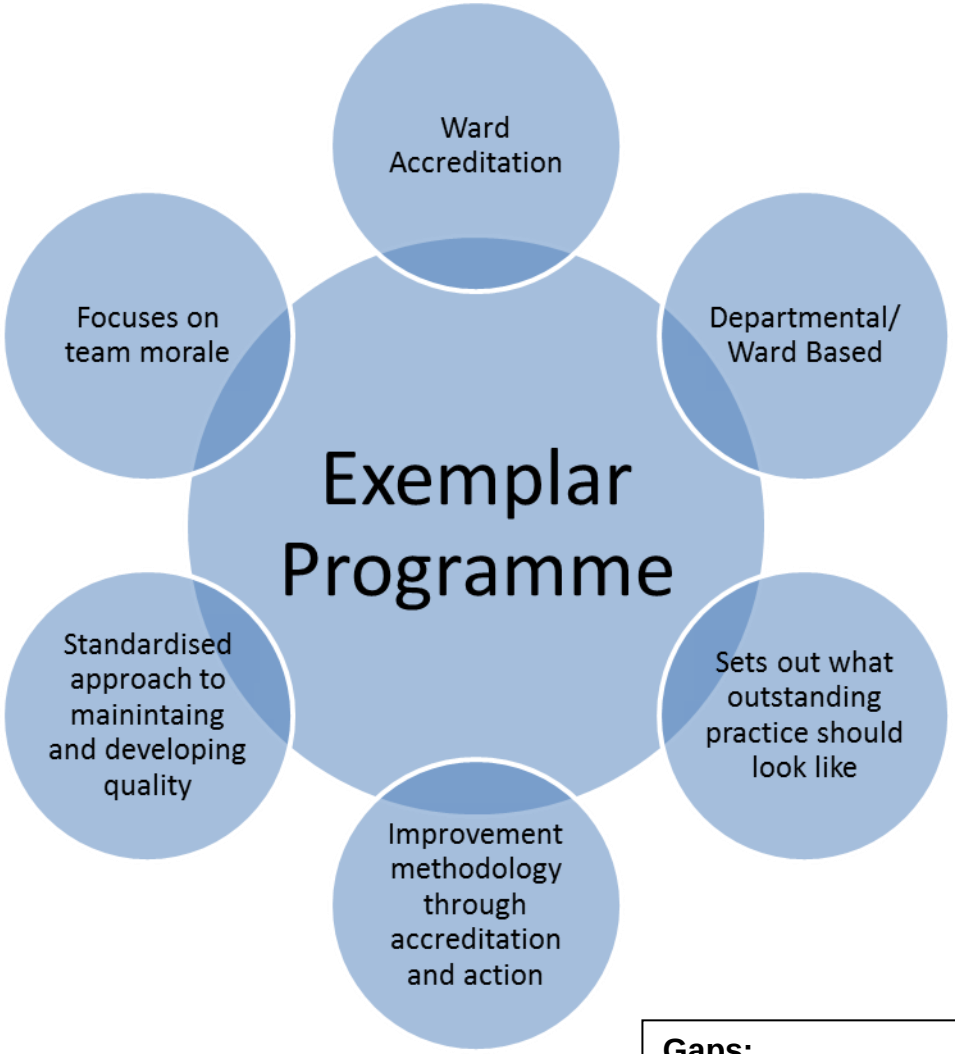
There is a structured training programme planned from September which Level 3 managers will go through

There are also further programmes of work being developed for Clinical Leads and the SLT

Resource:
Supported by KPO and OD Team. The team also have support from external contracts to deliver content

Gaps:

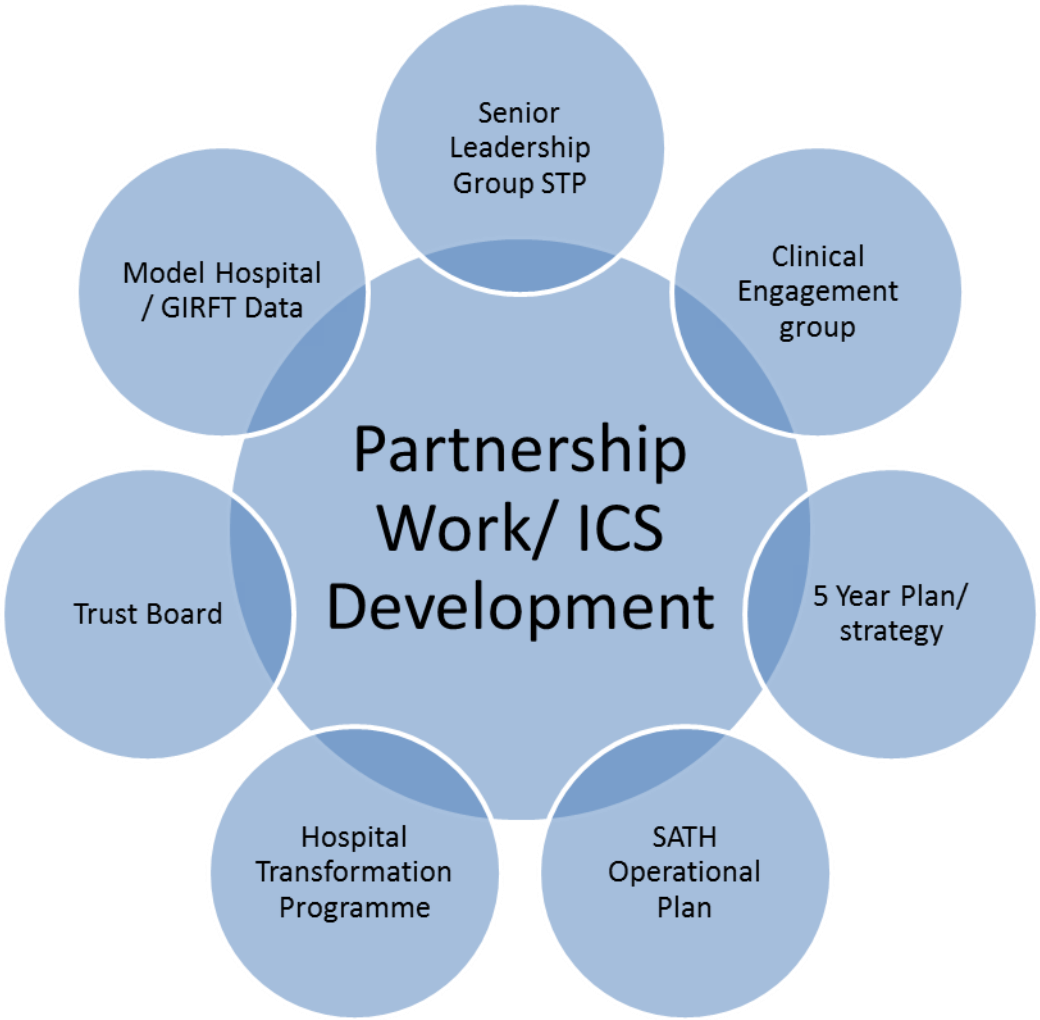
1. Delivery timelines are unclear/ is the focus on the right things (Culture/ Behaviour)
2. Priority areas are not identified i.e. the SLT focus and Top 50 Managers
3. Key measures of success are not identified
4. Do we clearly outline the links with our local and regional university bases?
5. Is this programme clearly linked to performance and appraisal conversations



1. Exemplar programme is an initiative undertaken by Trusts keen to improve safety and the patient experience; it involves an accreditation framework for all ward/units. It is important to note the Exemplar ward goes further than the Productive Ward programme (2009) as the focus is on not only the environment, but the process also uses supporting metrics to assess the environment and the standard of care. The framework is designed to incorporate elements of care, efficiency and effectiveness, patient experience, patient safety and leadership, CQUINS, together with workforce metrics and finance metrics, thus enabling the ward/unit/department to be performance managed in a holistic manner.
2. The exemplar program allows the Shrewsbury and Telford Trust to undertake a standardised review of the ward environments and assess pivotal fundamental aspects of care and safety. The purpose of this is to highlight areas of excellent care across the Trust so that other wards and departments can learn from them and work to improve their own.

Resource:
Exemplar team in place. Co-opted support from across the MDT are used to undertake assessments.

Gaps:
1. Programme isn't understood across the Trust in relation to the focus and outputs.
2. No reward programme include in the current framework.
3. Standards are assessed subjectively because numerous assessors are utilised.
4. Not linked to the KPO programme.
5. No action planning process in place



1. Improved engagement in system meeting
2. Trust SRO for the support services work stream, which includes back office support, clinical and non-clinical support, green agenda and Transport (Across system)
3. Some representation from Trust on specific work streams
4. 5 year plan development underway with key engagement events in place
5. Governance processes for the STP now agreed and in place
6. Good financial engagement

Resource:
Key personnel supported by the STP budget.
No identified resource for clinical involvement.

Gaps:
1. Need to understand Trust financial contribution to support development of ICS going forward
2. Clinical involvement needs to be strengthened particularly as the HTP moves forward
3. Current understanding of the STP work programme is limited
4. Current operational objectives do not link wider to the system objectives (they do in relation to A/E but not on the wider platform)
5. Currently our data isn't utilised well in discussions

1. ISG work progressing in relation to completion of root causes associated with Must Do / Should Do.
2. PMO Support in place for the QIP programme
3. Corporate Nursing complete the weekly submission process
4. KPO now included in the ISG meetings

Resource:
Lead for PMO in place with supportive team 3 FTEs (Band 6)

Gaps:

1. Must Do Should Do priority work presently unclear – however more focus is being placed on this
2. Sustainability and transformation are not included in the ISG discussion regarding the delivery and completion of actions
3. KPO are at the meeting however their input has been in relation to where they are supporting an individual action not an overview of the priority and sustainability piece
4. The QIP has not yet fully focused on the preparation for re-inspection?
5. There isn't clarity in relation to how the programme will move us to 'Good' and beyond.

The Shrewsbury and Telford Hospital NHS Trust

Shrewsbury & Telford Hospital NHS Trust

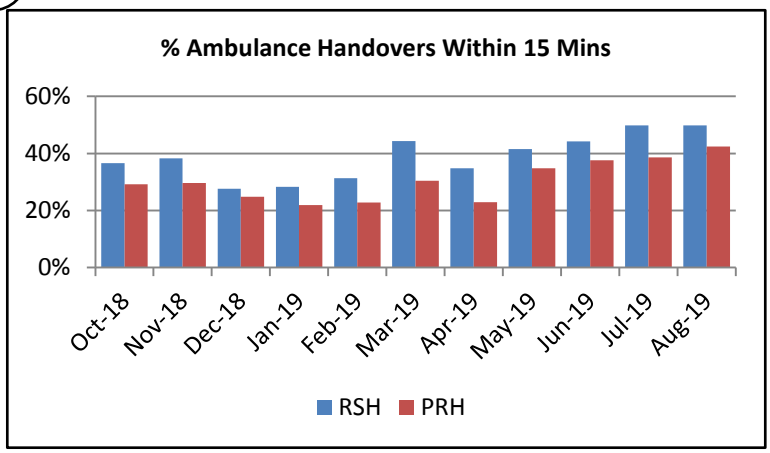
Quality and People Report

M6 2019

Final 1

Time to Initial Assessment Performance

1a Ambulance attendances to ED with handover within 15 minutes

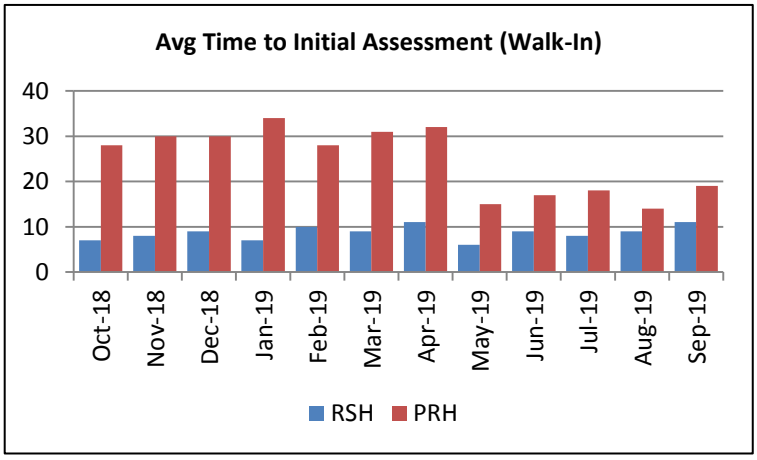


SaTH have not met this standard throughout the reporting period.

The likelihood of achieving the standard going forward is low until staffing has improved. The department is working through some data collection concerns they have to ensure accurate reporting.

Not Achieving Standard

1b Average time to initial Assessment (Walk-In)



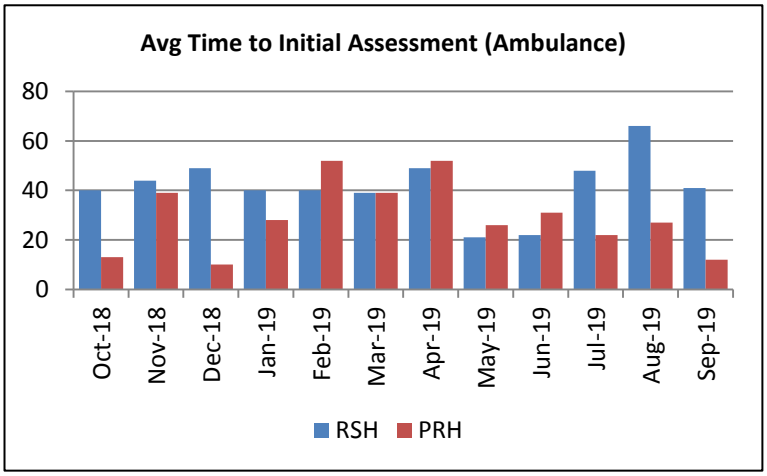
SaTH have not met this standard fully throughout the reporting period.

Performance appears more sustainable at RSH. Improvements to be undertaken at PRH inc. encouraging staff to stream directly to UCC. Action plan, new protocols and trajectory being developed.

The likelihood of achieving the standard going forward is medium.

Partially Achieving Standard

1c Average time to initial Assessment (Ambulance)



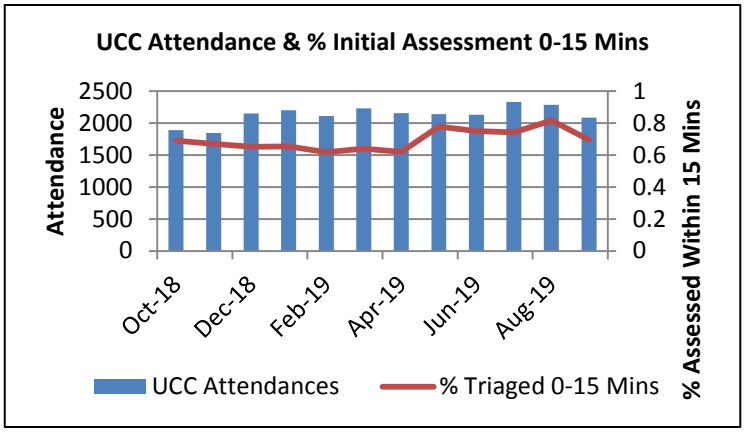
SaTH have not met this standard throughout the reporting period.

RSH performance is better – there are less attenders. There are data collection concerns at both sites due to the high number of agency nurses, this is being worked through and with the recruitment of admin support for ambulances this should improve.

The likelihood of achieving the standard going forward is medium.

Not Achieving Standard

2 Patients triaged to UCC within 15 minutes



Performance appears sustainable. The likelihood of achieving the standard going forward is high. An action plan, new protocols and a trajectory is being agreed to send additional patients to UCC from streaming.

Not Achieving Standard

3 Triage assessments are undertaken by a trained nurse

SaTH have met this standard since the review of the Streaming and Triage SoP and the introduction of a rota to ensure 24/7 cover since April 2019. Performance appears sustainable.

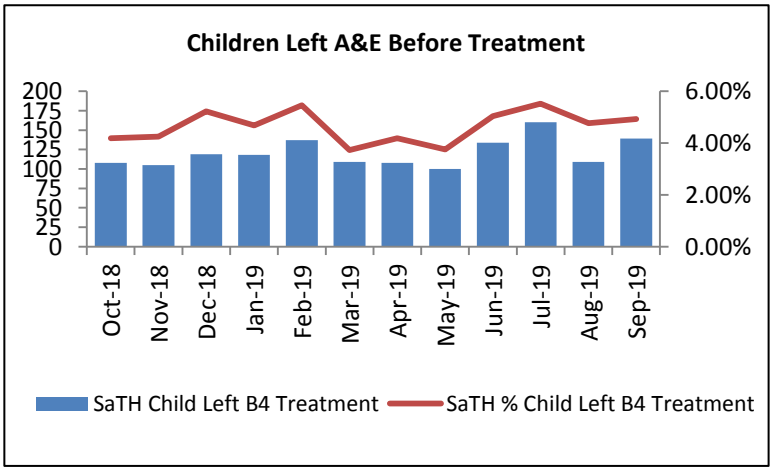
The likelihood of achieving the standard going forward is high.

Daily "Safe Today Report" provides evidence of this taking place; steps in place to collate data to illustrate the shifts being covered on daily basis by site.

Following the April CQC visit, SaTH committed to having streaming and triage trained nurses in the dept. 24/7 – this is being achieved.

Achieving Standard

4 Children who leave the ED without being treated



The Trust target is that no child will leave the department without being treated. However, on occasions this does still happen and is the decision of the patient/parent. Paeds are prioritised appropriately to be seen to reduce their waiting times. There is a process in place to ensure all Paeds LBS are followed up.

Not Achieving Standard

SaTH have implemented an SoP since April 2019 that ensure the ED consultants contact every parent that has left the department following streaming without being seen. This occurs within 24 hours Mon-Fri and weekends are followed up on Monday.

Triage Summary

Assurance

Evidence submitted as part of the Regulation additional condition reports includes rotas from both departments demonstrating that streaming and triage nurses are allocated to every shift on a monthly basis. Daily checks are undertaken to implement mitigation as required.

Walk-in patients are seen and assessed on average within 15 mins over the last 6 weeks.

Below is the latest 6 weeks of the Emergency Care Dashboard:

Measure		26/08/2019	02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019	Average For Period
Average Time to Initial Assessment		26	17	19	21	18	22	20
Avg Time to Initial Assessment (Amb)		56.35	26.88	34.44	31.94	16.40	29.16	32.53
Avg Time to Inital Assessment (Walk-Ins)		13.40	13.03	12.28	16.52	18.18	18.25	15.28
Average Time to Treatment		140	136	143	148	167	182	153
Average Time to DTA		219	210	209	219	208	230	216
Average Total Time in Department		258	248	248	338	491	571	359

Benchmarking

While NICE guidelines state that 95% of patients should be triaged within 15 minutes there is no national dataset or performance benchmarking for specific areas of triage; most Trusts report triage as a total overall performance.

Sepsis management

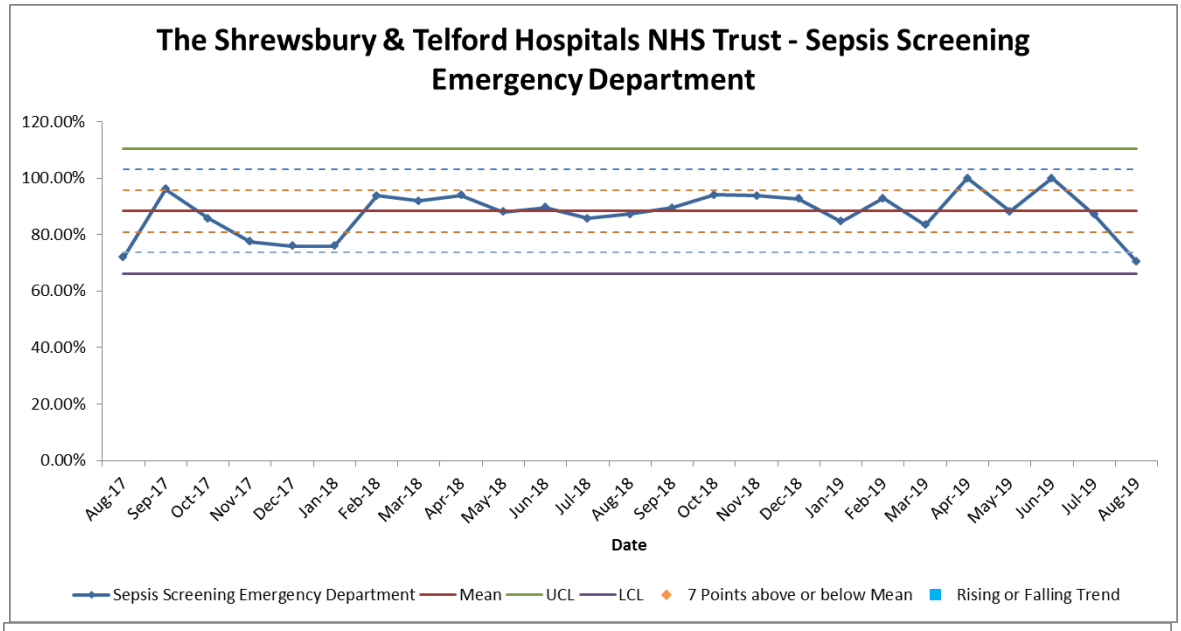
Section 31 Standard: That there is an effective system in place to identify, escalate and manage patients who may present with sepsis or a deteriorating medical condition in line with the relevant national clinical guidelines

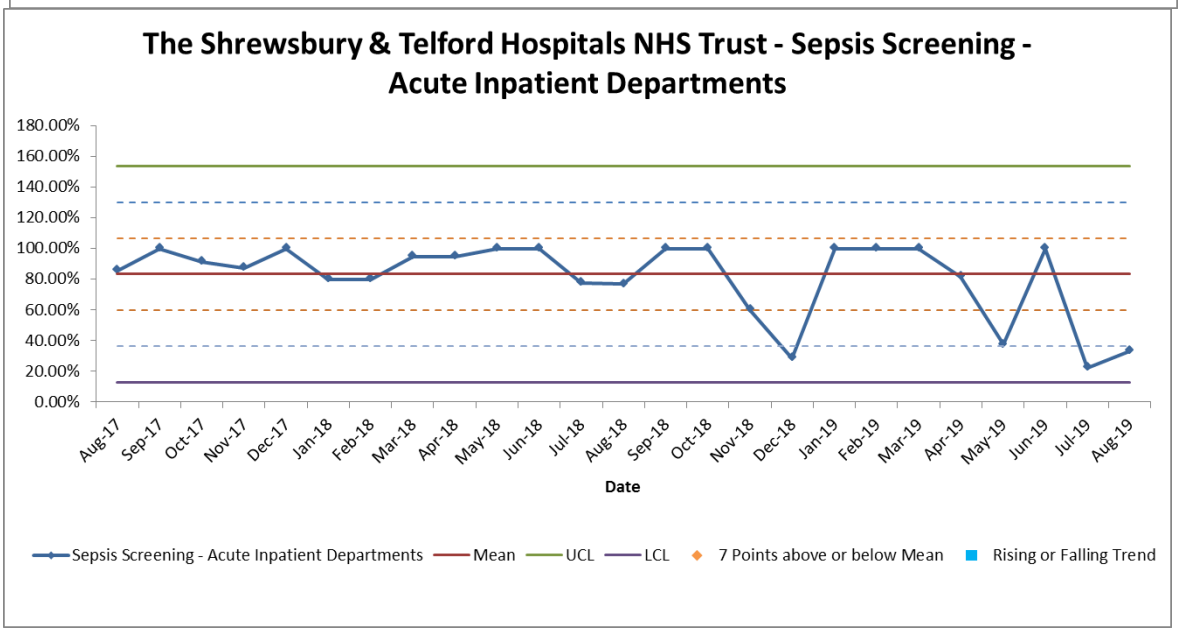
1 To ensure that eligible patients are screened for sepsis

SaTH has not met this standard throughout the reporting period.

Performance appears to be static. There are plans in place with the new Sepsis Nurse to ensure compliance of the standard in a sustainable way.
The likelihood of achieving the standard going forward is high and is dependent on the full implementation of the improvement work that the trust has been developing. A key requirement is ensuring compliance with agreed pathway improvements.

Not Achieving Standard





Not Achieving Standard

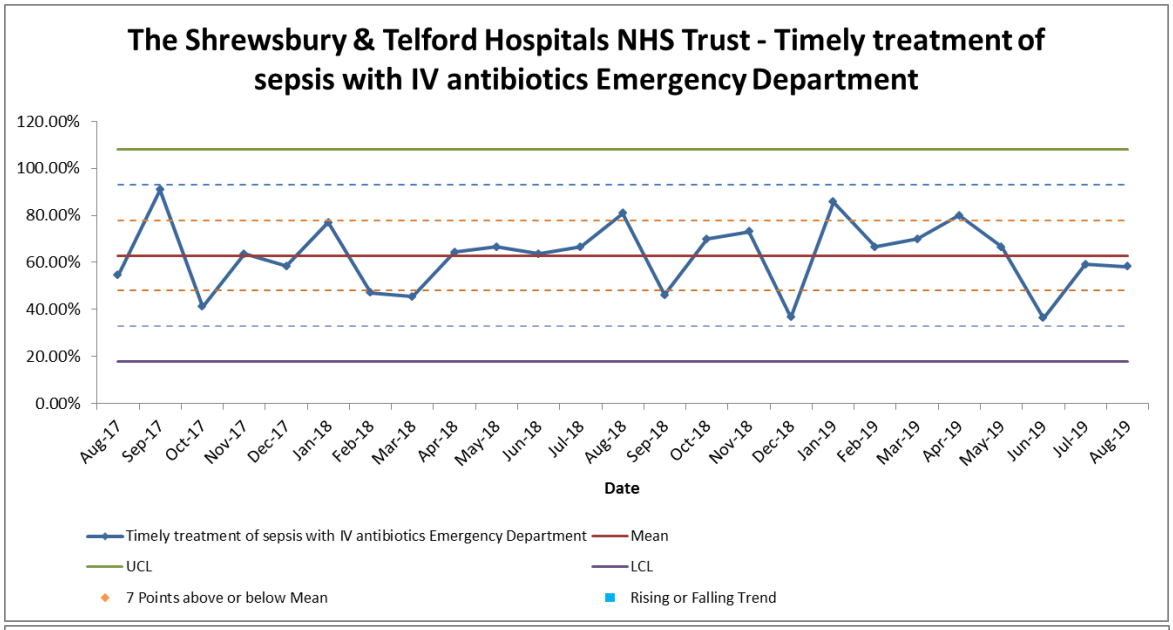
Sepsis management

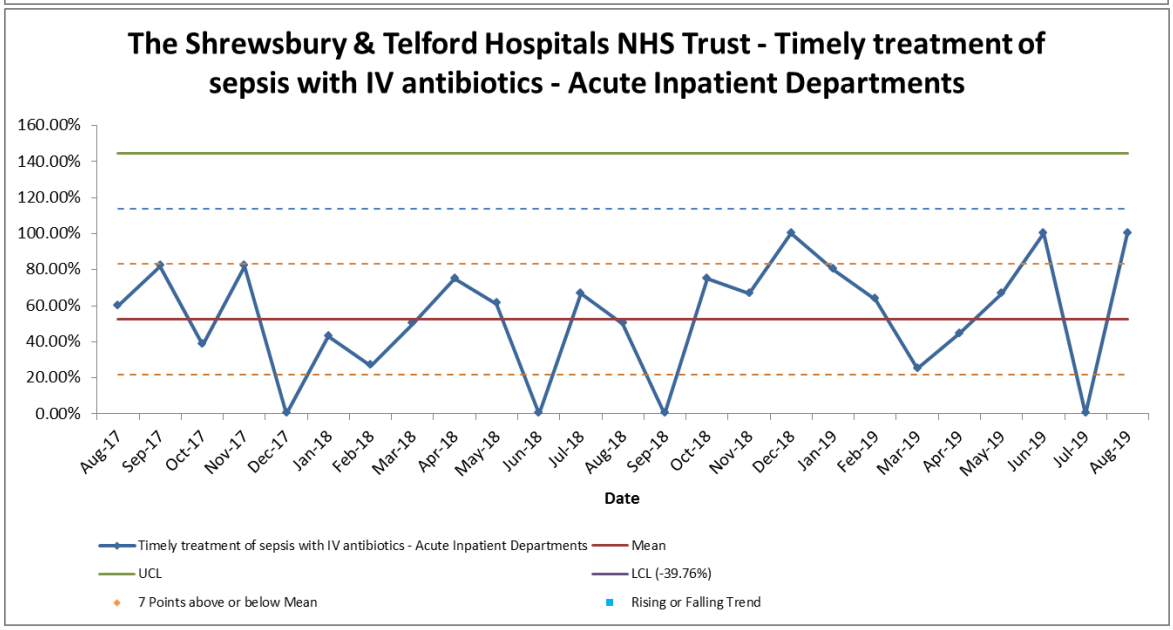
Section 31 Standard: That there is an effective system in place to identify, escalate and manage patients who may present with sepsis or a deteriorating medical condition in line with the relevant national clinical guidelines

2 To ensure that patients screened positive for sepsis receive antibiotics within 60 minutes.

SaTH has not met this standard throughout the reporting period.
Pathway improvement work has increased performance in this area, but further improvement is still needed and is dependent on ensuring compliance with the agreed pathways

Not Achieving Standard





Whilst the compliance is low for Inpatient departments, this is related to the low number inpatients diagnosed with Sepsis.

Sepsis Summary

Assurance

There is clear organisational overview of Trust performance in relation to identification, management and escalation of patients with Sepsis since the introduction of a sepsis Working Group and sepsis Nurse Practitioner.
There is an overview of all of these elements within the separate Care Groups across both hospital sites which departments are focusing their efforts in achieving (with emphasis at present being on the emergency portals likely to see greater numbers of Sepsis Patients) and aiming to ensure that 100 % of eligible patients are screened for sepsis and to ensure that patients screened positive for sepsis receive antibiotics within 60 minutes.
Departments across the trust have Sepsis Champions and there is a centralised record of which Champions are located where, meetings with this group are undertaken on a monthly basis across both sites with attendance where clinical need allows. There is at least one champion identified for each clinical area but due to colleagues taking up new roles in other clinical areas this list is constantly refreshed.

Necessary equipment and medication has been standardised to reflect the Sepsis 6 approach (facilitating delivery of Oxygenation, taking of blood samples, fluid administration, antibiotic therapy and urine output monitoring quickly in line with early goal directed recommendations) and as such each department. The current focus is on consistency of available equipment in every clinical area.

Equipment is checked locally within the department to ensure compliance with the above.

Benchmarking

The Sepsis Screening tool utilised within the Trust across the Emergency Department and wider ward area is a modification of the UK Sepsis Trust Screening tool utilising the Red Flag method of identification and Amber Flag to identify those patients at risk of deteriorating

NEWS2 has been implemented and used across the hospital in the management of the deteriorating patient and the Sepsis patient.

The use of the Sepsis 6 bundle in the management of the Sepsis patient standardises the delivery of care in line with recommended early goal directed therapy .

Next steps

A focused review of the process within both Emergency Departments has been undertaken allowing for improvement work in tools and processes used in Sepsis Patient identification, Escalation and management in line with Lean methodologies. This will be reviewed at 30,60,90 days to see the impact of the changes on the above standards .
30 days – suggest 31/10/19
60 days – suggest 30/11/19
90 days – suggest 31/12/19

Maximising staff engagement whilst building on knowledge base and identifying expected and agreed gold standard of practice for Sepsis Patients within the Emergency Departments replicable across both sites. July 2020 – measurement will be via improvement in KPIs.

The intention is that the above process will be repeated in the AMU's and SAU in order to similarly implement improvement strategies that would bring about the desired improvements in the standards outlined. To be agreed with KPO Team.

Development of an Educational programme – Formal which sets out training for each staff group and the desired time frame to ensure all staff educated on Sepsis to the level required of their role to maximise patient identification and escalation of care. This is not yet mandated as we are reviewing available education packages.
Currently scoping potential packages, training needs analysis and resource requirements. Plan to be ready for discussion by 6th December 2019.

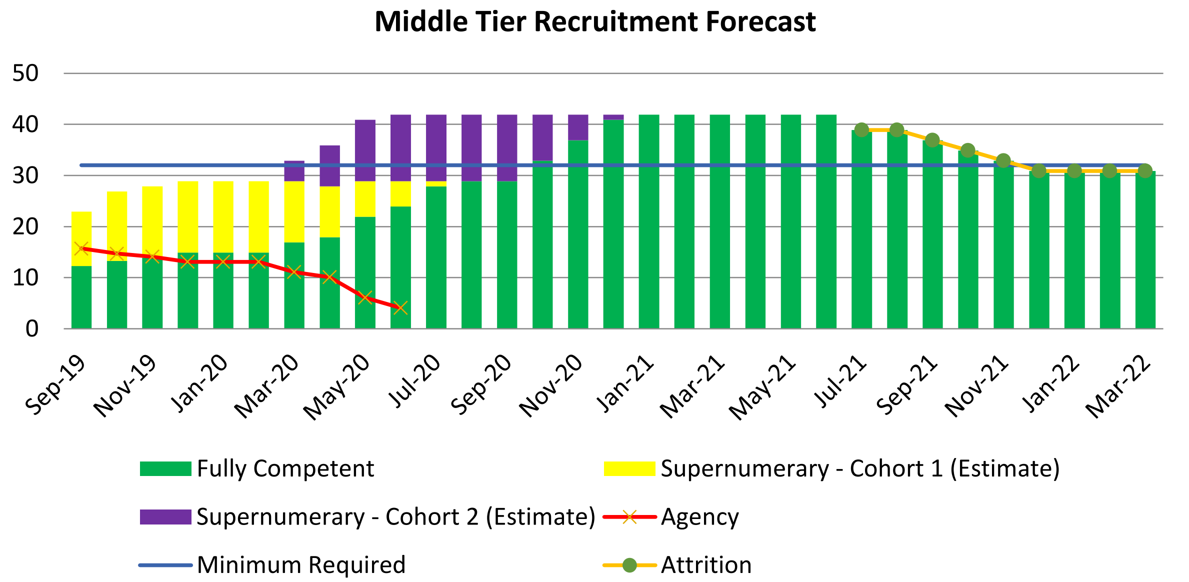
Sepsis Summary

Next steps continued

Database being finalised to hold the data of training per department accessible by Sepsis Nurse Practitioner departmental heads etc. Part of a wider corporate training database that is under development. (Outside of Sepsis team remit).

Finalising of the patient group directive for the management of Sepsis Patients when there is delay in attendance of a doctor which may constitute harm to the patient through delay in delivering treatment. Currently have a PGD drafted and a decision making flow diagram – going to PGD Group on 15th December. Development of SOP, Training and competency document to be formalised. 20th December Bedside Education to be undertaken across ward sites ensuring education delivered in keeping with the environment in which staff work. On-going, no definitive timeline as completed on an opportunistic basis.

Middle Tier New Recruits in ED



	WTE	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Middle grades																		
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1					1	1	1	1	1	1	1	1	1	1	1	1	1
In Post	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Not Yet Arrived	1				1	1	1	1	1	1	1	1	1	1	1	1	1	1

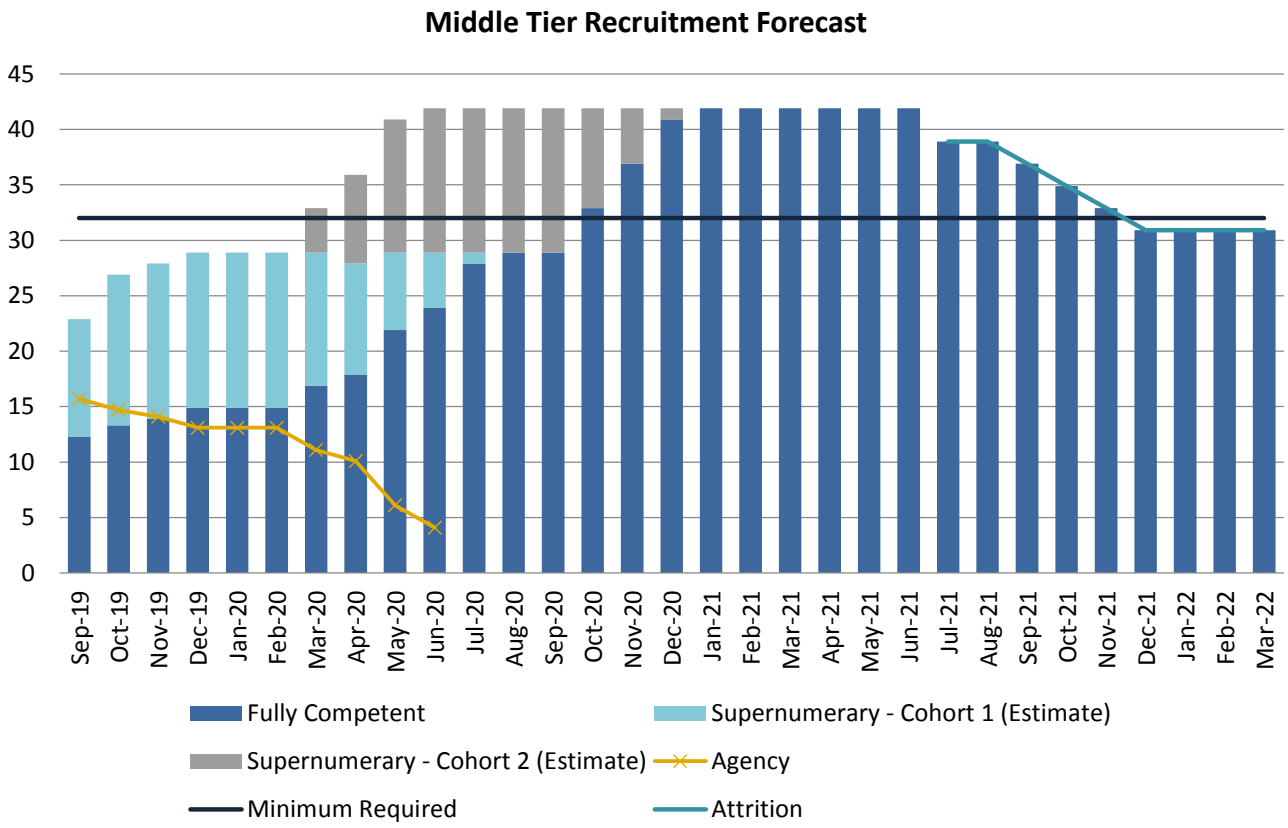
= Supernumerary / need support

= Ready to work independently

Action:

- International recruitment programme (9 recruited in cohort 1, 13 offers on cohort 2)
- Rolling advert for Speciality Doctors
- Enhanced remuneration packages for doctors including bonus on start and bonus after 2 years (retention package) flights, relocation packages etc.
- Support with relocating to UK, loans, finding accommodation, pick up from airport, support with English language, development programme etc.
- Overseas recruitment trips for doctors and nurses.
- Developed comprehensive business case for expansion and investment of new roles for nursing.
- Development programme for nurses.
- Support from NHSE/I on recruitment practices, cultural development and reducing agency.

Middle Tier New Recruits in ED



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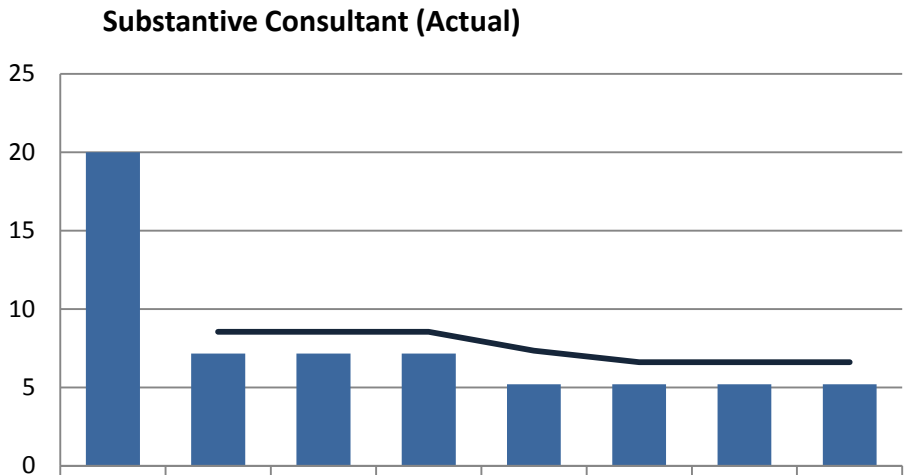
ED Consultant



	RCEM Recommend	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Whole Time Equivilent	20	7.15	7.15	7.15	5.2	5.2	5.2	5.2
Programme Activity		8.55	8.55	8.55	7.35	6.6	6.6	6.6

<u>ED Consultant Gaps</u>

Reduction of ED Consultant capacity due to resignation (1wte December), maternity leave (1wte January) and reduction of Programme Activity (10 sessions approximately January).

Action:

- Rolling advert for ED Consultants – revising advert / offer and purchased enhanced BMJ package.
- Recruiting Locum Consultants to support future gaps in workforce 6 month placements
- Long term plan to recruit into CESR programme to develop future Consultants. Programme now in place commencing November. One ED Specialty Doctor placed on programme.

Registered Nursing Staff in ED

Total Hours for September

Department	Agency	Agency Block Booking	Bank	Substantive	Grand Total
Accident & Emergency Department (PRH)	1250	2953	741	3359	8303
Accident & Emergency Department (RSH)	1336	1879	690	3635	7540
Grand Total	**2586**	**4832**	**1431**	**6994**	**15842**

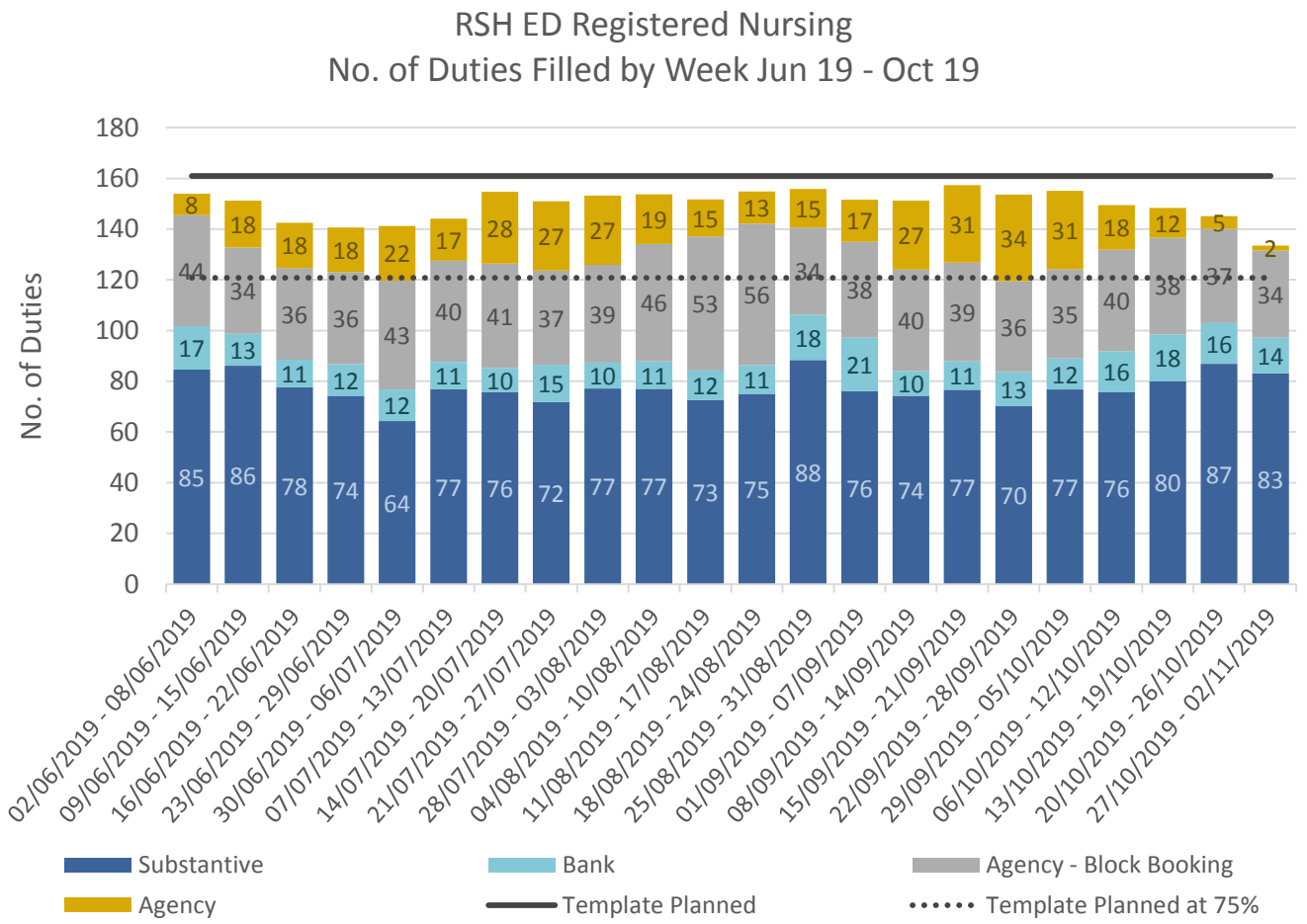
Total Hours as a Percentage

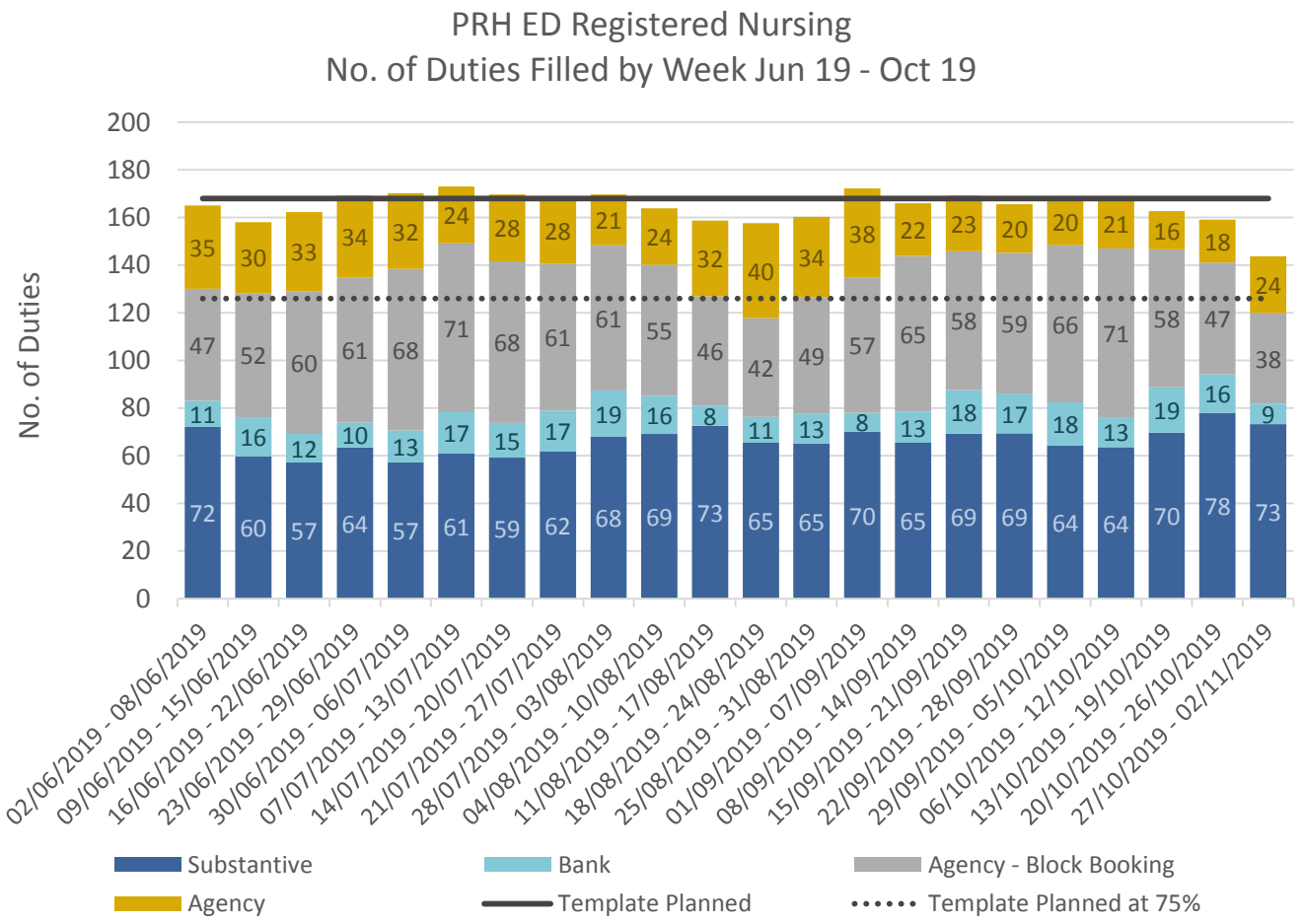
Department	Agency	Agency Block Booking	Bank	Substantive	Grand Total
Accident & Emergency Department (PRH)	15%	36%	9%	40%	100%
Accident & Emergency Department (RSH)	18%	25%	9%	48%	100%
Grand Total	**16%**	**30%**	**9%**	**44%**	**100%**

Total Hours as an FTE

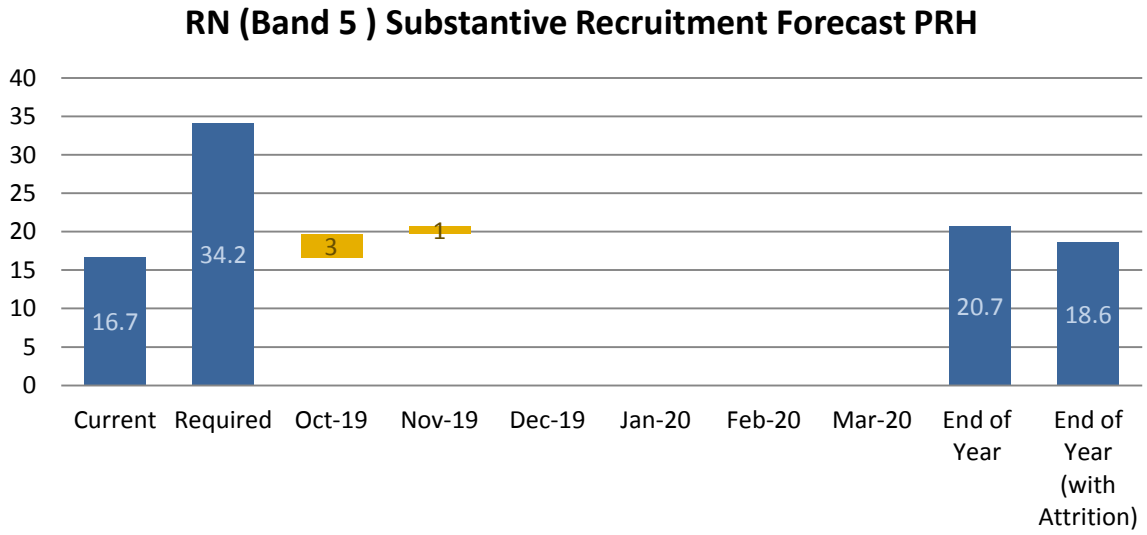
Department	Agency	Agency Block Booking	Bank	Substantive	Grand Total
Accident & Emergency Department (PRH)	7.8	18.4	4.6	20.9	51.7
Accident & Emergency Department (RSH)	8.3	11.7	4.3	22.6	46.9
Grand Total	**16.1**	**30.1**	**8.9**	**43.5**	**98.6**

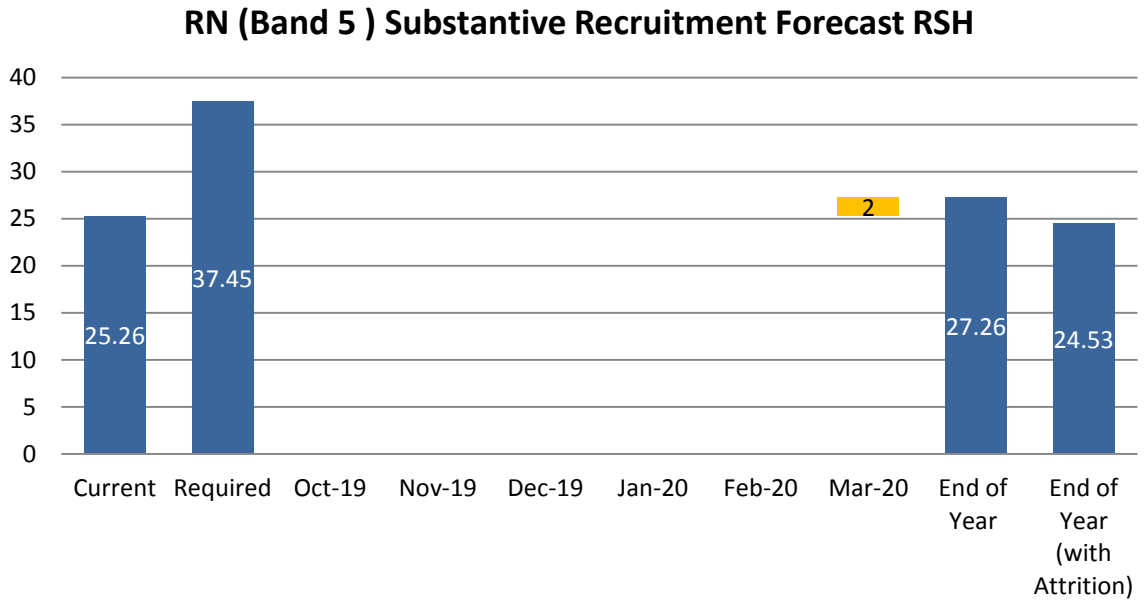
Registered Nursing Staff in ED





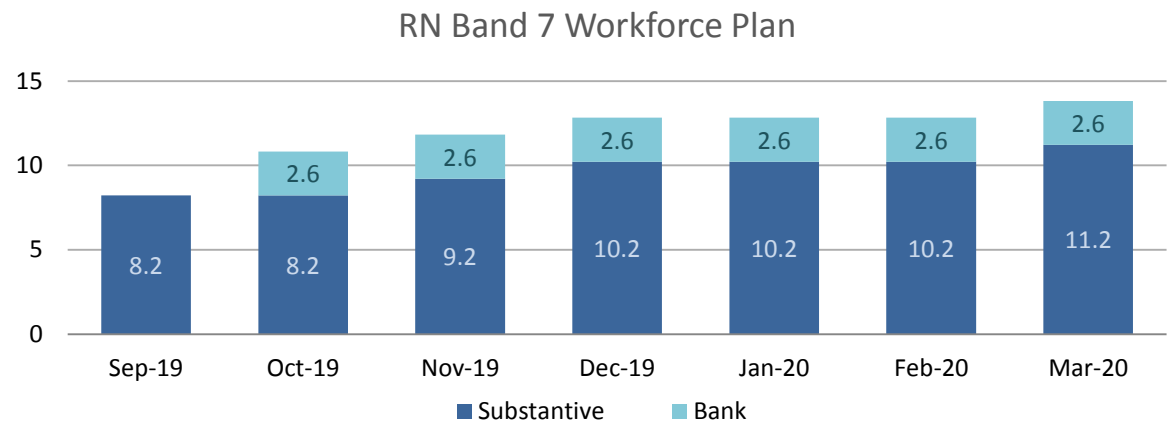
Registered Nursing Staff in ED

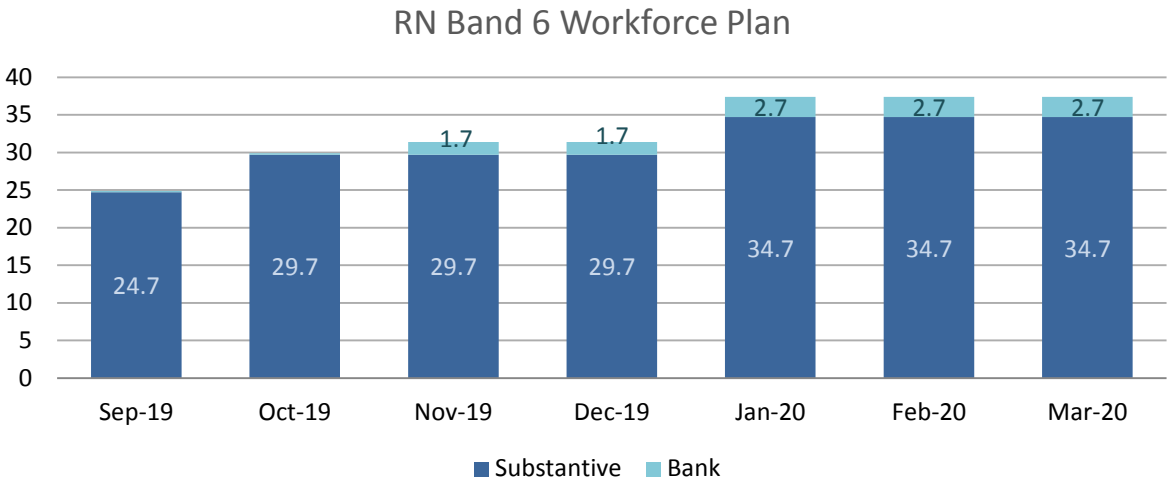


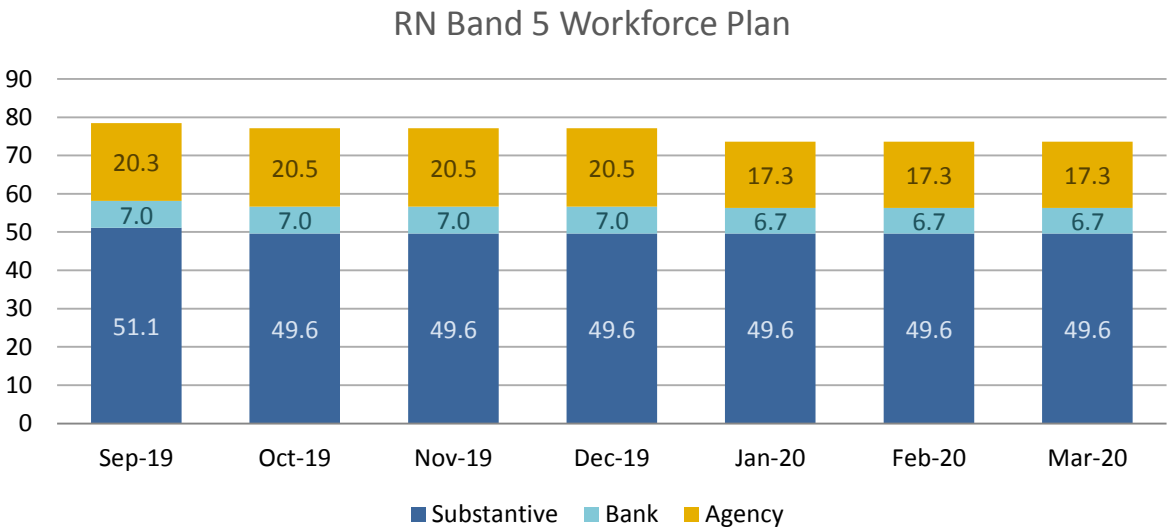


- Currently advertising for Paediatric Nurses
- All adverts for bands 5,6 and 7 active
- A recruitment trip to Dublin is being planned
- Advertising on Facebook is supporting current recruitment activities

Registered Nursing Staff in ED







International Recruitment

Health Education England's Global Learners programme was implemented to meet the shortfall of over 270 wte Band 5 nursing and midwifery vacancies in the Trust and to keep patients safe.

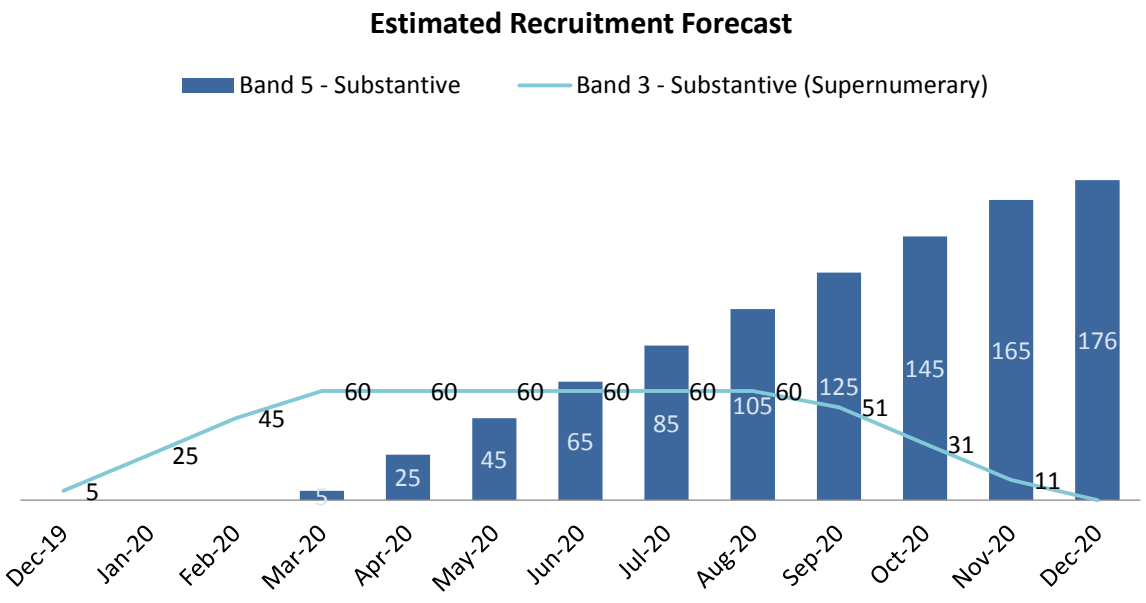
Health Education England's Global Health Exchange is working with healthcare providers globally to improve the quality and volume of the NHS workforce through global education and workplace exchanges. The Global Learners Programme offers an educational programme for healthcare workers from other countries who would like to spend three years on an earn, learn and return scheme.

The HEE GLP has been working with the Trust to recruit nurses from India. We have conducted over 280 interviews and found the candidates to be of a high calibre with very good English.

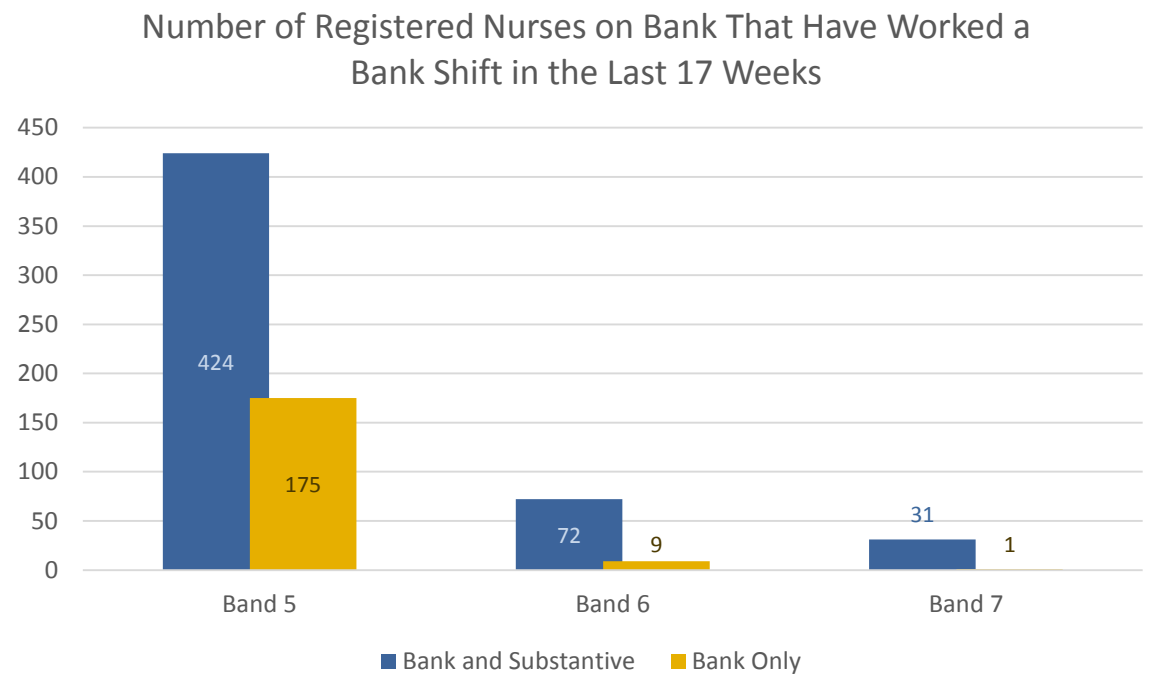
Number of Nurses Recruited:

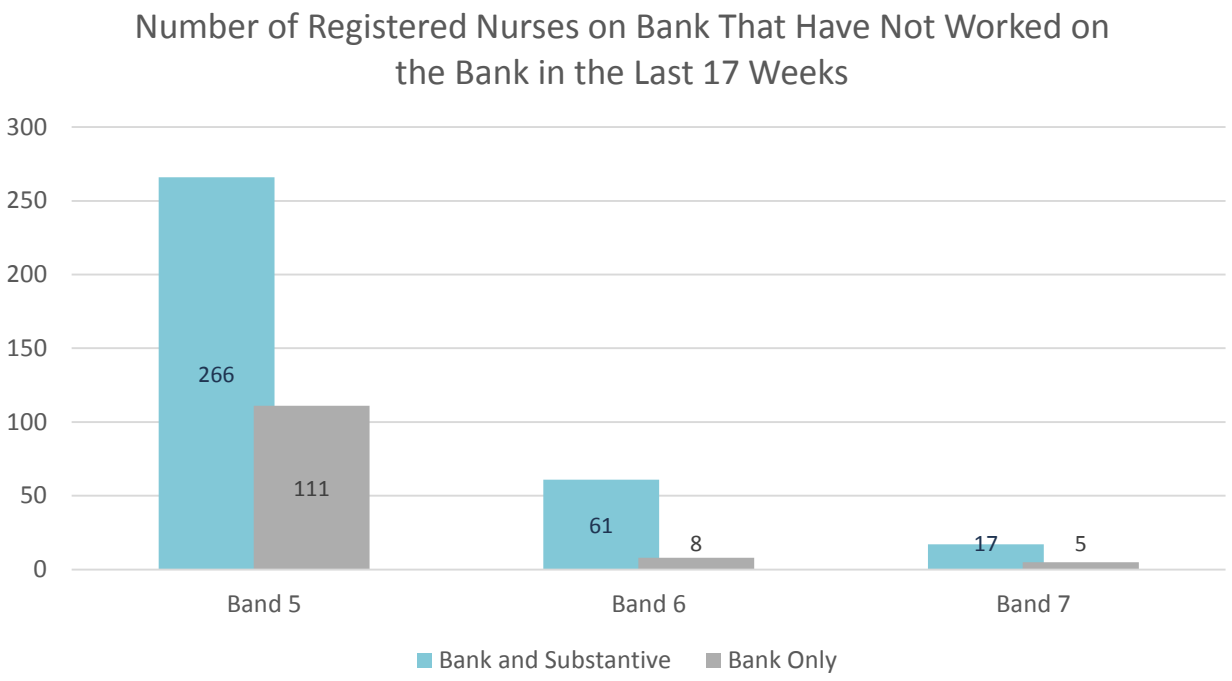
	Cohort 1	Cohort 2	Cohort 3
No. Interviewed	78	84	86
No. of offers Given	73	74	80
No. accepted and still in system	59	70	44 (this is still open so will increase)

There will be a period of supernumerary time for the new nurses for a period of 13 weeks (11 weeks supernumerary and 2 weeks between passing OSCI and receiving registration pin). During this period the nurse will be paid at AfC band 3. The Trust is planning for an intake of approximately 176 nurses.



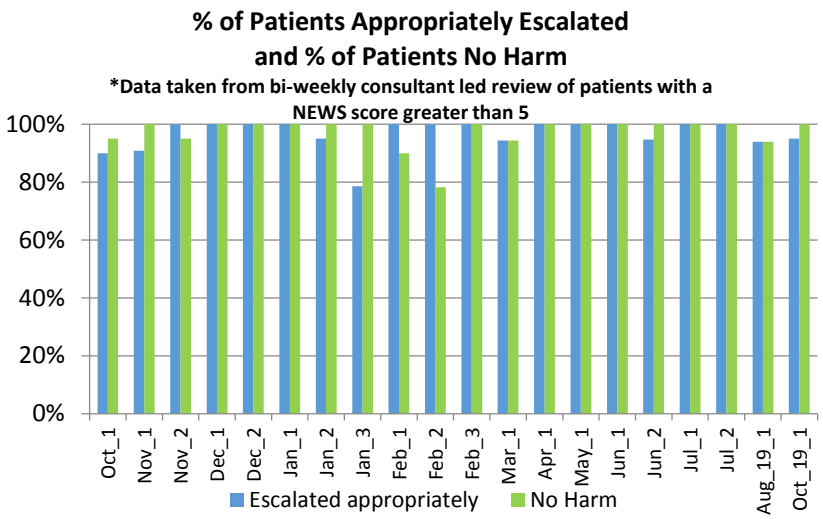
Registered Nursing on Bank





Observations

1 No harm to patients resulting from failure to recognise a deteriorating patient (based on spot check audits)



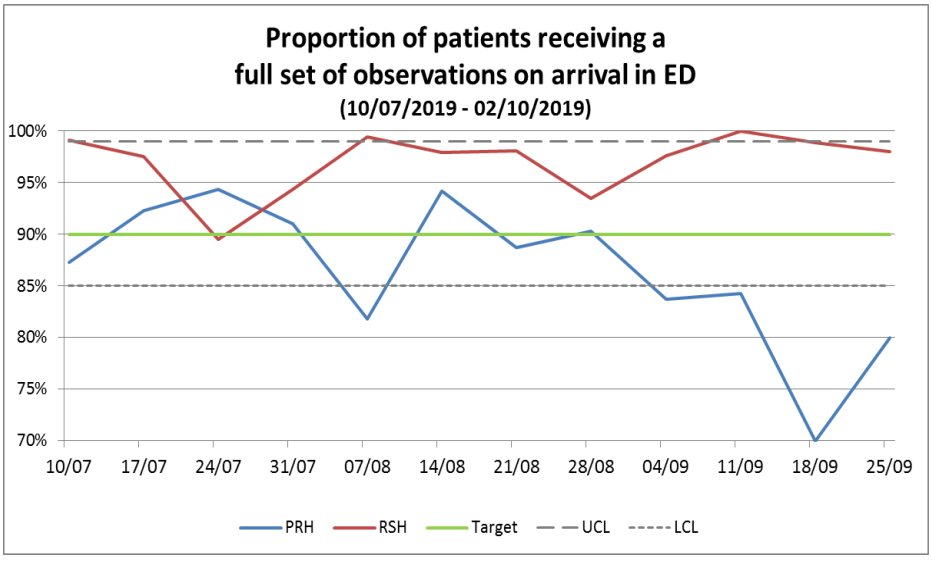
SaTH have met this standard throughout the reporting period.

Performance appears sustainable.
The likelihood of achieving the standard going forward is high.

Following a meeting with CQC on 10/09/19 a revised data set has been agreed as part on the regulation 31 breach reporting, which will be reviewed mid-October.

Achieving Standard

2 Eligible patients have a recorded set of observations in ED on arrival (based on spot check audits)

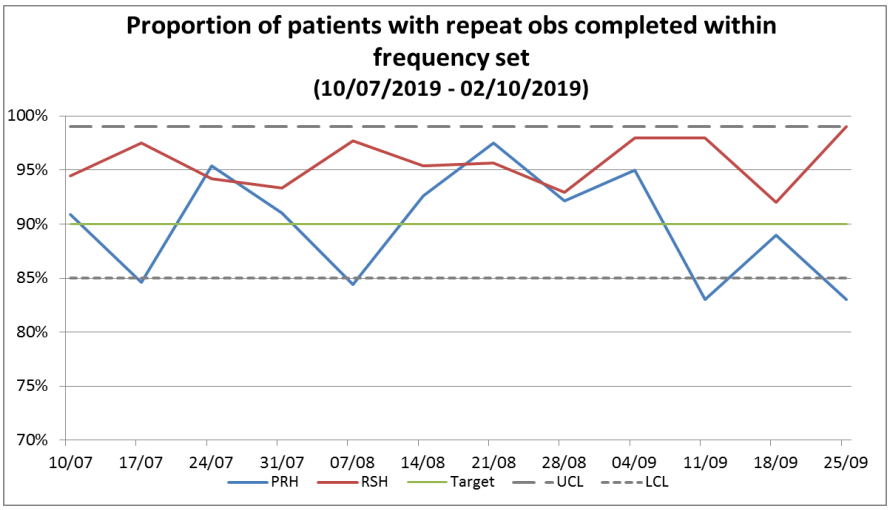


SaTH have met this standard most of the time throughout the reporting period.

The likelihood of achieving the standard going forward is high.
There was a dip in Sept at PRH.
To ensure improvement's are made and seen the Senior Nursing Team will ensure the following:
Reminder to staff at Handover Huddles
2 hourly board rounds, additional spot checks & challenge from Dr's.

Partially Achieving Standard

3 Eligible patients will each have observations recorded at a minimum by the time required by their early warning score trigger (unless a clinical decision is made to increase or decrease the frequency for individual patients) – below is data captured through the ED spot checks – "were the last set of obs done within frequency set**".** The auditor addresses areas of non-compliance at time of audit and records action taken.



Partially Achieving Standard

Reported via CQC weekly submissions and evidence submitted through to the CQC portal. There have been some recent dips at PRH, To ensure improvement's are seen the Senior Nursing Team will ensure the following: Reminder to staff at Handover Huddles, 2 hourly board rounds, additional spot checks & challenge from Dr's

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Observations Summary

Assurance
The ED department undertake an audit of 5 sets of patient notes every 2 hours (35 per day and 10 sets of notes per day at weekends) to review observations and compliance with other expected standards of care. This is reported weekly to the CQC.
Additional a safety huddle was introduced daily and two hourly nurse and consultant in charge board rounds to ensure that patient safety was paramount and deteriorating and sick patient are recognised quickly and remedial action taken.
A further monthly audit is undertaken and learning shared to ensure continuous improvement

Evidence from week 57 submission is as follows:

Audit Completion Compliance:
RSH = 97% 185/195, previous week 95%, week. on week change = +2%
PRH = 103% 200/195, previous week 62%, week on week change = +41%

The mitigation put in place to address the previous week's poor compliance has shown a marked improvement at PRH in week 57.

The frequency of observations set in line with the protocol (or more frequently) for week 57 was reported as 349/390 (90%) compared to the previous week's performance of 91% (week on week =-1% change). For RSH the performance was 99% (188/190) compared to 81% (161/200) at PRH.

Actions taken to address non-compliance (41 patients):

- Was addressed with staff at the time of audit (11 patients)
- Reviewed and the protocol was overridden by clinical judgement (4 patients)
- Nurse in charge informed (2 patients)
- Reviewed paperwork, no additional action taken as not required (24 patients)

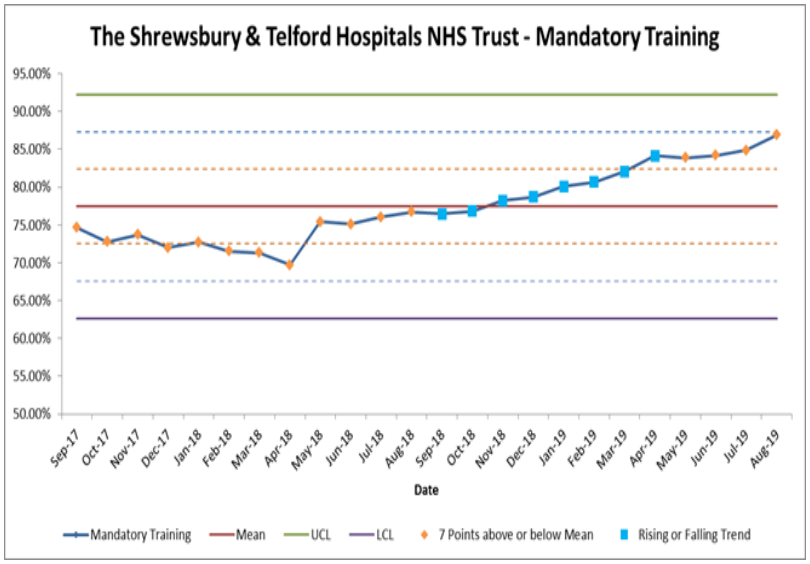
The proportion of patients receiving their last set of observations completed within the frequency set for week 57 showed 353/390= 91% compliance compared to 91% in the previous week, week on week compliance = no change.

Actions taken to address non-compliance:

- 18 patients: Addressed with staff at time of the audit
- 8 patients: No additional action taken as not required
- 8 patients: No more than 30 minutes overdue
- 3 patients: Informed Nurse in Charge

This will continue to be monitored and discussed at huddles to ensure any learning is cascaded.

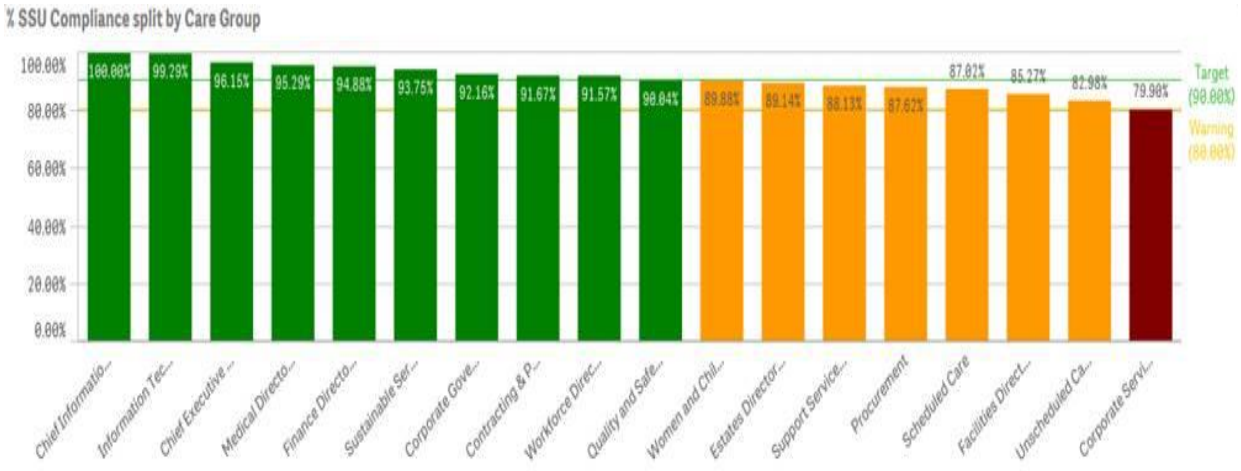
Mandatory Training Compliance

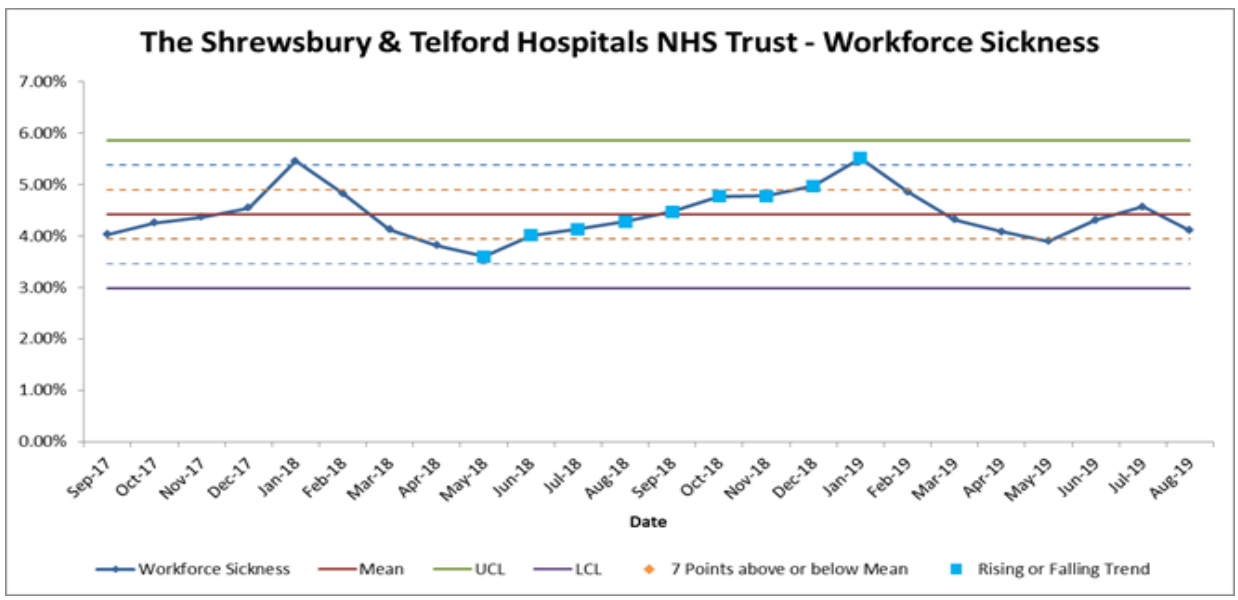


SaTH is continuing to make steady progress to full achievement of the 90% target by December 2019. This is despite considerable operating and staffing pressures in many areas (including sickness, as seen in the graph below) and additional training requirements being confirmed and implemented to meet patient and staff safety needs. Below the graph illustrates the compliance split by the care groups

Partially Achieving Standard

% SSU Compliance split by Care Group





Infection Prevention and Control

Measure	Annual Target 2019/20	Monthly Target 2019/20	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Year to date 19/20
Total CDI reported	43	4	2	1	1	1	1	1	0	1	2	2			5
CDI due to lapse in care (CCG panel)	43	4	2	1	1	2	1	2	1	2	3	7	5	6	23
MRSA Bacteraemia Infections *Contaminant	0	0	0	0	1*	1*	0	0	0	0	1	0	0	0	1
MSSA Bacteraemia Infections	None	None	3	1	2	1	5	0	0	1	1	3	4	3	13
E. Coli Bacteraemia Infections	None	None	3	7	8	5	2	3	3	2	6	3	2	4	17
MRSA Screening (elective) (%)	95%	95%	97.6%	95.4%	95.9%	95.2%	96.5%	96.1%	95.6%	95.9%	91.8%	95.9%	95.6%	96.1%	95.1%
MRSA Screening (non elective) (%)	95%	95%	96.7%	96.5%	97.1%	97.0%	96.8%	96.5%	96.4%	96.4%	95.9%	94.3%	95.7%	95.5%	95.5%

The new criteria for C.diff reporting were implemented in April 2019. Acute provider objectives have been set using two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission

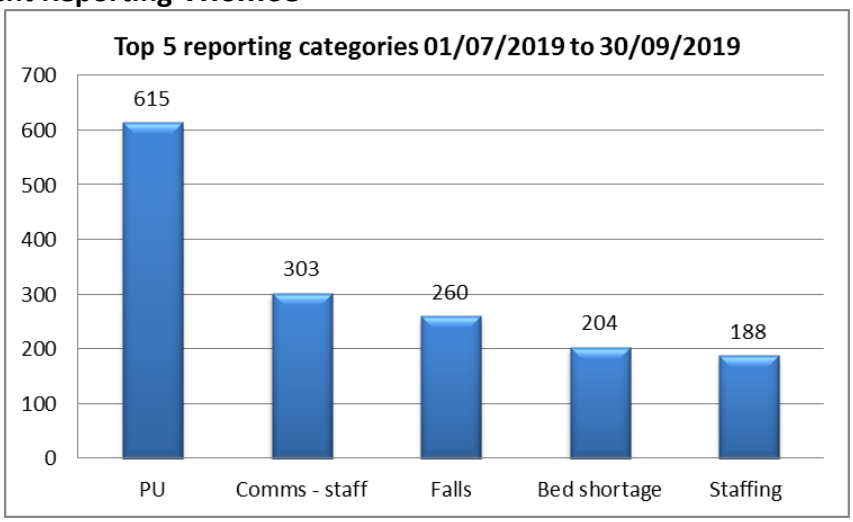
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

These changes affect SaTH as an acute Trust meaning that there is a reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission. Cases are also assigned to SaTH if the patient has been cared for in the Trust within the last 4 weeks.

In August the re were 6 cases of C diff apportioned to the Trust, 3 cases were pre 48 hours but had been an inpatient in SaTH in the previous 28 days and were therefore attributed to the Trust and 3 cases were post 48 hours. The YTD total is 23 against a Trust target of no more than 43 cases in 2019-2020.

Incident Reporting

1 Incident Reporting Themes



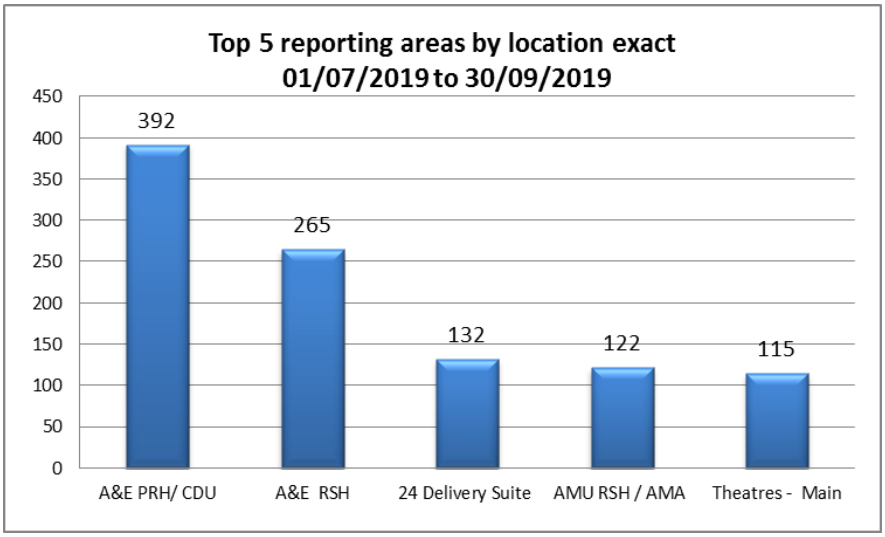
- Pressure ulcers remain the highest reporting category. All hospital acquired PU's are reviewed and will be subject to local High Risk Case review or SI if grade 3 or 4 based on a decision tool approved by CCG's and NHSE. TVN services are subject to a 'deep dive' review lead by the Director of Nursing, Quality and Midwifery.

- As outlined previously review of the communications category has revealed no clear significant themes or trends.

- Falls remains the 3rd highest reporting category but SaTH has remained below the national average outline by the RCP inpatient falls audits for both number of falls per 1000 bed days and number of falls per 1000 bed days resulting in moderate harm or above for the last 12 months. The Deputy Director of Nursing and Associate Director of Quality, Governance and Risk have agreed to review initial decision making and category of harm decisions around falls.

- Bed shortage and staffing issues consistently remain on the top 5 reporting categories. Issues related to beds shortages are linked to the 2019/20 Operational Plan. Workforce challenges and staffing issues are outlined in the appropriate sections of this report .

2 Top 5 Patient Safety Incident reporting areas by location

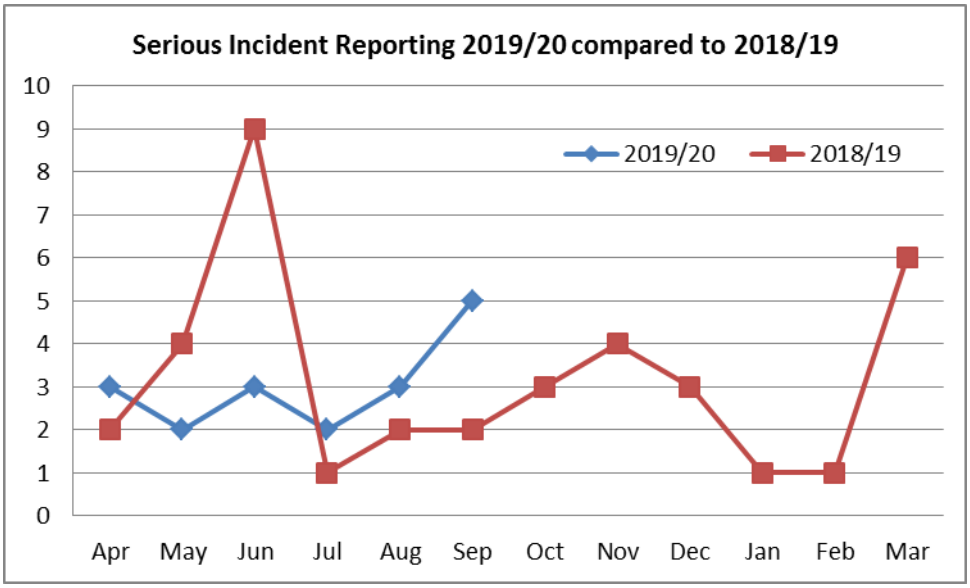


- PRH and RSH Emergency Departments remain the highest incident reporting location over the past 3 months

Incident Reporting

3

Serious Incident Reporting 2018/19 and 2019/20



Serious Incidents

There have been 5 SIs reported in September 2019 compared to 2 for the same period in 2018/19. Reporting is monitored for trends and themes, at present the most significant theme identified relates to failure to follow up radiology diagnostic results.

Work undertaken in both the radiology and colorectal cancer value streams and initial scoping of the 'RadAlert' has been brought together in September by a working group convened by the Director of Clinical Effectiveness. A number of actions have been agreed with a view to testing to mitigate risk. This remains a complex issue with solutions that could significantly reduce risk relating to the development IT systems set against the relative current immaturity of SaTH IT infrastructure.

A N2N incident report relating to Cauda Equina pathways has flagged a risk around the out of hours pathway for patients. The MSK centre is working with colleagues in support services and at RJAH to scope the current pathway and pathway requirements. This is being discussed at Clinical Governance Executive in October with a view to identifying actions to reduce risk.

The Executive Serious Incident Review Group (ESIRG) is now in place and has been reviewing decisions around SI's and signing off draft SI reports. A monthly incident summary and incident learning report will be a key output of ESRIG which will be discussed a Clinical Governance Executive and by exception to Quality and Safety Committee.

Incident Reporting Summary

Assurance

Incident reporting remains in the upper quartile of providers based on NRLS data. Incident reporting is monitored for themes and trends. Currently a Corporate Rapid Review Group meets weekly tor review all moderate or above Datix's raised in a week , complaints and legal cases. The group maintains oversight of incidents to ensure they are subject to the appropriate level of scrutiny and raised as an SI is appropriate. The group also ensures any complaints that need to be raised as incidents are dealt with appropriately and looks for themes and trends across incidents, complaints and legal cases. The group has been strengthened by decision making and scrutiny via the Executive Serious Incident Review Group.

Benchmarking

SaTH remains in the top 25% of incident reporting providers based on NRLS data

Next steps

Based on consistent feedback from staff work is being undertaken to improve feedback following submission of a Datix 'Doing Datix Differently'. A high level set of actions has been agreed by Clinical Governance Executive and a further consultation with staff/call for ideas has been undertaken in during June/August. A plan relating to Datix feedback has been taken through the appropriate Governance route for approval during September as a key component of a wider response to the recently published NHSI Patient Safety Strategy.

Mortality

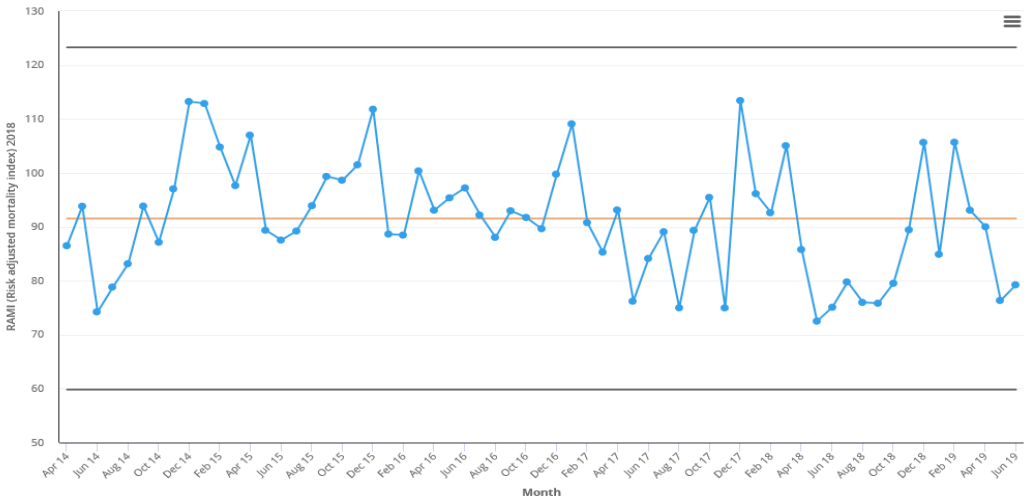
Mortality metrics CHKS July 2018 – June 2019

Description	Local Numerator	Local Denominator	Jul 17 - Jun 19	Jul 16 - Jun 18	Change	Peer Value	Performance
HSMR (Hospital Standardised Mortality Ratio)	3134	3459	90.60	94.54		95.07	
SHMI (Summary Hospital-Level Mortality Index) +	4412	4373	100.88	102.12		100.36	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018	3420	5604	61.03	64.03		68.86	
Mortality Rate	3420	324881	1.0527%	1.1259%		1.2054%	
RAMI (Risk adjusted mortality index) 2018	3420	3890	87.91	90.08		91.70	
Rate of Mortality in hospital within 30 days of elective surgery	7	6434	0.10880%	0.13499%		0.13567%	
Rate of Mortality in hospital within 30 days of Non elective surgery	182	16204	1.1232%	1.2082%		1.3860%	
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	19	528	3.598%	4.797%		4.872%	
Rates of mortality in hospital within 30 days of emergency admission with a stroke	209	1889	11.064%	10.879%		12.264%	
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	6	697	0.8608%	2.1795%		3.163%	
Deaths in Low Mortality CCS Groups	41	25334	0.16184%	0.15006%		0.10977%	
Post operative pulmonary embolism or deep vein thrombosis	19	51884	0.03662%	0.03293%		0.03469%	
% Still Births	38	8645	0.4396%	0.4696%		0.3977%	
Mortality Rate - Admitted via A&E	2466	59899	4.117%	4.431%		3.647%	

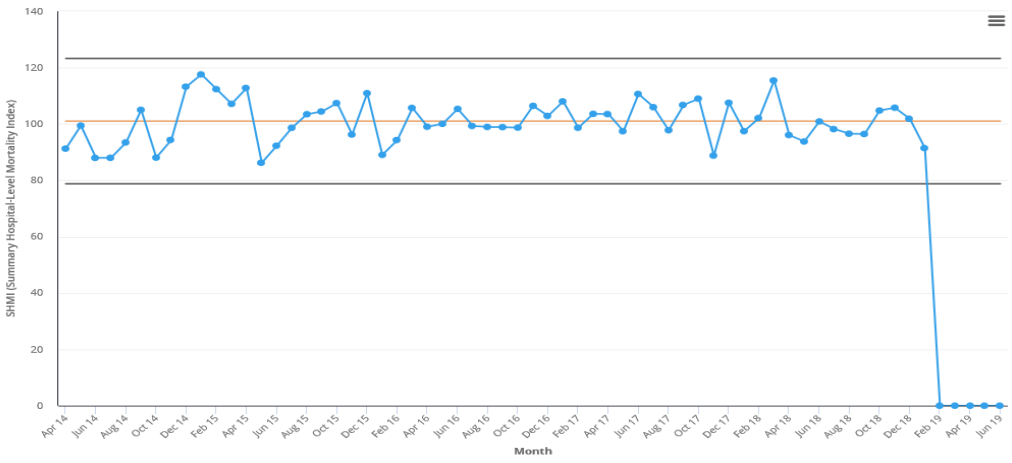
- Overall the Mortality metrics for the Trust, including HSMR, are within the expected range.
- *% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74* reported last month as worse than the previous year is now showing green for better, and is still below the expected range.
- *Deaths in Low Mortality CCS groups* has low numbers but is showing an increase in last year and is at the top end of the expected range. This group includes asthma, drug overdoses and patients coded with abdominal pain. This will be monitored.
- The Acute cerebrovascular disease mortality review is attached as a separate paper

Mortality_5 year Trend April 2014 to June 2019

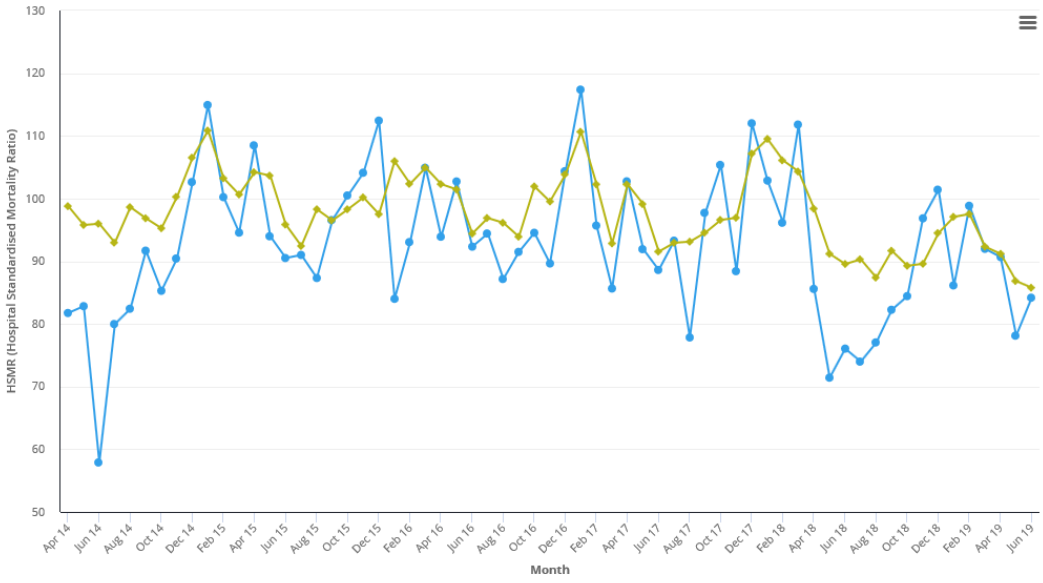
RAMI



SHMI – (note data not updated on CHKS from Feb 19)



HSMR - Monthly variation compared to peer average (Trust blue line)



Mortality

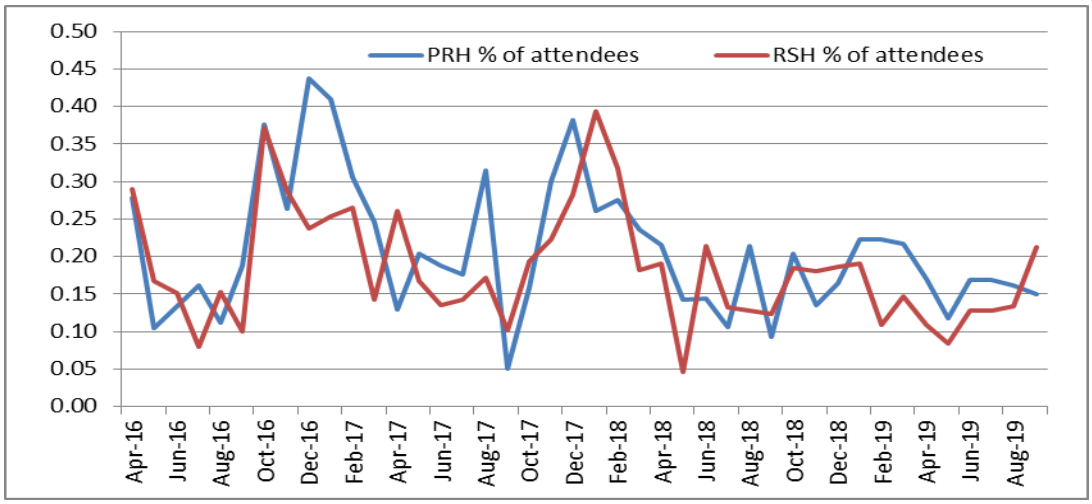
Avoidable deaths September 2019

Two Serious Incidents were reported in September where the patient has died. Both cases were reported to the Coroner, and Death Certificates issued without further investigation.

1. 2019/19528 A patient was treated correctly for C. Difficile prior to her death, but as part of the review, it was found she had possibly developed C. Diff following treatment with antibiotics in June.
2. 2019/21007 A patient sustained a fractured neck of femur following an in- patient fall. The primary cause of death was due to her concurrent illnesses, but immobility from the fall may have contributed to her death.

ED deaths September 2019

Total deaths in ED, as a percentage of attendees, by site



Due to the timing of this report, the attendance data is till provisional. All deaths from September have not yet been reviewed, and will be confirmed in the next report.

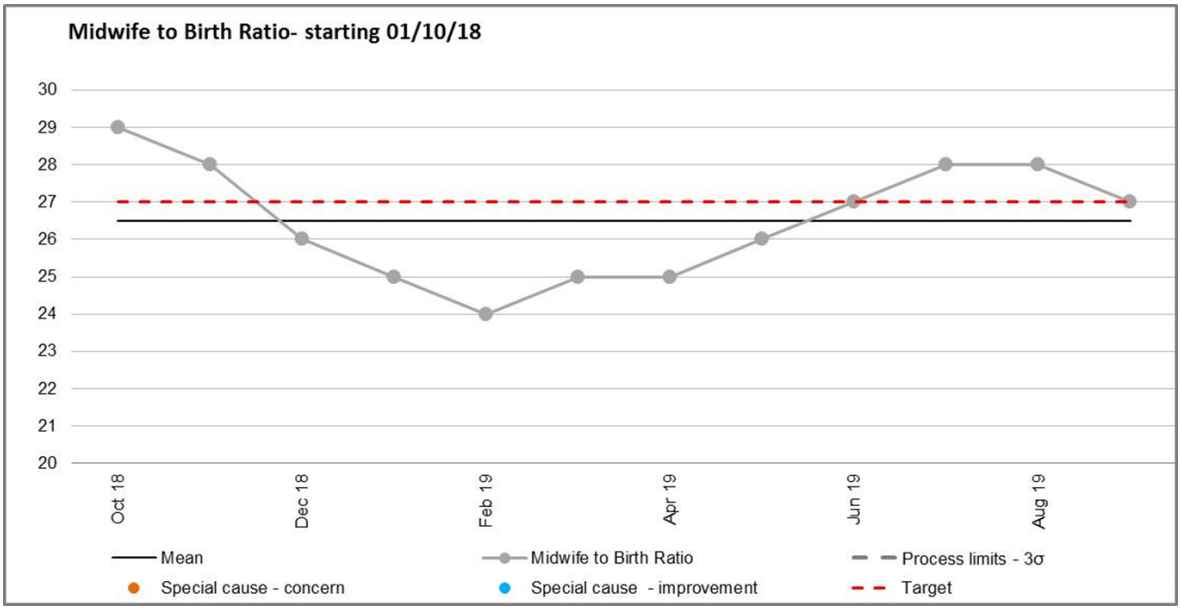
	PRH			
	Attendances	Deaths	OOH	In ED
Apr-19	5902	10	6	3
May-19	7237	9	6	3
Jun-19	5936	10	6	3
Jul-19	6179	14	10	3
Aug-19	7029	8	5	3
Sep-19	5993*	9	tbc	tbc

	RSH			
	Attendances	Deaths	OOH	In ED
Apr-19	5551	6	4	2
May-19	6747	6	4	1
Jun-19	5478	7	5	2
Jul-19	5975	9	2	7
Aug-19	6827	9	3	6
Sep-19	5651	12	tbc	tbc

A Serious incident has been reported (2019/21622) concerning a lady who nearly died at home after leaving the ED because there was a 7 hour wait to be seen, and it has been reported by her son that she thought she was being a burden. The lady had been triaged as very urgent with chest pain, and should not have left. We have been informed she had a cardiac arrest at home, but a paramedic crew had just arrived and she was successfully resuscitated and taken to UHB where she is recovering.

Midwife to Birth Ratio

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Contracted available	166	170	166	168	166	165	163	167	168	168	170	172
Births	405	393	362	346	332	339	341	360	373	395	392	385
Ratio	1:29	1:28	1:26	1:25	1:24	1:25	1:25	1:26	1:27	1:28	1:28	1:27



Achieving Standard

Birth rate overall work on an establishment of 1:27 (1.25 high risk and 1:35 for low risk)
The Birth rate plus 2017 report demonstrated that SaTH required 195.2 WTE Midwives based on 4,194 high risk women and 857 low risk women.
However during 2018/19, 97% of Women delivered on the Consultant unit.

Maternity Summary

The Maternity Services are continuing to drive forward their quality improvement plan. They underwent their CQC mock inspection on 2 October 2019. The feedback is both positive and encouraging with the services moving into the right direction.

Maternity Services and Local CCG's are going out to consultation for the midwifery units.

The excellent improvements made to improve care have been recognised through the Labour unit being awarded Exemplar Diamond for its care.

The continuous improvements made :

•We have reviewed and improved midwifery staffing levels to meet the needs of women and keep women and babies safe to meet BR+

•Quality Improvement Information Boards _ Quality Improvement Information Boards have been introduced to all Maternity Services areas. Feedback and learning from incidents and complaints. Used to highlight continuous improvement, risk register, engagement topic of the month.

•Maternity Movement Bracelet _Increasing awareness of alteredfetaloetal movements

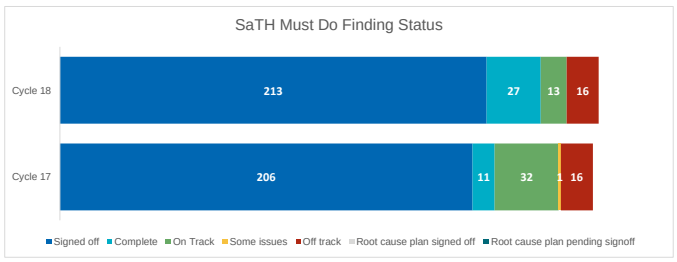
Resourcing
The Interviews for the Director of Midwifery have been held, with offers pending confirmation.

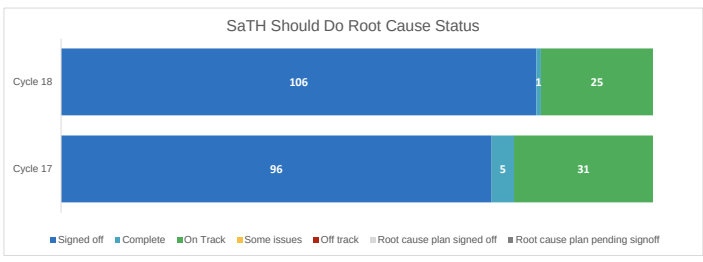
Trust Dashboard - Must Do and Should Do's by Root Cause — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	The Trust has made good progress through Cycle 18, with 347 Root Causes of 401 Must do and Should do Root Causes now complete or signed off (87%). This is behind the planned trajectory of 356 with 16 Root Causes Off track and a number of actions being completed ahead of the initial timescale offsetting this. There are currently 28 Root Causes that are complete and waiting sign off at the Cycle 19 ISG. 96% of all Root Causes rated as on track, complete or signed off. However, 16 Root Causes were identified as being off track at Cycle 18. • Women and Children's RAG status is Green. They have completed 77 of 82 Root Causes with a number of these completed ahead of the trajectory. There is only 5 left to compete with all of the remaining actions on track. • Scheduled Care RAG status remains Green with 93 of the 101 Root cause actions Complete or Signed Off. There is only 8 left to complete with all of the remaining actions on track. • Unscheduled Care RAG status remains Amber as there are now 6 Off Track root causes, see details below. 85 of the 95 Root Causes now rated as either complete or signed off. MD047.2 - Corporate. Due 31/07/19 - Head of Capacity has created a series of cards to be laminated and kept on each ward as a quick reference point. This will be in place of the planned One Minute brief. These are expected to be distributed wc 28/10/19 MD036.1 - Corporate. Due 31/07/19 - SOP being drafted to cover transfer of patients on the ward MD034.1 - Corporate. Due 31/08/19 - Raised with Director of Nursing. Task and finish group scheduled for 4th November to resolve way forward on actions related to protected meal times and patient transfers. MD045.1 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Action to ensure that the 'Deteriorating Patients Policy', 'Deteriorating Patient - Vital Sign Assessment and the use of National Early Warning Scores in adults SOP' and the 'Sepsis Tool and Care Bundle SOP (SOP 2604)' clearly articulate roles and responsibilities within the pathway (including expectations regarding timeliness of response) - to be taken forward by the Deteriorating Patient Committee MD045.3 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Plan to trial PGD on AMU. Aiming for training and competency documents to be rolled out early next year MD033.5 - Corporate. Due 31/10/19. Awaiting new nursing documentation. • Workforce RAG Status remains Amber, with 92 of 123 (75%) Root Causes Complete or Signed Off. 10 Root Causes are rated as Off Track, details below; MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6) MDTRAIN01.9 The trust must ensure staff complete mandatory training in line with the trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9) MD067.21. Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.

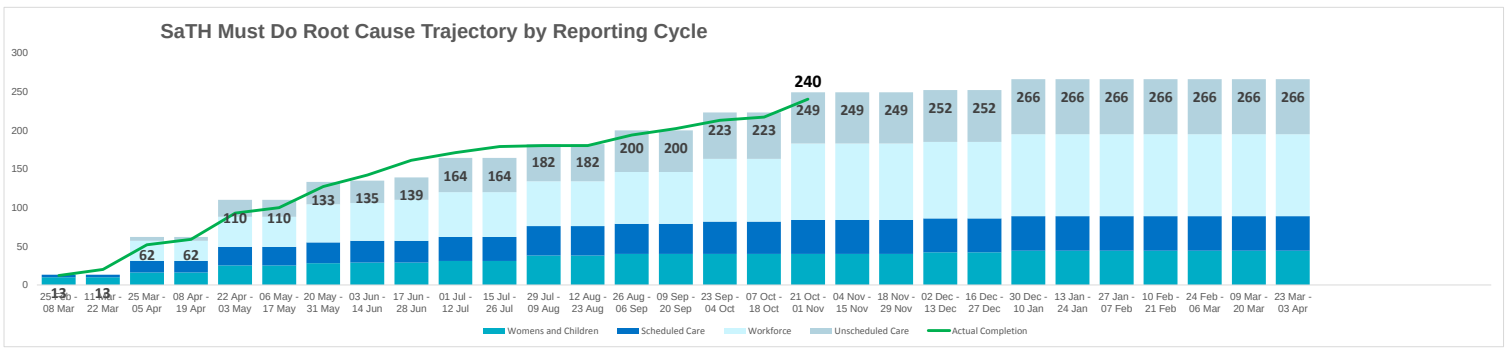
Root Cause Status

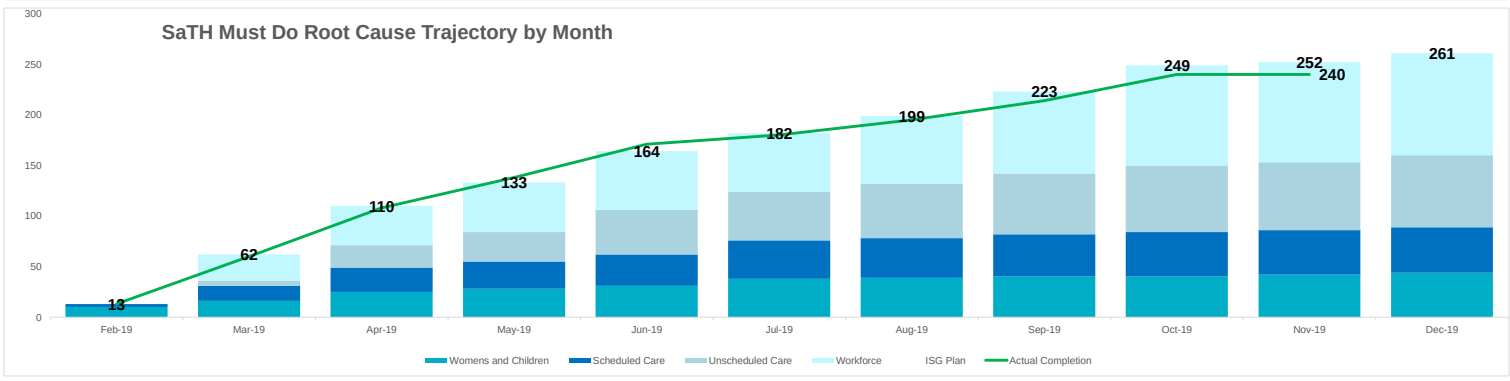




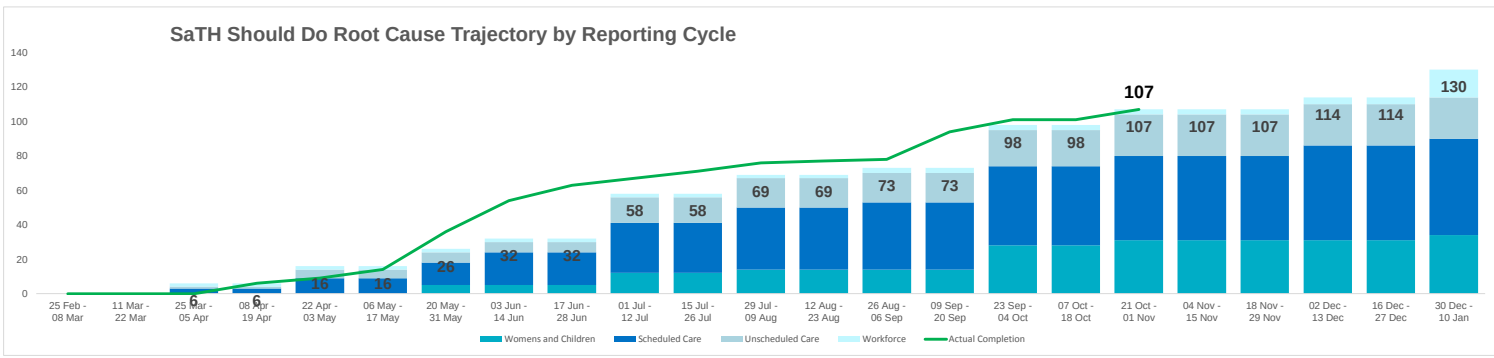
	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	269	213 (79%)	27 (10%)	13 (5%)	0 (0%)	16 (6%)
Should Dos	132	106 (80%)	1 (1%)	25 (19%)	0 (0%)	0 (0%)

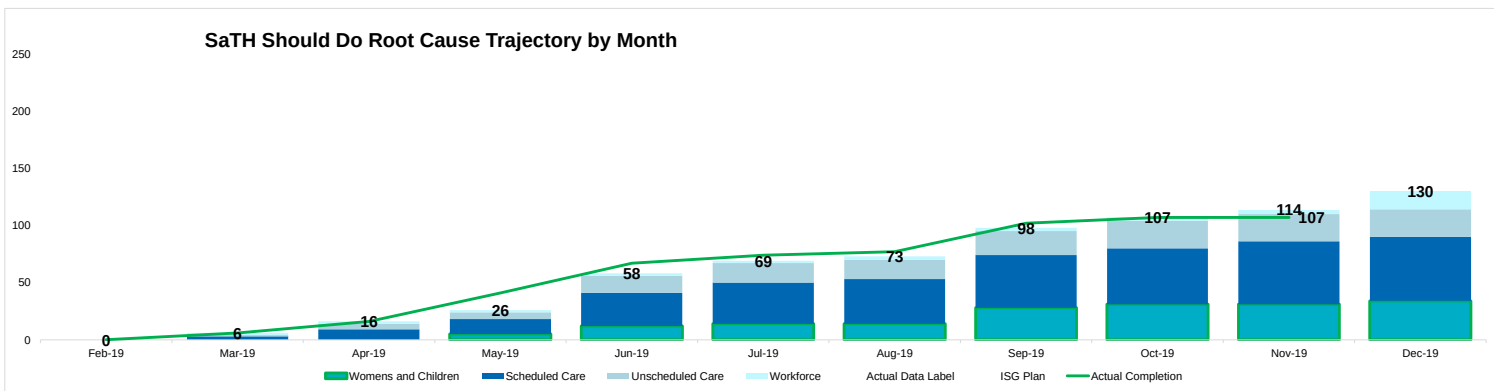
Must Do Trajectories





Should Do Trajectory



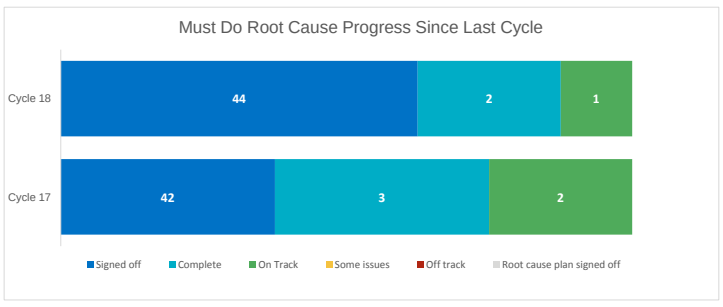


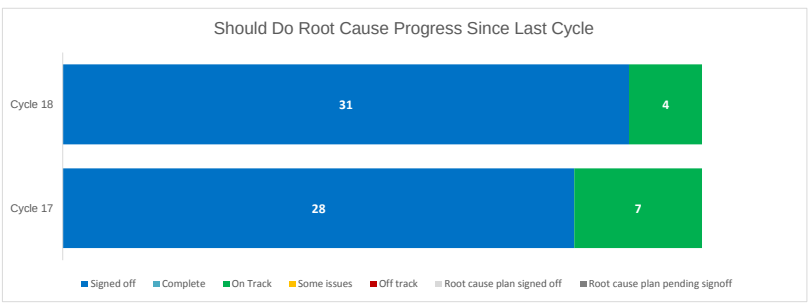
Womens and Children Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
G	G	Women and Children's has made progress through Cycle 18, with 77 Root Causes of 82 Must do and Should do Root Causes now complete or signed off (94 % in total). This is ahead of the trajectory of 71. All Root Causes are rated as on track, complete or signed off. Overall summary of progress for Cycle 18: * 75 Root Causes have been signed off. * 2 Root Causes are complete awaiting sign off. * 5 Root Causes are currently on track, all due for completion by 28/02/2020 (Following MLU relocation).

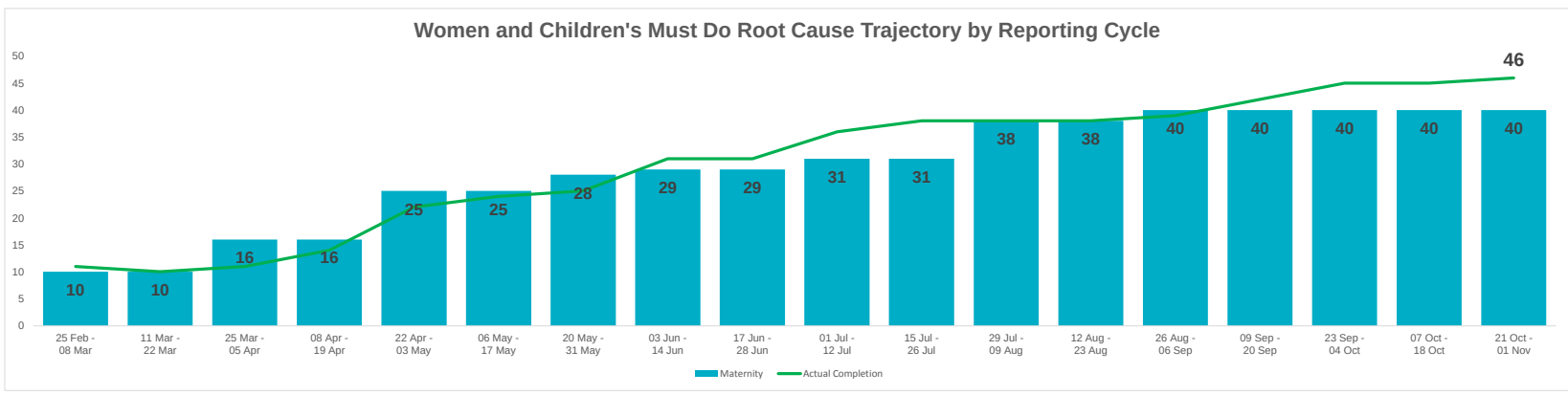
Root Cause Status



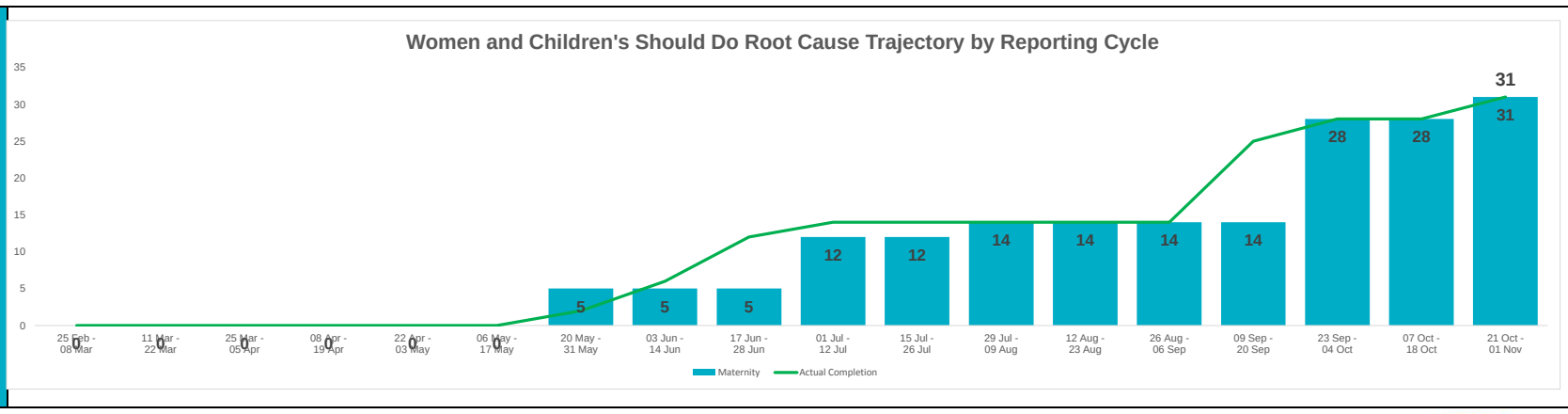


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	47	44 (94%)	2 (4%)	1 (2%)	0 (0%)	0 (0%)
Should Dos	35	31 (89%)	0 (0%)	4 (11%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory

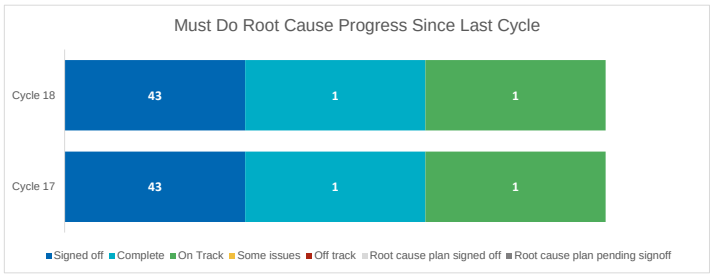


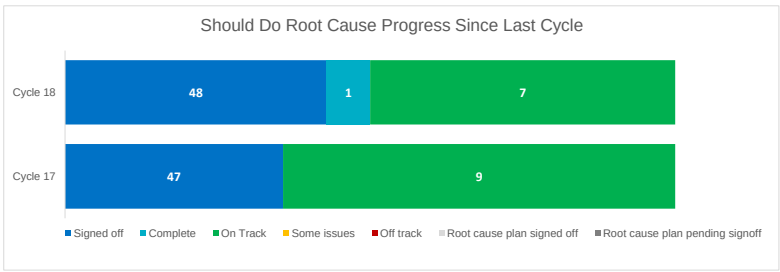
Scheduled Care Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
G	G	Scheduled Care is working towards completion of the QIP and continues to make progress with Cycle 18 with no items off track and with several Root Causes completed ahead of the planned trajectory. 43 (96%) of 45 Must Do's signed off, 1 is complete awaiting evidence for sign off (MD068.2 the work to be done with Clinical Audits has been escalated in preparation for this) and the remaining Root Cause is on track for completion by 31.12.19. No Must Do's are off Track. For Should Do's 48 of the 56 (86%) are signed off, 1 is complete awaiting Sign Off and 7 (13%) are On Track for completion within the planned timescale. Overall summary of progress: *91 Root Causes of the total of 101 have been signed off. *2 Root Cause are complete awaiting sign off. *8 Root Causes are on track, with 6 due for completion by the end of November. The KPIS/metrics are being tracked monthly. The ISG meetings are taking place monthly on the last Friday of the month, based on the continuing positive progress made. The additional time is being invested in embedding the learning and improvements to taking place with staff. The information gathered is being collated to form an audit report for further actions. The Quality Walks started on Friday 13th September and the outcomes are discussed and reviewed at the ISG meeting.

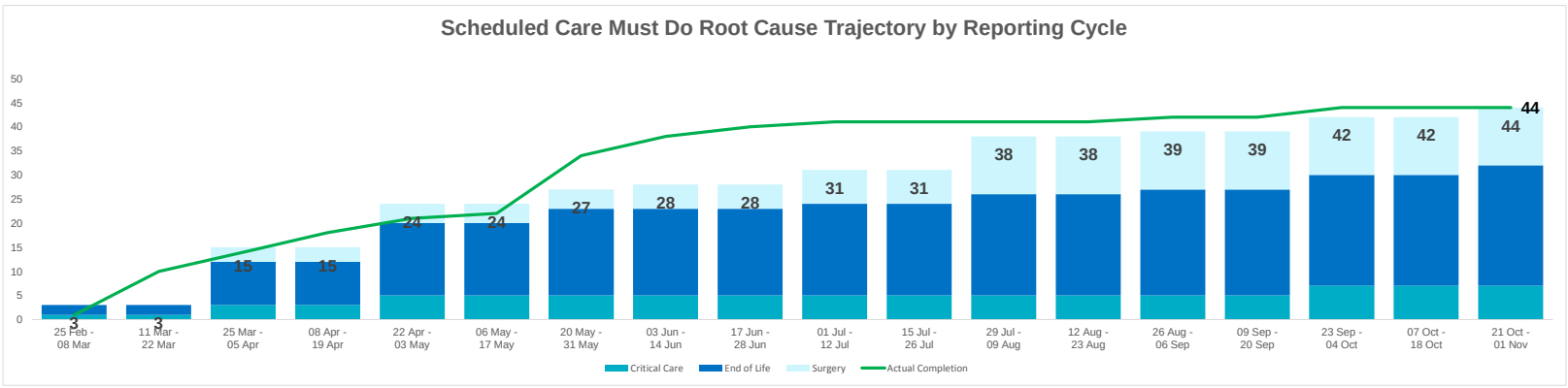
Root Cause Status



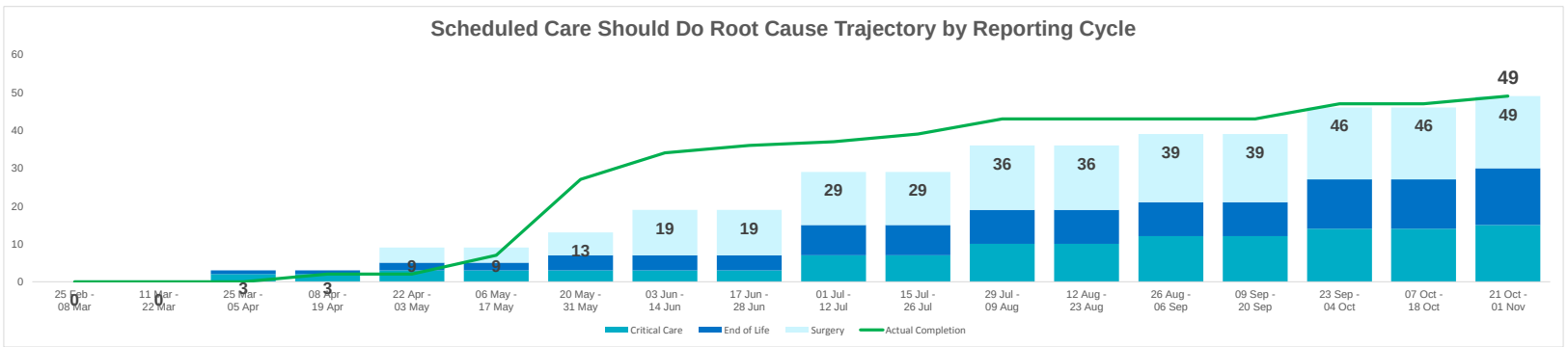


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	45	43 (96%)	1 (2%)	1 (2%)	0 (0%)	0 (0%)
Should Dos	56	48 (86%)	1 (2%)	7 (13%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory

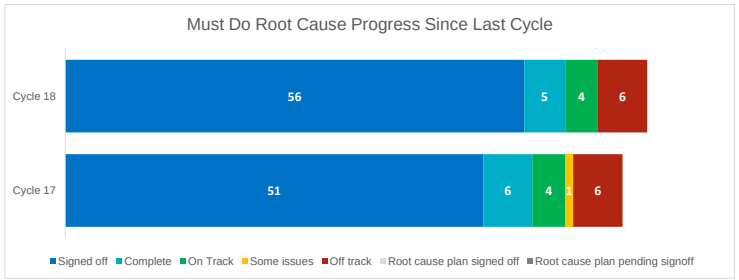


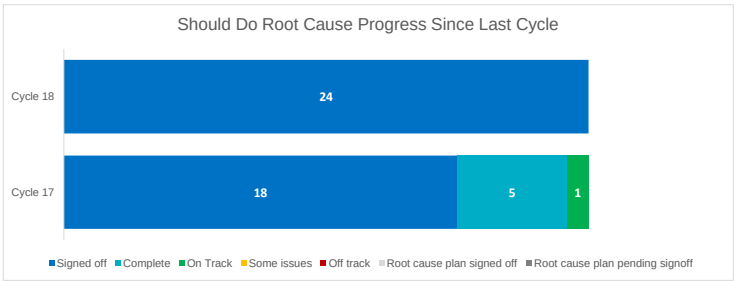
Unscheduled Care Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	Following the splitting of several Root Causes, the total number of Root Causes has increased from 92 to 95 since the last reporting period. 85 Root Causes of 95 Must do and Should do now complete or signed off (89%), this is below of the planned trajectory of 90. There are currently 5 Root Cause that are complete and awaiting sign off and 4 on track. This results in 94% of all Root Causes rated as on track, complete or signed off. All Should Do Root Causes have now been signed off. Overall summary of progress: *80 Root Causes have been signed off. *5 are complete and awaiting validation of evidence by the ISG. *4 are on track *6 are off track. 1 relates to Equipment, 1 to Flow, 2 to Sepsis, 1 relates to Nursing documentation and 1 to Mental Health/Capacity. Significant work is being undertaken to resolve this. MD047.2 - Corporate. Due 31/07/19 - Head of Capacity has created a series of cards to be laminated and kept on each ward as a quick reference point. This will be in place of the planned One Minute brief. These are expected to be distributed wc 28/10/19 MD036.1 - Corporate. Due 31/07/19 - SOP being drafted to cover transfer of patients on the ward MD034.1 - Corporate. Due 31/08/19 - Raised with Director of Nursing. Task and finish group scheduled for 4th November to resolve way forward on actions related to protected meal times and patient transfers. MD045.1 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Action to ensure that the 'Deteriorating Patients Policy', 'Deteriorating Patient - Vital Sign Assessment and the use of National Early Warning Scores in adults SOP' and the 'Sepsis Tool and Care Bundle SOP (SOP 2604)' clearly articulate roles and responsibilities within the pathway (including expectations regarding timeliness of response) - to be taken forward by the Deteriorating Patient Committee MD045.3 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Plan to trial PGD on AMU. Aiming for training and competency documents to be rolled out early next year MD033.5 - Corporate. Due 31/10/19. Awaiting new nursing documentation.

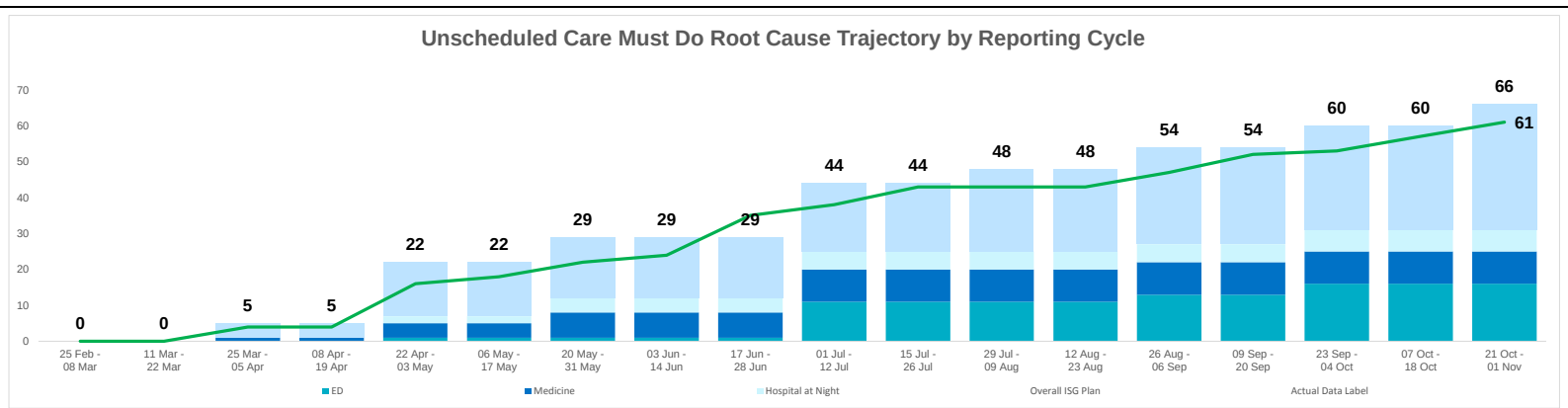
Root Cause Status



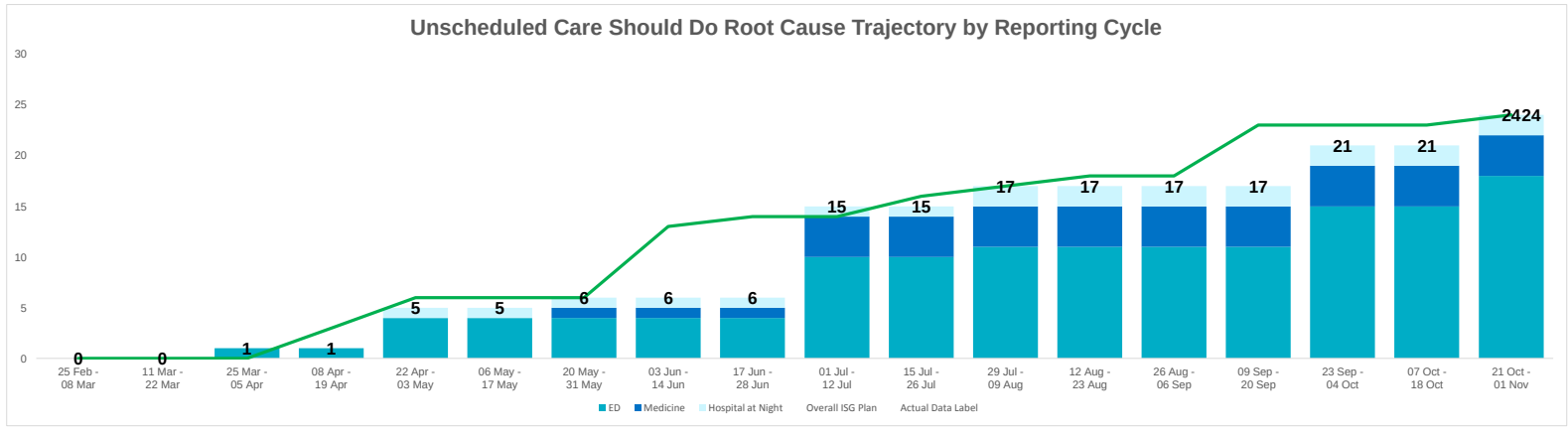


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	71	56 (79%)	5 (7%)	4 (6%)	0 (0%)	6 (8%)
Should Dos	24	24 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory



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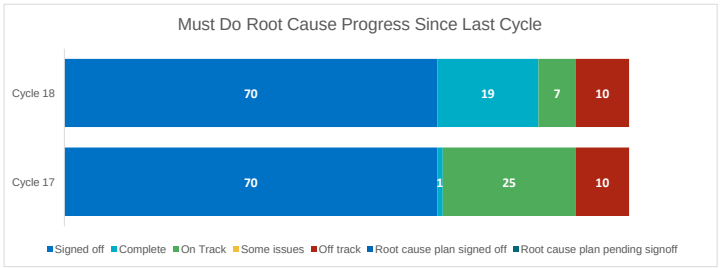
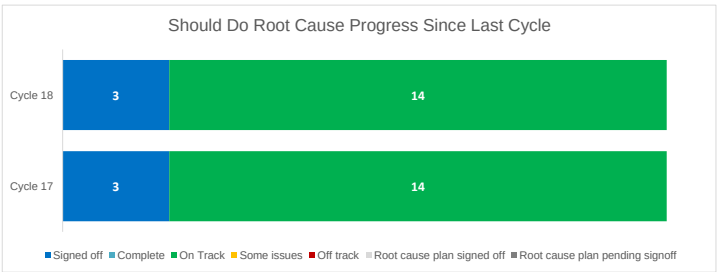
Workforce Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	Workforce has made a little progress through Cycle 18, with 92 Root Causes of 123 (75%) Must do and Should do now complete or signed off. This is behind the target for the planned trajectory of 102. Progress during Cycle 18 continues to be severely impacted by the inter-dependencies of the challenges being faced particularly around recruitment and staffing levels as well as Executive capacity to consider escalated items. There are currently 19 Root Causes that are complete and awaiting sign off awaiting evidence verification as a result of a number of items identified as complete at the Cycle 18 ISG but without Exec presence to be able to sign them off and evidence files not fully populated. 10 Root Causes remain off track at Cycle 18. This is linked to progress on 3 sets of actions addressing long-standing and complex issues. 92% of all Root Causes rated as on track, complete or signed off. Overall summary of progress: *73 Root Causes have been signed off in total. *19 are complete and awaiting validation of evidence by the ISG *21 are on track, with the majority of all outstanding actions due for completion by the end of December. *10 are Off Track and have been escalated. Details as follows ; MDSTAFF01.1 (second part) cannot be evidenced as completed as Trust business planning cycle is not evidently in progress in Q3 .Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6) MDTRAIN01.9 The trust must ensure staff complete mandatory training in line with the trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9) MD067.21.Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision which is a specialism encountering national shortages.

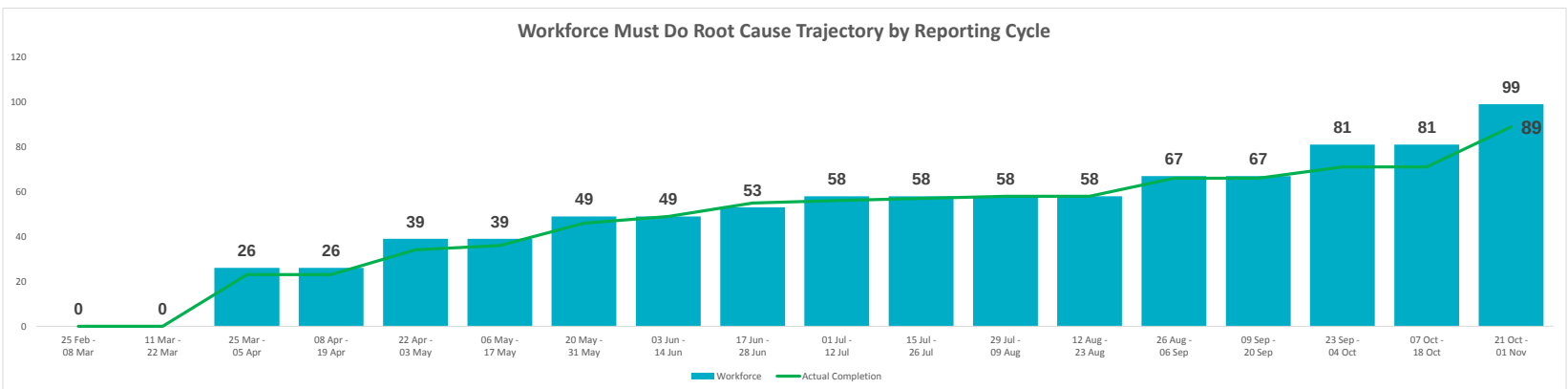
Root Cause Status



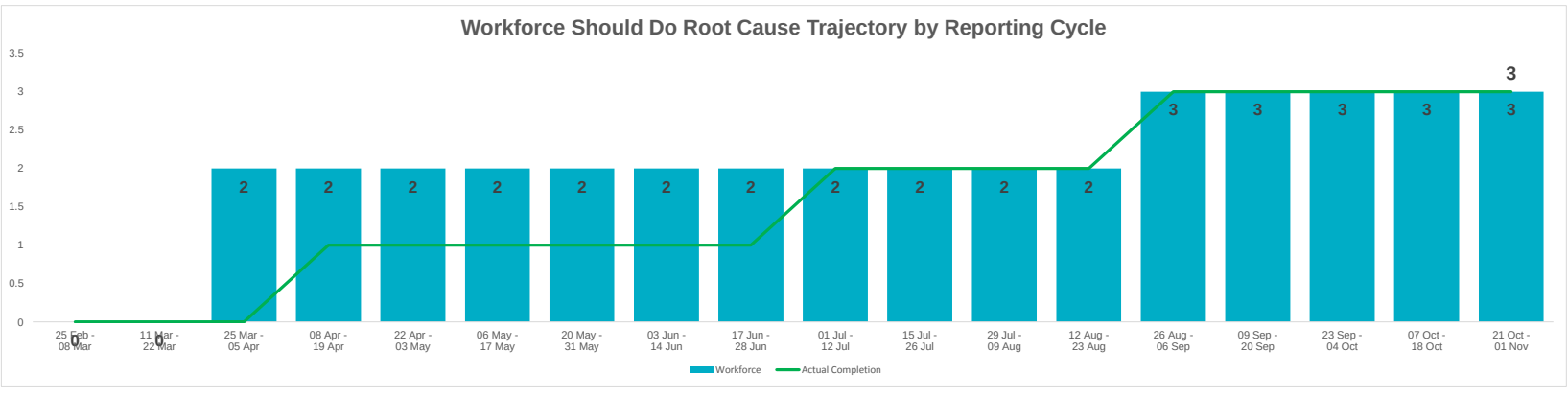


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	106	70 (66%)	19 (18%)	7 (7%)	0 (0%)	10 (9%)
Should Dos	17	3 (18%)	0 (0%)	14 (82%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory



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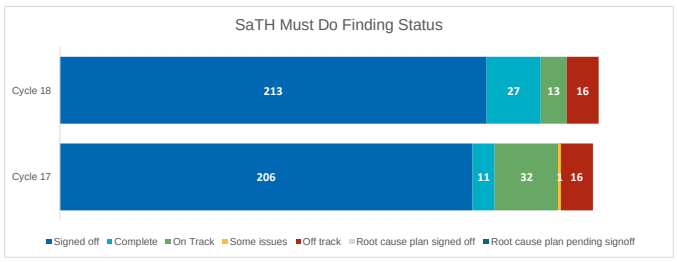
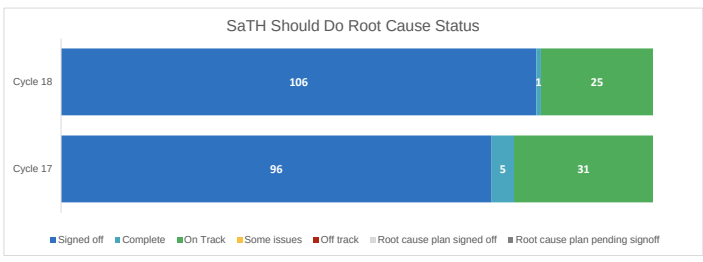
Trust Dashboard - Must Do and Should Do's by Root Cause — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	The Trust has made good progress through Cycle 18, with 347 Root Causes of 401 Must do and Should do Root Causes now complete or signed off (87%). This is behind the planned trajectory of 356 with 16 Root Causes Off track and a number of actions being completed ahead of the initial timescale offsetting this. There are currently 28 Root Causes that are complete and waiting sign off at the Cycle 19 ISG. 96% of all Root Causes rated as on track, complete or signed off. However, 16 Root Causes were identified as being off track at Cycle 18. • Women and Children's RAG status is Green. They have completed 77 of 82 Root Causes with a number of these completed ahead of the trajectory. There is only 5 left to compete with all of the remaining actions on track. • Scheduled Care RAG status remains Green with 93 of the 101 Root cause actions Complete or Signed Off. There is only 8 left to complete with all of the remaining actions on track. • Unscheduled Care RAG status remains Amber as there are now 6 Off Track root causes, see details below. 85 of the 95 Root Causes now rated as either complete or signed off. MD047.2 - Corporate. Due 31/07/19 - Head of Capacity has created a series of cards to be laminated and kept on each ward as a quick reference point. This will be in place of the planned One Minute brief. These are expected to be distributed wc 28/10/19 MD036.1 - Corporate. Due 31/07/19 - SOP being drafted to cover transfer of patients on the ward MD034.1 - Corporate. Due 31/08/19 - Raised with Director of Nursing. Task and finish group scheduled for 4th November to resolve way forward on actions related to protected meal times and patient transfers. MD045.1 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Action to ensure that the 'Deteriorating Patients Policy', 'Deteriorating Patient - Vital Sign Assessment and the use of National Early Warning Scores in adults SOP' and the 'Sepsis Tool and Care Bundle SOP (SOP 2604)' clearly articulate roles and responsibilities within the pathway (including expectations regarding timeliness of response) - to be taken forward by the Deteriorating Patient Committee MD045.3 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Plan to trial PGD on AMU. Aiming for training and competency documents to be rolled out early next year MD033.5 - Corporate. Due 31/10/19. Awaiting new nursing documentation. • Workforce RAG Status remains Amber, with 92 of 123 (75%) Root Causes Complete or Signed Off. 10 Root Causes are rated as Off Track, details below; MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6) MDTRAIN01.9 The trust must ensure staff complete mandatory training in line with the trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9) MD067.21. Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.

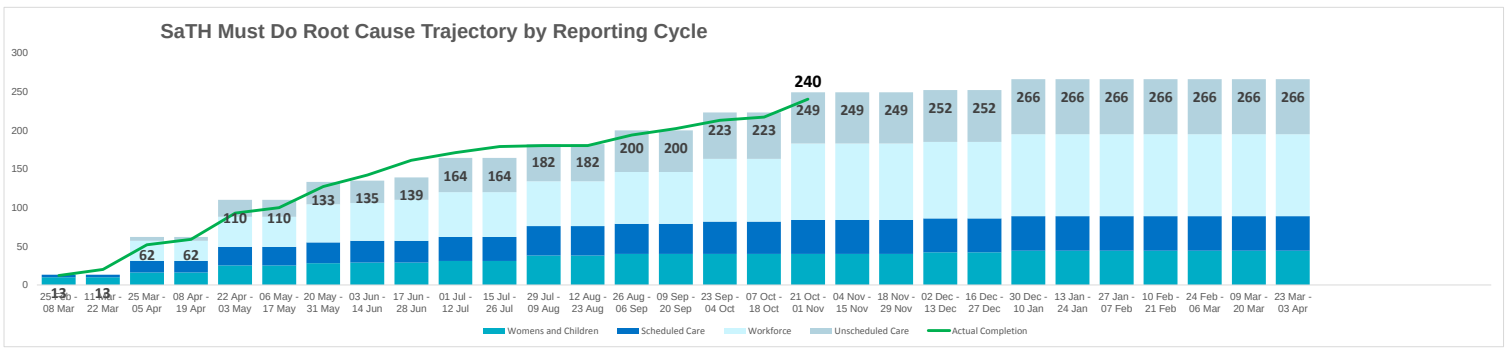
Root Cause Status

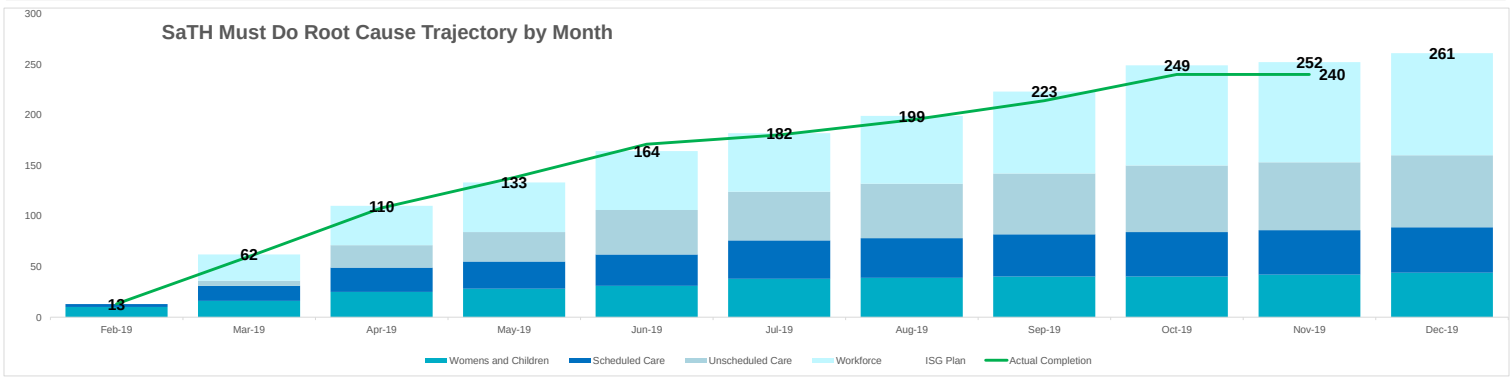




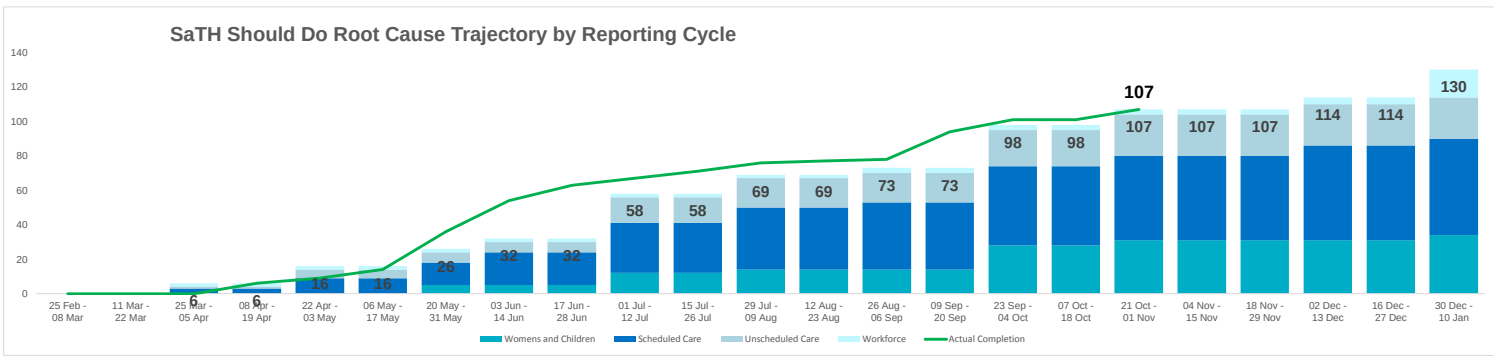
	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	269	213 (79%)	27 (10%)	13 (5%)	0 (0%)	16 (6%)
Should Dos	132	106 (80%)	1 (1%)	25 (19%)	0 (0%)	0 (0%)

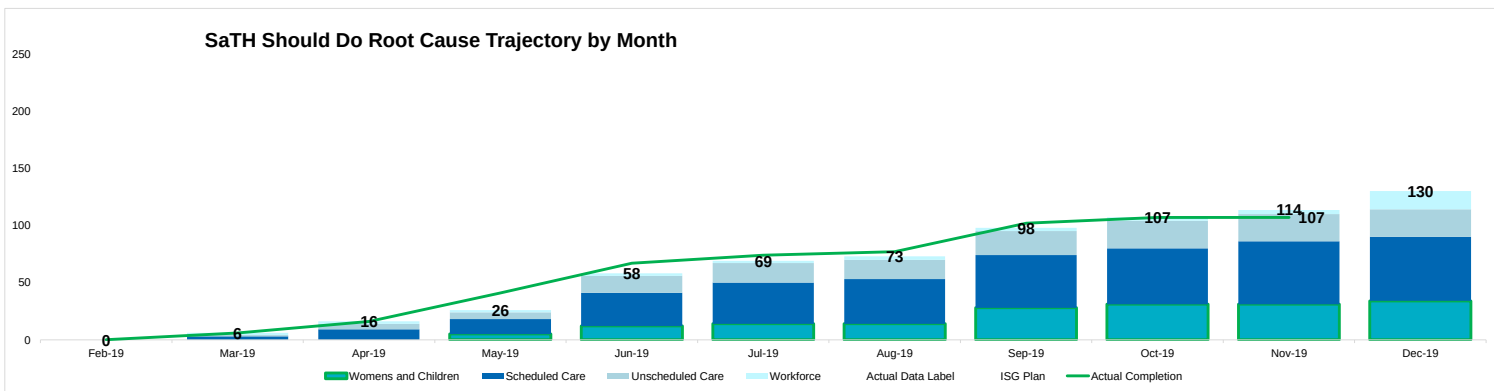
Must Do Trajectories





Should Do Trajectory



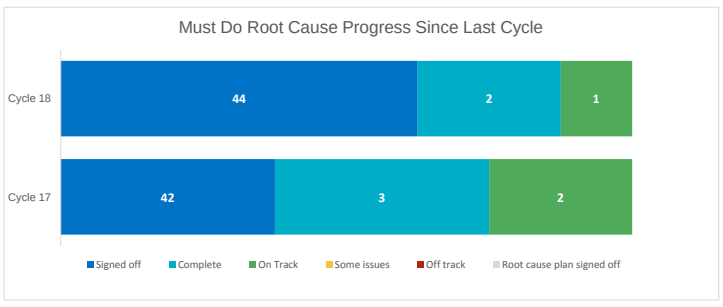


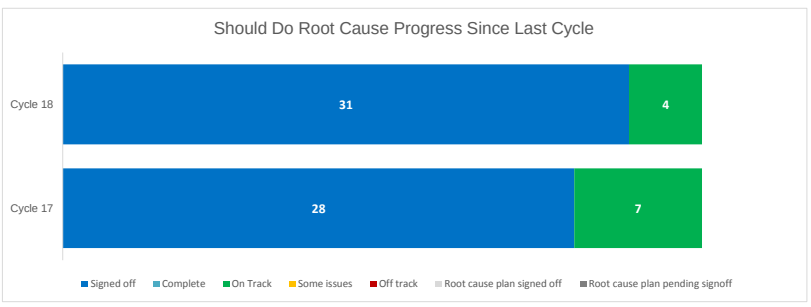
Womens and Children Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
G	G	Women and Children's has made progress through Cycle 18, with 77 Root Causes of 82 Must do and Should do Root Causes now complete or signed off (94 % in total). This is ahead of the trajectory of 71. All Root Causes are rated as on track, complete or signed off. Overall summary of progress for Cycle 18: * 75 Root Causes have been signed off. * 2 Root Causes are complete awaiting sign off. * 5 Root Causes are currently on track, all due for completion by 28/02/2020 (Following MLU relocation).

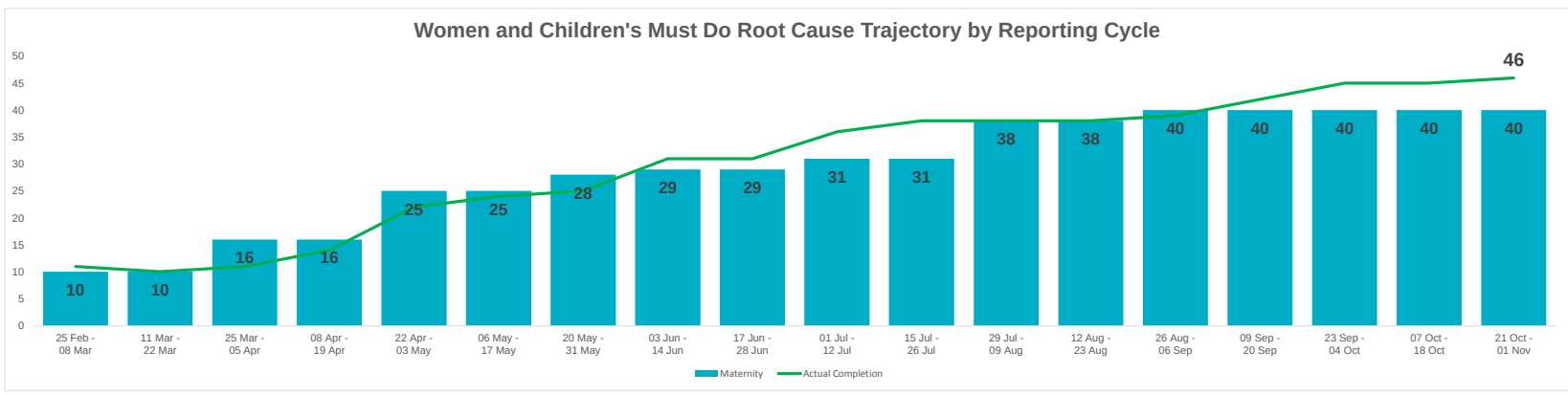
Root Cause Status



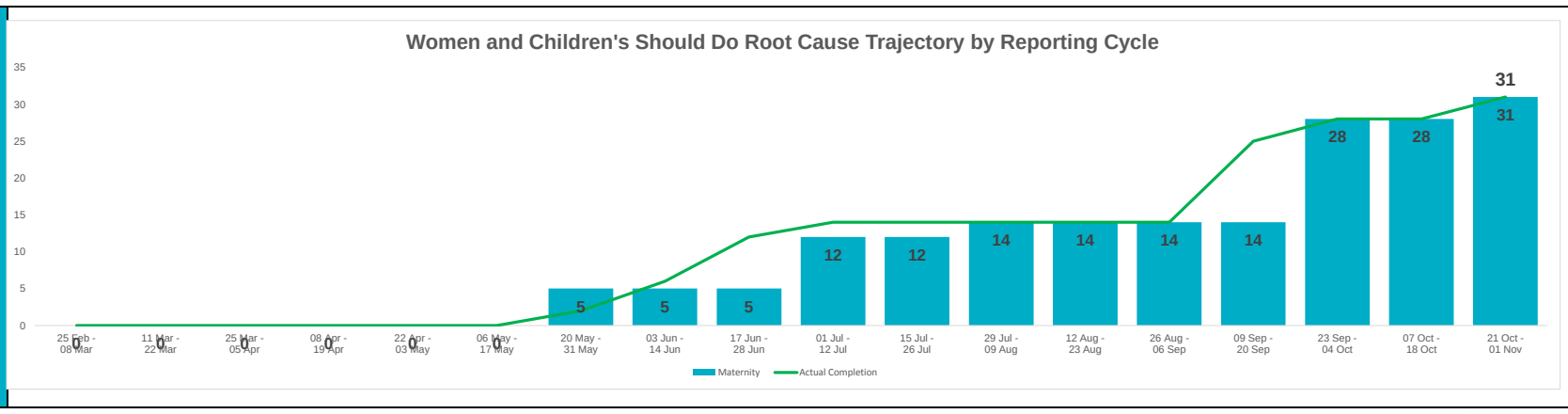


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	47	44 (94%)	2 (4%)	1 (2%)	0 (0%)	0 (0%)
Should Dos	35	31 (89%)	0 (0%)	4 (11%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory

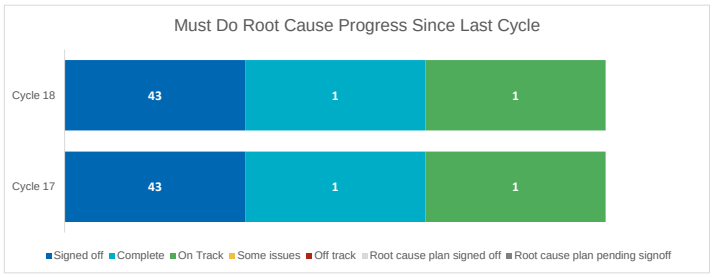


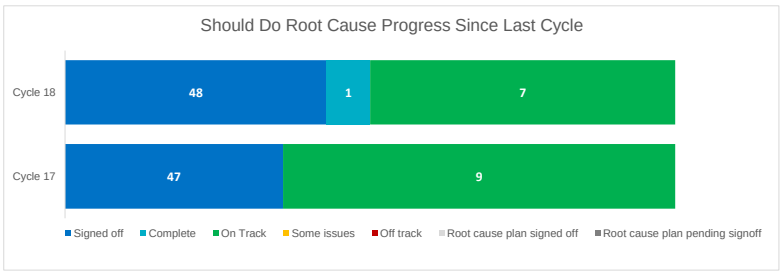
Scheduled Care Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
G	G	Scheduled Care is working towards completion of the QIP and continues to make progress with Cycle 18 with no items off track and with several Root Causes completed ahead of the planned trajectory. 43 (96%) of 45 Must Do's signed off, 1 is complete awaiting evidence for sign off (MD068.2 the work to be done with Clinical Audits has been escalated in preparation for this) and the remaining Root Cause is on track for completion by 31.12.19. No Must Do's are off Track. For Should Do's 48 of the 56 (86%) are signed off, 1 is complete awaiting Sign Off and 7 (13%) are On Track for completion within the planned timescale. Overall summary of progress: *91 Root Causes of the total of 101 have been signed off. *2 Root Cause are complete awaiting sign off. *8 Root Causes are on track, with 6 due for completion by the end of November. The KPIS/metrics are being tracked monthly. The ISG meetings are taking place monthly on the last Friday of the month, based on the continuing positive progress made. The additional time is being invested in embedding the learning and improvements to taking place with staff. The information gathered is being collated to form an audit report for further actions. The Quality Walks started on Friday 13th September and the outcomes are discussed and reviewed at the ISG meeting.

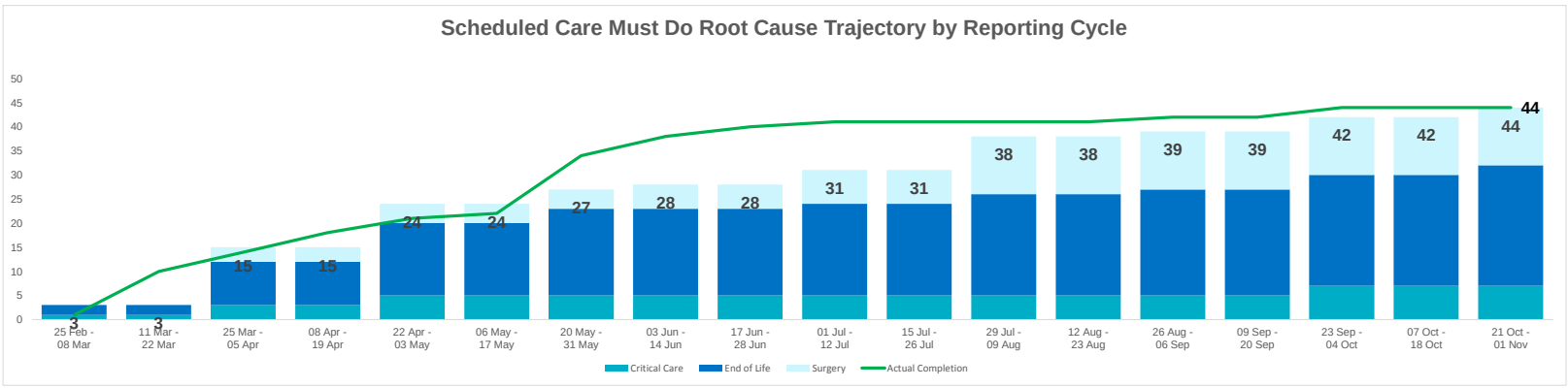
Root Cause Status



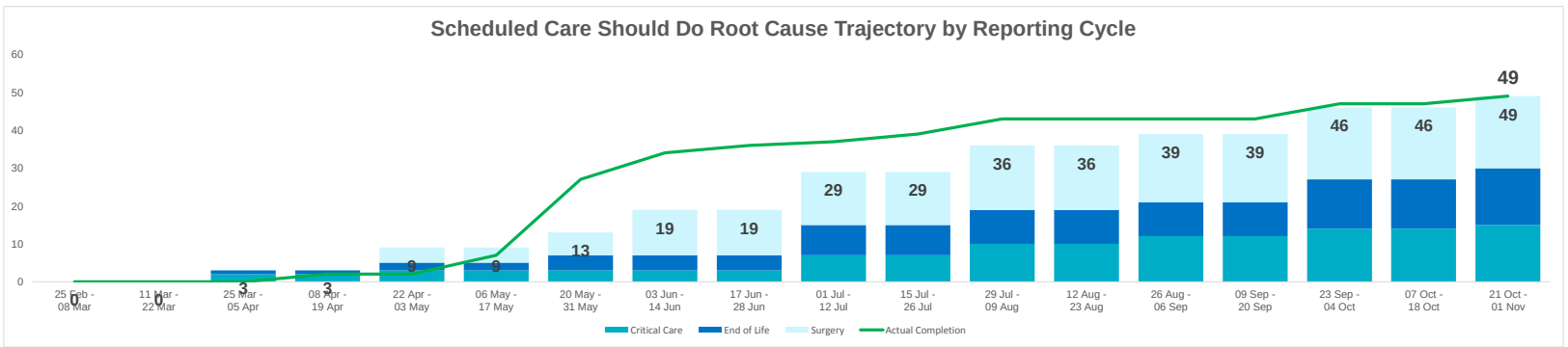


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	45	43 (96%)	1 (2%)	1 (2%)	0 (0%)	0 (0%)
Should Dos	56	48 (86%)	1 (2%)	7 (13%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory

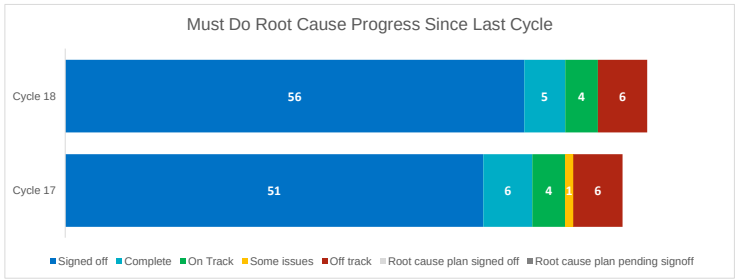


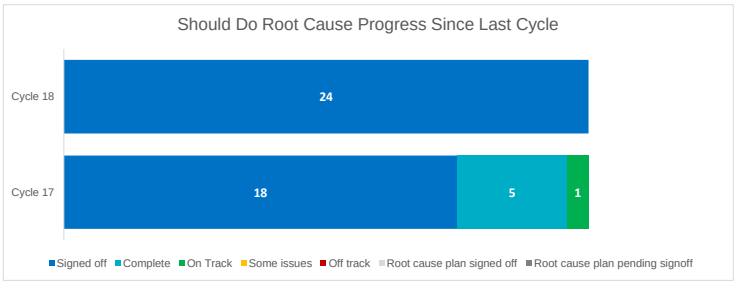
Unscheduled Care Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	Following the splitting of several Root Causes, the total number of Root Causes has increased from 92 to 95 since the last reporting period. 85 Root Causes of 95 Must do and Should do now complete or signed off (89%), this is below of the planned trajectory of 90. There are currently 5 Root Cause that are complete and awaiting sign off and 4 on track. This results in 94% of all Root Causes rated as on track, complete or signed off. All Should Do Root Causes have now been signed off. Overall summary of progress: *80 Root Causes have been signed off. *5 are complete and awaiting validation of evidence by the ISG. *4 are on track *6 are off track. 1 relates to Equipment, 1 to Flow, 2 to Sepsis, 1 relates to Nursing documentation and 1 to Mental Health/Capacity. Significant work is being undertaken to resolve this. MD047.2 - Corporate. Due 31/07/19 - Head of Capacity has created a series of cards to be laminated and kept on each ward as a quick reference point. This will be in place of the planned One Minute brief. These are expected to be distributed wc 28/10/19 MD036.1 - Corporate. Due 31/07/19 - SOP being drafted to cover transfer of patients on the ward MD034.1 - Corporate. Due 31/08/19 - Raised with Director of Nursing. Task and finish group scheduled for 4th November to resolve way forward on actions related to protected meal times and patient transfers. MD045.1 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Action to ensure that the 'Deteriorating Patients Policy', 'Deteriorating Patient - Vital Sign Assessment and the use of National Early Warning Scores in adults SOP' and the 'Sepsis Tool and Care Bundle SOP (SOP 2604)' clearly articulate roles and responsibilities within the pathway (including expectations regarding timeliness of response) - to be taken forward by the Deteriorating Patient Committee MD045.3 - Corporate. Due 31/08/19. All Sepsis Root Causes being reviewed via Sepsis Steering Group to ensure pace of progress. Plan to trial PGD on AMU. Aiming for training and competency documents to be rolled out early next year MD033.5 - Corporate. Due 31/10/19. Awaiting new nursing documentation.

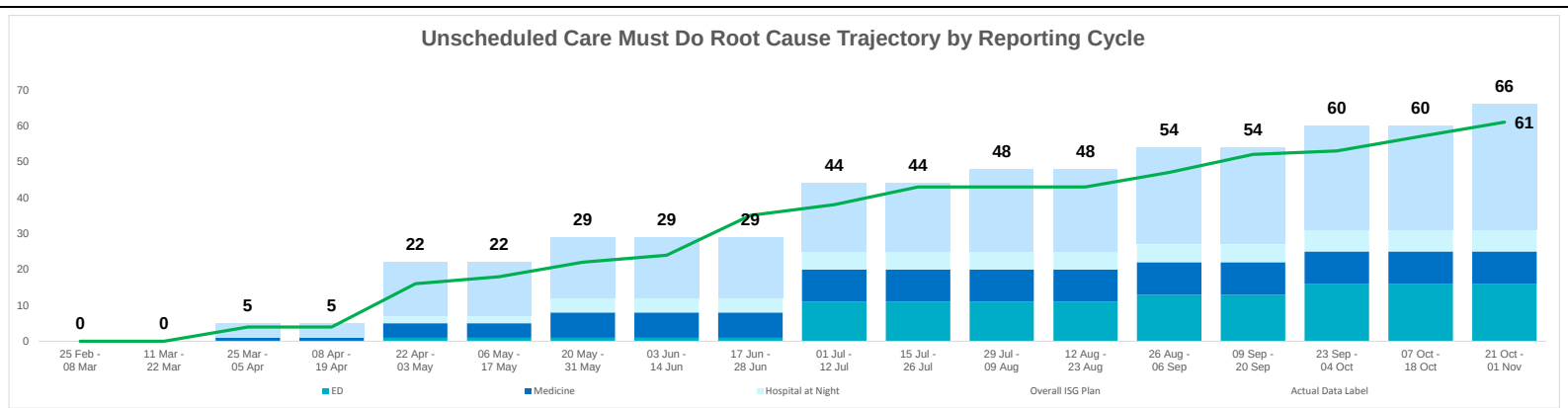
Root Cause Status



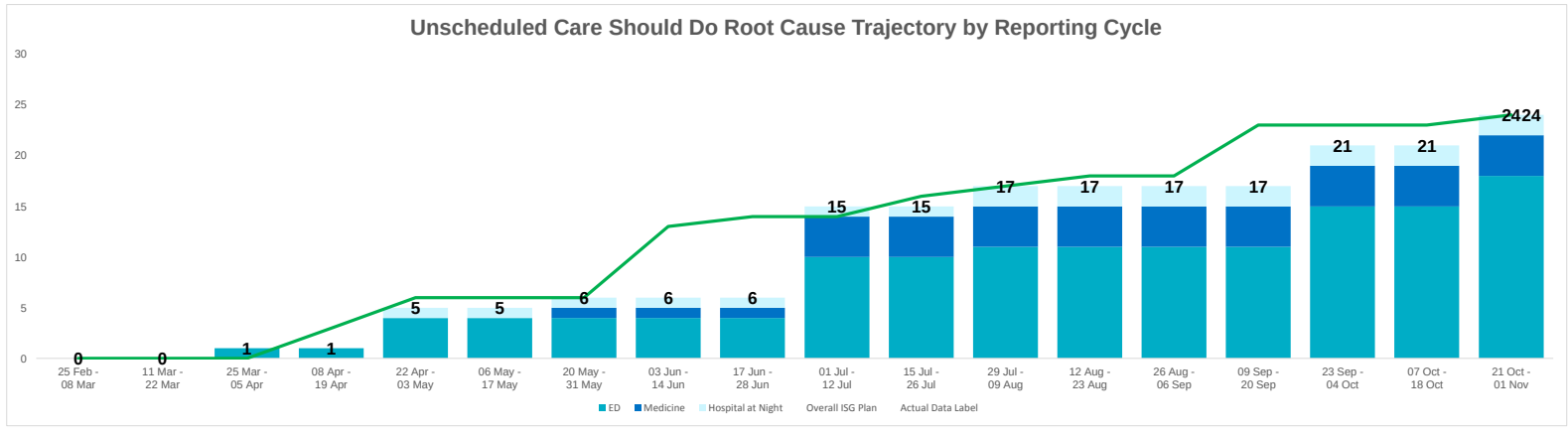


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	71	56 (79%)	5 (7%)	4 (6%)	0 (0%)	6 (8%)
Should Dos	24	24 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory



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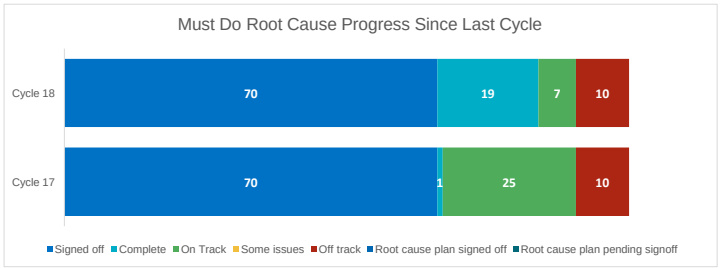
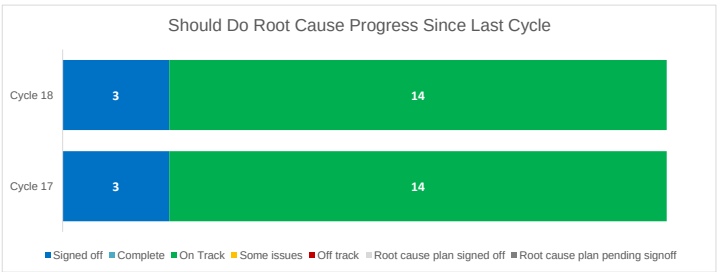
Workforce Dashboard — Cycle 18

Executive Summary

Last Cycle	This Cycle	Narrative
A	A	Workforce has made a little progress through Cycle 18, with 92 Root Causes of 123 (75%) Must do and Should do now complete or signed off. This is behind the target for the planned trajectory of 102. Progress during Cycle 18 continues to be severely impacted by the inter-dependencies of the challenges being faced particularly around recruitment and staffing levels as well as Executive capacity to consider escalated items. There are currently 19 Root Causes that are complete and awaiting sign off awaiting evidence verification as a result of a number of items identified as complete at the Cycle 18 ISG but without Exec presence to be able to sign them off and evidence files not fully populated. 10 Root Causes remain off track at Cycle 18. This is linked to progress on 3 sets of actions addressing long-standing and complex issues. 92% of all Root Causes rated as on track, complete or signed off. Overall summary of progress: *73 Root Causes have been signed off in total. *19 are complete and awaiting validation of evidence by the ISG *21 are on track, with the majority of all outstanding actions due for completion by the end of December. *10 are Off Track and have been escalated. Details as follows ; MDSTAFF01.1 (second part) cannot be evidenced as completed as Trust business planning cycle is not evidently in progress in Q3 .Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6) MDTRAIN01.9 The trust must ensure staff complete mandatory training in line with the trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9) MD067.21.Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision which is a specialism encountering national shortages.

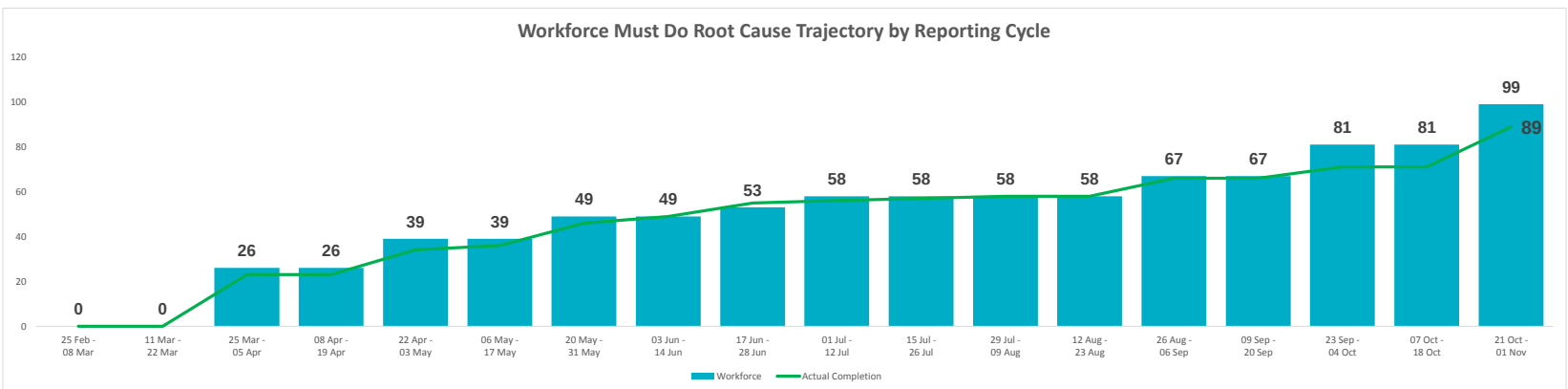
Root Cause Status



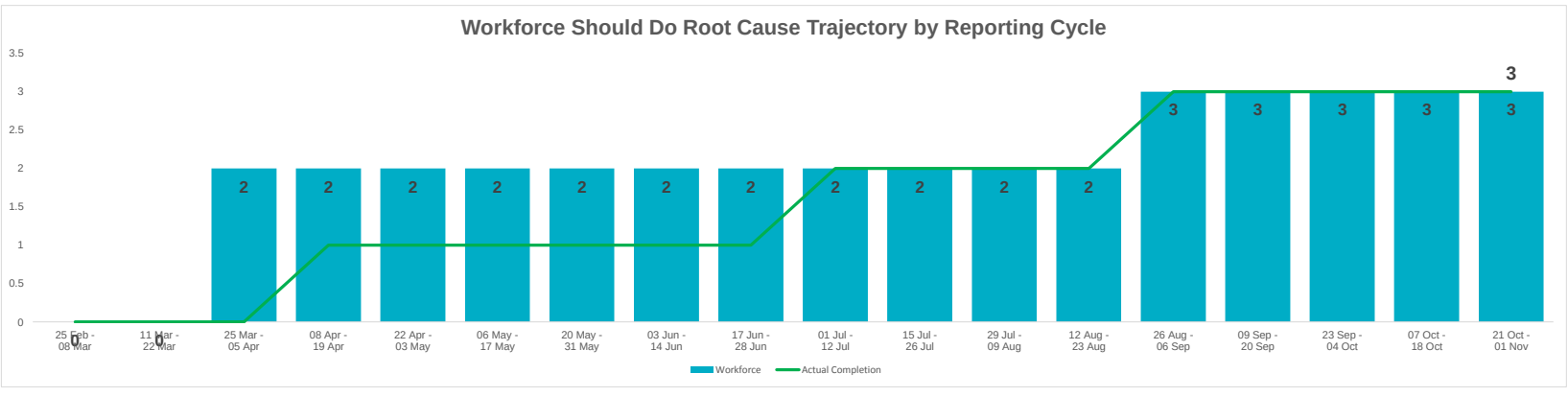


	Number of Root Causes	Signed off	Complete	On Track	Some issues	Off track
Must Dos	106	70 (66%)	19 (18%)	7 (7%)	0 (0%)	10 (9%)
Should Dos	17	3 (18%)	0 (0%)	14 (82%)	0 (0%)	0 (0%)

Must Do Trajectory



Should Do Trajectory



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NHS
The Shrewsbury and Telford Hospital
NHS Trust

PAPER 1

Time Period: Cycle 18 is up to the 01 November 2019.

Background: The CQC Findings report has multiple root cause actions identified at Trust level to demonstrate an enhanced improvement of the finding's identified. This is summarised on the dashboard as a singular finding, but in essence is made up of multiple root cause actions.

Summary Review: The Trust has made progress through Cycle 18, with 117 Findings of 157 Must Do and Should Do Findings now complete or signed off (75%). This is behind the planned trajectory of 125 by the end of October.

There are currently 11 Findings that are complete and waiting sign off at the Cycle 19 ISG.

90% of all Findings rated as on track, complete or signed off. However, 15 Findings were identified as being off track with some Findings completed ahead of trajectory.

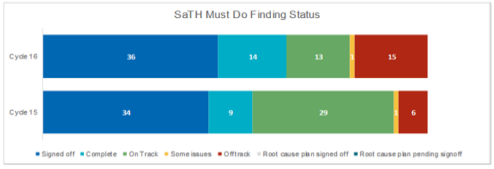
- **Women and Children's are rated Green at Cycle 18 with 43 of 48 Findings now Complete or Signed Off (90%) and the remaining 5 Findings On Track.**
- **Scheduled Care continues to be rated as Green with 40 of 48 Findings now Complete or Signed off (83%) and the remaining 8 Findings On Track.**
- **Unscheduled Care RAG status remains Amber with 22 of 28 (79%) of all actions are now either signed off or complete. There are 5 off track issues listed below :**

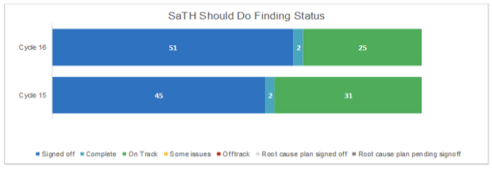
MD041 - Corporate - Mental Health - Implementation of ReSPECT form is being driven by local health economy. Root Cause requires post implementation audit so will not be completed at this point. Requested to extend deadline. Await confirmation of agreement to extend.
MD036 - Corporate - Equipment task & finish group set up. 2 meetings held with good progress made. Final meeting planned to ensure completion and closure of all equipment related actions.
MD047- Corporate - One minute brief to be created and circulated.
MD034 - Corporate - On going work to identify protected Meal Times and to review capacity issues.
MD045 - Corporate. Assurance of progress being sought from Sepsis Working Group/Sepsis Nurse Practitioner.

- **Workforce RAG Status is Amber, with 12 of 33 (36%) of all actions are now either signed off or complete, with 10 Finding Off Track.**

Most of the actions due for completion later than the other ISG's, with the majority of actions due for completion by March 2020 with one final action sue for December 2020.
Off Track item listed below :
MDSTAFF03.1 Ensure staffing levels are adequate to provide safe and appropriate services in and out of hours (covers MD005.6, MD0059S.6, MD0059T.6, MD0060S.6, MD0060T.6)
MDTRAIN01.9 The trust must ensure staff complete mandatory training in line with the trust target (covers MD011.9, MD032S.9, MD032T.9, MD063.9)
MD067.21.Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.

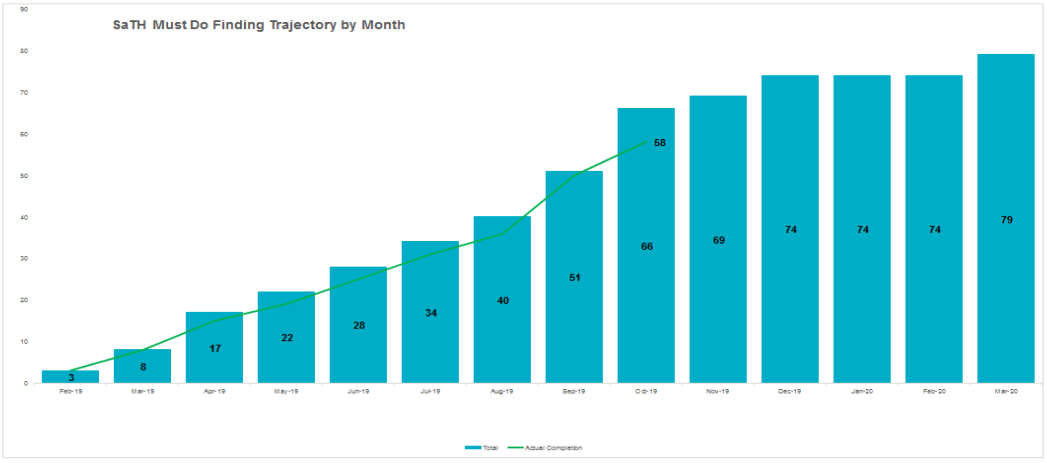
Finding Status



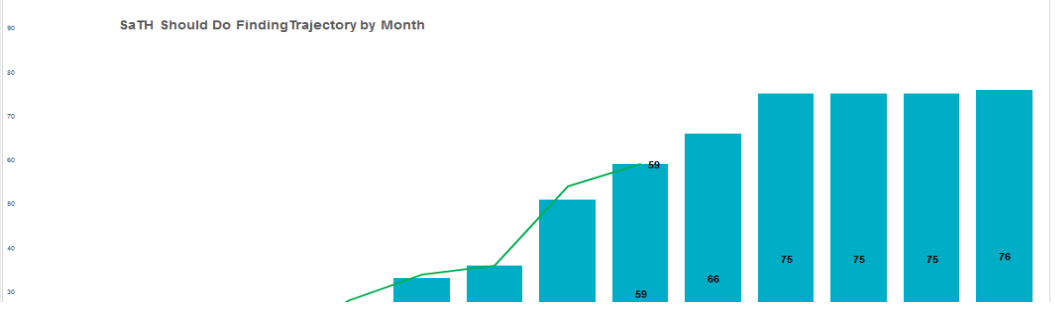


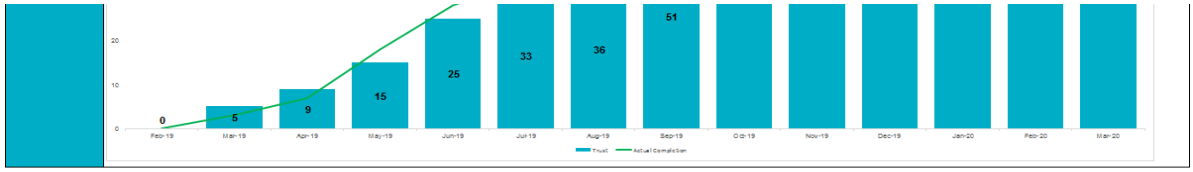
	Number of Findings	Signed off	Complete	On Track	Some issues	Off track
Must Dos	79	36 (46%)	14 (18%)	13 (16%)	1 (1%)	15 (19%)
Should Dos	78	51 (65%)	2 (3%)	25 (32%)	0 (0%)	0 (0%)

Must Do Trajectories



Should Do Trajectory




20
10
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36
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Feb-19
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May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Trust
Actual Cumulative

Overall Trust Summary

Count of Completion Status CQC Domain Status	Completion Status Signed off	 Complete
Inadequate	35	2
Requires Improvement	57	8
Good	14	1
Grand Total	**106**	**11**

ISG	USC

Count of Completion Status CQC Domain Status	Completion Status Signed off	 Complete
Inadequate	5	
Requires Improvement	15	1
Good	1	
Grand Total	**21**	**1**

ISG	SC

Count of Completion Status CQC Domain Status	Completion Status Signed off	 Complete
Inadequate	10	
Requires Improvement	20	2
Good	8	
Grand Total	**38**	**2**

ISG	W&C

Count of Completion Status CQC Domain Status	Completion Status Signed off	 Complete
Inadequate	20	2
Requires Improvement	16	
Good	5	
Grand Total	**41**	**2**

ISG	Workforce

Count of Completion Status CQC Domain Status	Completion Status Signed off	 Complete
Inadequate		
Requires Improvement	6	5
Good		1
Grand Total	**6**	**6**

On Track	Off track
3	4
22	10
	1
25	**15**

On Track	Off track
1	4
	1
1	**5**

On Track
1
7
8

On Track
2
3
5

On Track	Off track
	4
11	6
11	**10**

Reporting Cycle	18
CQC Findings	156

QIP Dashboard CQC Findings - Overall Completion Status Report

		Signed off	Complete	On Track	Some issues	Off track	Root cause plan signed off	Root cause plan pending signoff
Reporting Cycle	17	95 (61%)	9 (6%)	37 (24%)	1 (1%)	15 (10%)	0 (0%)	0 (0%)
Reporting Cycle	18	106 (68%)	11 (7%)	25 (16%)	0 (0%)	14 (9%)	0 (0%)	0 (0%)

				CQC Domain					
CQC Domain Status	ISG	CQC Finding #	CQC Finding	Safe	Effective	Caring	Responsive	Well Led	Completion Status
Inadequate	Workforce	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.	Off track					Off track
Inadequate	Workforce	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.	Off track					Off track
Inadequate	Workforce	MD060S	Ensure medical staffing is adequate to keep all patients safe, especially during nights	Off track					Off track
Inadequate	Workforce	MD060T	Ensure medical staffing is adequate to keep all patients safe, especially during nights	Off track					Off track
Inadequate	W&C	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					On Track
Inadequate	SC	MD055	Ensure staff are supported to report incidents.					On Track	On Track
Inadequate	W&C	SD044	Ensure all incidents are reviewed and closed in a timely manner.	On Track					On Track
Inadequate	W&C	MD027	Implement action plan to respond to recommendation contained Report commissioned from RCOG by SaTH in 2017 and published in February 2018					Complete	Complete
Inadequate	W&C	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.	Complete					Complete
Inadequate	W&C	MD009S	Ensure that the Head of Midwifery has direct access to the board in line with better births 2016					Signed off	Signed off
Inadequate	W&C	MD009T	Ensure that the Head of Midwifery has direct access to the board in line with better births 2016					Signed off	Signed off
Inadequate	W&C	MD013	Ensure that the lone working policy is adhered to ensure staff safety	Signed off					Signed off
Inadequate	W&C	MD014	Ensure that the women's weight is recorded on the prescription charts					Signed off	Signed off
Inadequate	W&C	MD016	Ensure high risk women are reviewed in the appropriate environment by the correct member of staff	Signed off					Signed off
Inadequate	W&C	MD018	Ensure that the community midwives are carrying the correct equipment to carry out their work in line with best practice	Signed off					Signed off
Inadequate	W&C	MD019	Ensure Maternity Early Obstetric Warning Score (MEOWS) charts are fully completed	Signed off					Signed off
Inadequate	W&C	MD020	Ensure all staff complete the cardiotocography (CTG) training defined by the service	Signed off					Signed off
Inadequate	W&C	MD021	Ensure that prescription and observation charts are stored confidentially.	Signed off					Signed off
Inadequate	W&C	MD022	Ensure grading of incidents reflects the level of harm	Signed off					Signed off
Inadequate	W&C	MD023	Ensure that, in line with the 'Lone Working & Peripatetic Policy', midwives use the safety devices when working alone	Signed off					Signed off
Inadequate	W&C	MD025	Ensure that environmental risks are identified and acted on in a timely way.					Signed off	Signed off
Inadequate	W&C	MD026	Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe	Signed off					Signed off

Inadequate	W&C	MD029	Review the policy on reduced fetal movements so there is a clear and defined pathway for midwives and sonographers to follow	Signed off					Signed off
Inadequate	SC	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	Signed off
Inadequate	SC	MD049	Ensure that end of life performance measurements is part of the trusts					Signed off	Signed off
Inadequate	SC	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	Signed off
Inadequate	SC	MD052	Ensure that end of life patients have appropriate access to mental health input or advice					Signed off	Signed off
Inadequate	SC	MD053	Ensure that equipment is stored safely and that ward areas are free from clutter.					Signed off	Signed off
Inadequate	SC	MD054	Ensure records are properly completed and used by appropriate staff including EOLP.					Signed off	Signed off
Inadequate	USC	MD064	Ensure rooms allocated for use with psychiatric patients meet requirements to keep patients safe	Signed off					Signed off
Inadequate	USC	SD005	The trust should ensure that data protection regulations are adhered to					Signed off	Signed off
Inadequate	USC	SD007	Review all policies regarding managing deteriorating patients, especially the use of a bleep system to prioritise patients with sepsis					Signed off	Signed off
Inadequate	USC	SD008	Review departmental risk registers to ensure actions are updated in a timely manner					Signed off	Signed off
Inadequate	USC	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.					Signed off	Signed off
Inadequate	W&C	SD042	Ensure that SBAR forms are fully completed.	Signed off					Signed off
Inadequate	W&C	SD043	Ensure that midwives prescribing antibiotics comply with the medications policy.	Signed off					Signed off
Inadequate	W&C	SD046	Ensure that there is a system in place to know that equipment has been	Signed off					Signed off
Inadequate	W&C	SD047	Ensure that medicines prescribed are in line with the antibiotic formulary.	Signed off					Signed off
Inadequate	W&C	SD048	Ensure that the safety thermometer results are displayed for staff and the public to see.	Signed off					Signed off
Inadequate	W&C	SD052	Ensure women receive carbon monoxide screening in line with national guidance.	Signed off					Signed off
Inadequate	SC	SD066	The provider should ensure that the specialist palliative care team maintain a central list of patients who were receiving specialist palliative care or details of the ward areas where they were being cared for.					Signed off	Signed off
Inadequate	SC	SD069	The provider should ensure that its end of life strategy links to national and local objectives in relation to improving end of life care and definitive timescales and commitments to achieve service improvements.					Signed off	Signed off
Inadequate	SC	SD072	Review the governance structures in place to ensure they are fit for purpose, result in meaningful change and result in timely progress.					Signed off	Signed off
Inadequate	SC	SD078	Fast track discharges should be monitored and audited.					Signed off	Signed off
Requires Improvement	Workforce	MD005	Ensure sufficient permanent staff are employed to keep people safe from avoidable harm and abuse and that they attend safeguarding training in line with the trust target.	Off track					Off track
Requires Improvement	Workforce	MD011	The trust must ensure staff complete mandatory training in line with the trust target.		Off track				Off track
Requires Improvement	Workforce	MD032S	Ensure staff mandatory training rates meet trust targets		Off track				Off track
Requires Improvement	Workforce	MD032T	Ensure staff mandatory training rates meet trust targets		Off track				Off track
Requires Improvement	USC	MD034	Ensure that all patients are consistently treated with dignity and respect			Off track			Off track
Requires Improvement	USC	MD036	Ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm		Off track				Off track
Requires Improvement	USC	MD045	Improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis	Off track					Off track
Requires Improvement	USC	MD047	Ensure that it has appropriate processes and governance in place to ensure that patients detained under the Mental Health Act 1983 receive the right to appeal the detention					Off track	Off track
Requires Improvement	Workforce	MD063	Ensure staff receive appropriate mandatory training to undertake their roles in a safe and effective way.		Off track				Off track
Requires Improvement	Workforce	MD067	Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.		Off track				Off track
Requires Improvement	Workforce	MD006	Ensure all staff complete mandatory training, Mental Capacity Act training and become familiar with lessons learnt.		On Track				On Track
Requires Improvement	USC	MD041	Ensure mental capacity assessments are consistently carried out where required		On Track				On Track
Requires Improvement	Workforce	MD056	Review staffing levels against Royal College of Physicians guidance	On Track					On Track
Requires Improvement	Workforce	MD072	Ensure there are sufficient staff (physiotherapists, nurses, dieticians) with	On Track					On Track
Requires Improvement	Workforce	SD011	Improve training rates for learning disability training among staff within		On Track				On Track
Requires Improvement	SC	SD016	The trust should continue to work to improve the admitted referral to treatment time					On Track	On Track
Requires Improvement	SC	SD023	Ensure monthly mortality and morbidity meetings take place, are recorded and any learning shared with the appropriate parties.					On Track	On Track
Requires Improvement	Workforce	SD025S	Ensure the cover provided by the critical care outreach team complies with required standards.					On Track	On Track

Requires Improvement	Workforce	SD025T	Ensure the cover provided by the critical care outreach team complies with required standards.					On Track	On Track
Requires Improvement	SC	SD027S	Ensure that appropriate audits are carried out and used to improve the performance of the unit and outcomes for patients.					On Track	On Track
Requires Improvement	SC	SD027T	Ensure that appropriate audits are carried out and used to improve the					On Track	On Track
Requires Improvement	SC	SD028S	Ensure all relevant policies are up to date.					On Track	On Track
Requires Improvement	SC	SD028T	Ensure all relevant policies are up to date.					On Track	On Track
Requires Improvement	SC	SD032	Ensure access and flow into and out of the critical care unit is improved so patients receive the right care at the right time and in the right place.				On Track		On Track
Requires Improvement	W&C	SD041	The trust should have identified a plan to work towards compliance with the Department of Heath recommendations 2013 to have en suite facilities in a labour room.					On Track	On Track
Requires Improvement	W&C	SD045	Ensure staffing is appropriate on the postnatal ward to enable midwives to care for babies on transitional care		On Track				On Track
Requires Improvement	W&C	SD051	The trust should share the plans to implement a new process to replace statutory supervision of midwives which ceased in April 2017 with all staff.					On Track	On Track
Requires Improvement	Workforce	SD067	The provider should ensure that it provides it meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is a 9am to 5pm, seven-days per week.		On Track				On Track
Requires Improvement	Workforce	SD068	The provider should ensure that medical staffing meets the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care standard (NCPC) which states there should be a minimum of one consultant per 50 beds.		On Track				On Track
Requires Improvement	Workforce	SD070	Review service provision against National Institute of Health and Care Excellence guidance.		On Track				On Track
Requires Improvement	Workforce	SD079	Should continue to strengthen its workforce management systems to maintain the favourable retention rates, improve recruitment rates and					On Track	On Track
Requires Improvement	Workforce	SD080	Should work at pace to embed systems that will optimise output from its medical workforce		On Track				On Track
Requires Improvement	Workforce	MD004	Ensure all medical staff are trained to the required level of safeguarding for both adult and children.		Complete				Complete
Requires Improvement	Workforce	MD012	The trust must ensure staff complete adult safeguarding training in line with the trust target		Complete				Complete
Requires Improvement	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		Complete				Complete
Requires Improvement	Workforce	MD038	Ensure that sufficient permanent staff are employed to keep people safe from avoidable harm and abuse		Complete				Complete
Requires Improvement	USC	MD039	Ensure that no patients are unlawfully detained at the hospital		Complete				Complete
Requires Improvement	Workforce	MD040	Ensure that safeguarding training rates meet the trust target.		Complete				Complete
Requires Improvement	SC	MD068	Ensure there are effective systems to assess, monitor and review the performance of the unit so the safety and quality of care provided can be improved.					Complete	Complete
Requires Improvement	SC	SD024	Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are identified and included on the local risk register.					Complete	Complete
Requires Improvement	Workforce	MD001	Ensure compliance with the requirements of the fit and proper person's regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.					Signed off	Signed off
Requires Improvement	SC	MD003	Ensure all controlled drugs are checked daily and evidence is documented	Signed off					Signed off
Requires Improvement	SC	MD007	Ensure records are stored safely and confidentiality is maintained.					Signed off	Signed off
Requires Improvement	SC	MD008	Ensure staff are confident with the procedure for sepsis management.		Signed off				Signed off
Requires Improvement	W&C	MD015	The trust must ensure handovers are completed regularly and high-risk women in labour are reviewed by medical staff.		Signed off				Signed off
Requires Improvement	W&C	MD031	Ensure National Institute of Health and Care Excellence (NICE) operational policies and guidelines are reviewed in date.		Signed off				Signed off
Requires Improvement	USC	MD035	Ensure that during periods of increased demand and capacity safe	Signed off					Signed off
Requires Improvement	USC	MD037	Ensure that effective systems are in place to reduce the risk of safety incidents from reoccurring.	Signed off					Signed off
Requires Improvement	USC	MD042	Ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance					Signed off	Signed off
Requires Improvement	USC	MD043	Ensure that all equipment is reviewed within trust and manufacturer guidelines		Signed off				Signed off
Requires Improvement	USC	MD044	Ensure that dietary risks to renal patients are identified and actioned appropriately	Signed off					Signed off
Requires Improvement	USC	MD046	Ensure best practice is followed when preparing, administering and	Signed off					Signed off
Requires Improvement	Workforce	MD057	Ensure doctors out of hours have the capability and confidence to review	Signed off					Signed off
Requires Improvement	SC	MD058	Ensure governance processes are fit for purpose, support those					Signed off	Signed off
Requires Improvement	USC	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.					Signed off	Signed off
Requires Improvement	USC	MD061T	Ensure they enable staff to consistently manage and review deteriorating					Signed off	Signed off
Requires Improvement	USC	MD062S	Review national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.		Signed off				Signed off
Requires Improvement	USC	MD062T	Review national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.		Signed off				Signed off
Requires Improvement	Workforce	MD065	Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding		Signed off				Signed off
Requires Improvement	USC	MD066	Ensure that all assessment forms are appropriate and that early warning scores are recorded on the correct, coloured documentation and not photocopies					Signed off	Signed off
Requires Improvement	USC	MD069	Ensure arrangements for the availability of the hospital at night team are robust to ensure there are sufficient and appropriate staff available to assess and treat deteriorating ward patients.		Signed off				Signed off
Requires Improvement	SC	MD073	Ensure that requirements of national standards are met.					Signed off	Signed off
Requires Improvement	Workforce	MD074	Ensure staff have training and understanding of deprivation of liberty		Signed off				Signed off
Requires Improvement	USC	SD004	The trust should ensure they respond to complaints in an appropriate timescale.				Signed off		Signed off
Requires Improvement	USC	SD006	The trust should consider bariatric facilities in waiting areas				Signed off		Signed off

Requires Improvement	SC	SD014	The trust should monitor staff compliance with the infection control		Signed off				Signed off
Requires Improvement	SC	SD015	The trust should monitor how records are stored safely and confidentially					Signed off	Signed off
Requires Improvement	SC	SD017S	The trust should review the complaint handling process				Signed off		Signed off
Requires Improvement	SC	SD017T	The trust should review the complaint handling process				Signed off		Signed off
Requires Improvement	SC	SD018	To continue progress to integrate a seven-day service.				Signed off		Signed off
Requires Improvement	SC	SD019	Address issues regarding staff not adhering to infection control policy	Signed off					Signed off
Requires Improvement	SC	SD020	Attend to building repairs in a timely way.					Signed off	Signed off
Requires Improvement	SC	SD022S	Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance		Signed off				Signed off
Requires Improvement	SC	SD022T	Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance		Signed off				Signed off
Requires Improvement	USC	SD026	Ensure the cover provided by the hospital at night team is safe	Signed off					Signed off
Requires Improvement	SC	SD031	Ensure follow-up clinics are available and offered to suitable patients.				Signed off		Signed off
Requires Improvement	SC	SD033	Ensure the risk register in use within the department includes all risks identified by the unit and actions discussed to ensure all relevant parties are kept up to date.					Signed off	Signed off
Requires Improvement	Workforce	SD035S	Review the provision of physiotherapy resource to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).					Signed off	Signed off
Requires Improvement	Workforce	SD035T	Review the provision of physiotherapy resource to improve compliance					Signed off	Signed off
Requires Improvement	SC	SD037	Multidisciplinary team (MDT) working should be joined up across critical care to ensure there is coordinated MDT patient review and management.		Signed off				Signed off
Requires Improvement	W&C	SD049	Ensure the time women request an epidural to the time they received one is monitored.		Signed off				Signed off
Requires Improvement	W&C	SD050	Ensure the 2018 dashboard is colour coded and an agenda item at maternity governance meetings		Signed off				Signed off
Requires Improvement	W&C	SD055	The trust should have a defined maternity strategy.		Signed off				Signed off
Requires Improvement	W&C	SD056	Ensure staff are aware of the vision of the service and the trust's vision					Signed off	Signed off
Requires Improvement	W&C	SD057	Ensure the executive team are visible and supportive during challenging times within the maternity					Signed off	Signed off
Requires Improvement	W&C	SD058	Ensure staff morale is reviewed and plan to improve the staff survey results.					Signed off	Signed off
Requires Improvement	W&C	SD059	Ensure multidisciplinary attendance at the maternity governance meetings.					Signed off	Signed off
Requires Improvement	W&C	SD060	Ensure labour ward forum meetings are held at regular intervals.					Signed off	Signed off
Requires Improvement	W&C	SD061	Ensure that all risks within maternity services are added to the risk register.					Signed off	Signed off
Requires Improvement	W&C	SD062S	Engage with staff about changes and developments and include staff in discussions around these.					Signed off	Signed off
Requires Improvement	W&C	SD062T	Ensure staff are involved with proposed changes and developments					Signed off	Signed off
Requires Improvement	W&C	SD063	Encourage and facilitate managers and staff to be innovative and to discuss their ideas for positive changes					Signed off	Signed off
Requires Improvement	W&C	SD064	Ensure staff engagement and involvement with service change is improved					Signed off	Signed off
Requires Improvement	W&C	SD065	Ensure vision, strategy and trust values are shared with all staff, including how staff roles fit around this.					Signed off	Signed off
Requires Improvement	SC	SD071	Ensure current junior doctors continue to be engaged in training and have the opportunity to request more advanced training where needed.		Signed off				Signed off
Requires Improvement	SC	SD076	Establish a more robust system of identifying end of life care patients.		Signed off				Signed off
Requires Improvement	SC	SD077	Embed the use of the end of life plan to improve patient experience in the last days and hours of their life.				Signed off		Signed off
Good	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.				Off track		Off track
Good	W&C	MD024	Provide an MLU environment that is safe and fit for purpose			Signed off			Signed off
Good	W&C	MD030	Ensure complaints are addressed within the timescale of your complaints policy.				Signed off		Signed off
Good	SC	MD050	Ensure that all staff understand and implemented the SWAN scheme and or ensure that resources for the SWAN scheme are prioritised			Signed off			Signed off
Good	Workforce	MD050	Ensure that all staff understand and implemented the SWAN scheme and or ensure that resources for the SWAN scheme are prioritised			Complete			Complete
Good	SC	MD070	Ensure consent to care and treatment including deprivation of liberty must be sought in line with legislation and guidance			Signed off			Signed off
Good	USC	SD012	Improve its timeliness when investigating complaints.				Signed off		Signed off
Good	SC	SD030	Ensure there are adequate counselling arrangements for patients.			Signed off			Signed off
Good	SC	SD034S	Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.			Signed off			Signed off
Good	SC	SD034T	Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.			Signed off			Signed off
Good	W&C	SD040	Ensure staff are aware and can explain learning from serious incidents and complaints.				Signed off		Signed off
Good	W&C	SD053	Ensure that all leaflets are accessible in different languages and easy to read versions.				Signed off		Signed off
Good	W&C	SD054	Ensure displays and leaflets are available to inform women how to complain.				Signed off		Signed off
Good	SC	SD073	Review the results of the bereavement survey to identify trends and key issues, as outlined in our evidence appendix.			Signed off			Signed off
Good	SC	SD074	Review staffing levels for the bereavement office.			Signed off			Signed off
Good	SC	SD075	Ensure data is collected with regards to patients' preferred place of care,			Signed off			Signed off