AGENDA
for a Meeting of the Board
Part I

Venue:	Training Room 1 - Chippenham Community Hospital
Date:	Tuesday 28 November 2017
Time:	10:00 – 11:30

WHC Board Members		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Cara Charles-Barks	SFT Board Representative	CC-B
Sarah Truelove	RUH Board Representative	ST
Carol Nickell	Deputy GWH Board Representative	KM
Richard Barritt	Non Executive Member	RB
Celia Grummiitt	Non Executive Member	CG
Adibah Burch	Non Executive Member	AB

In Attendance		
Lisa Hodgson	Chief Operating Officer	LH
Lianna Bradshaw	Board Administrator	LB
Apologies		
Nerissa Vaughan	GWH Board Representative	NV

	Agenda Item	Lead	Paper	For Decision/ Discussion/ Information
1	**Welcome, Apologies and Declarations of Interest**	CB	Verbal	Information
2	**Part I Minutes, Actions and Matters Arising**	CB	Attached	Approval
3	**Chair's Report**	CB	Verbal	Information
4	**MD Report**	DB	Verbal	Information
	Scrutiny			
5	**Quality, Finance and Performance Report**	LH/SJP/AC	Attached	Information
6	**Falls Review**	SJP	Attached	Information
7	**CQC Action Report**	SJP	Attached	Information
8	**Risks** • Board Assurance Framework • Wiltshire Health and Care LLP Corporate Risk Register • Delivery Risks	 DB DB SJP	Attached	Discussion / Information
	Governance			
9	**Childrens' Safeguarding Declaration**	SJP	Attached	Decision
10	**Board Sub Committees**	CB	Verbal	Decision
11	**Nomination of Chief Operating Officer as Board member**	CB	Verbal	Decision
12	**Any Other Business**			
	Date of Next Meeting: Tuesday 19 December, 2-5pm, Melksham Community Hospital			

Welcome, Apologies and Declarations of Interest

VERBAL ONLY

MINUTES
Of a Wiltshire Health and Care
Board Meeting Part I

Venue:	Training Room 1, Chippenham Community Hospital
Date:	Tuesday 26th September 2017
Time:	10:00

WHC Board Members		
Richard Barritt (Chair)	Non Executive Member	RB
Douglas Blair	Managing Director	DB
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Cara Charles-Barks	SFT Board Representative	CC-B
Sarah Truelove	RUH Board Representative	ST
Nerissa Vaughan	GWH Board Representative	NV
Celia Grummiitt	Non Executive Member	CG
Adibah Burch	Non Executive Member	AB
In Attendance		
Natasha Griffin	Senior Administrator	NG
Apologies		
Carol Bode	Chair	CB

No.	Item	Action
1.	**Welcome, Apologies and Declarations of Interest**	
	Richard Barritt welcomed everyone to the meeting and noted that he had been asked to Chair the meeting in Carol Bode's absence. Declarations of interest – RB noted that he is working with Southern Health NHS Foundation Trust on patient engagement. ST stated that she will start a new position in January with the Bristol, North Somerset and South Gloucestershire CCGs.	
2.	**Part I Minutes, Actions and Matters Arising**	
	The minutes of the previous meeting held on 25th July 2017, were agreed as a true and accurate record. The meeting considered the actions arising and noted the updates.	
3.	**MD Report**	

	DB noted that some additional appointments had been made to the LLP. A new Communications and Engagement lead would be starting in early October and an appointment had been made to the Board Secretary role.	
4.	**Quality, finance and performance Report**	
	The Board considered the quality, finance and performance report and noted the following key points: • The review into the increased level of falls was ongoing. It was planned that SJP will present a summary report of the falls review to the board in October, as it had taken longer than anticipated to complete the review. In the meantime, an overview of findings so far had been provided. SJP noted that appropriate action is taken after a fall incident; however, focus is required on prevention and in reviewing current documentation. • There were currently 1700 Deprivation of Liberty Cases with Wiltshire Council that are not being reviewed due to capacity. SJP had raised this issue with the Council at the recent Adult Safeguarding Board but would raise again with Commissioners. • There had been an increase in sickness, up by 1% compared with last year. All cases are being effectively managed. The biggest concerns relate to anxiety. It was noted that support is in place for staff via Occupational Health and counselling; however, there were recognised challenges relating to the capacity of the Occupational Health service. There is a need to be proactive and look at strategies that enable us to respond before staff become unwell, recognising that staff may feel apprehensive about involvement with Occupational Health as this option may be viewed as too formal at an early stage. • Inpatient assessments – the figures for August showed unusually poor performance on MRSA screening on Longleat Ward. This might be reflective of staffing challenges on the ward. An action and recovery plan was in place. • There was a continuing reliance on agency staffing on Ailesbury Ward. A review of what roles are required on the ward is being undertaken to ensure that the skill mix represents the care needed. • A workshop was due to take place in October to start the development of a frailty strategy – this would include the original intention for dementia and falls strategies set out in the Delivery Plan. • The Winter period would mean added scrutiny on the contribution that community services were making to system flow. There were encouraging examples of change, such as the progress being made on the Home First pathway. There was a need to set out in more detail what improvements were expected and their impact on system flow. • On finance, the small surplus on the year to date position was noted. The Board agreed that:	

	Further work should be undertaken on the range of approaches that could be taken to ensure health and wellbeing and resilience of staff, taking into account programmes currently offer across the county. A plan should be considered by the Board before the end of the year. The October Board seminar session should include a focus on winter planning to include projected impact on system flow.	**SJP** **DB/LH**
5.	**Risks** • Board Assurance Framework • Wiltshire Health and Care LLP Corporate Risk Register • Delivery Risks	
	The Board reviewed the risk registers and noted the following: • **Board Assurance Framework**: No change from last month • **Wiltshire Health and Care LLP Corporate Risk Register:** increase in scoring for additional VAT costs falling to WHC • **Delivery Risks:** There were three risks with a score of 20: • Recruitment and retention – there is an improving picture in MIUs and more paramedics have been recruited. • Arriva transport contract – patients not being collected from wards and taken to other places of care in a timely fashion. The target score currently at 15 should be reviewed as it suggested low expectations that resolutions could be found. • CTPLD – related to a commissioning gap in this area. This issue will continue to be raised as part of contractual meetings. The Board commented that the effects of delays in discharge was not on the risk register and – given the level of DTOCs on community wards – this should be an area that is covered.	**DB**
6.	**Any Other Business** There was no further business. **Date of Next Meeting:** The Board discussed and agreed a proposal to hold a Board seminar on 24 October, in place of the scheduled Board meeting.	

BOARD
ACTION TRACKER Part I

MEETING	ACTION	LEAD	DUE	UPDATE	DATE
23.05.17	Liaise re independent Audit and Assurance Committee Chair	CC-B/ CB/DB	26.09.17	In progress. CB to update on	
23.05.17	Report back on physio waiting times	DB		Discussions with CCG on-going, no decision made on future pathway. Waiting time position unchanged. Report back when commissioning decision/s reached. 25.07.17 -No decision has been made so will bring back to September board. Verbal update to be given at September Board	
27.06.17	Falls: Audit and Strategy; report to QAC in August and inform Board in September.	SJP`	26.09.17	Update provided to Board in September. Full report on November agenda.	13/11/17
27.06.17	H&S, Fire and Security: Assess incidents of violence and aggression on patient to patient or patient to staff and change categories in information.	SJP	25.09.17	This change to categorisation will be taken forward as part of planning for a new clinical risk system.	
27.06.17	Estates fire safety: ensure that NHSPS prioritise safety and assurance; continue fire prevention and evacuation facilities improvement; make further inspections and take Fire Brigade advice.	SJP/DB	25.09.17	Ongoing. 21.09.17 – Further assurance work undertaken, but further assurance being sought from NHS Property Services before being brought back to Board. 13.11.17 Meeting with fire lead at NHS Property Services taken place in early November – awaiting formal report in December of actions being and have been taken. Will report back formally to Board once received.	

27.06.17	Update Mandatory Training table and identify and implement training mechanisms.	DB	22.08.17	To be picked up by new Board Secretary	13/11/17
25.07.17	Board members would be interested to see an analysis of the relative costs of providing a higher intensity care intervention as opposed to inpatient care. DB to update board in October.	DB		Further work to be done. Timescale has slipped.	
26.09.17	Further work should be undertaken on the range of approaches that could be taken to ensure health and wellbeing and resilience of staff, taking into account programmes currently offer across the county. A plan should be considered by the Board before the end of the year.	SJP	31.12.17	STP staff health and wellbeing strategy being discussed at LWAB in November – proposal is to develop a Wiltshire Health and Care action plan to sit underneath this strategy – means timescale will slip to January Board.	

Closed actions

27.06.17	Health and Safety - Board Statement of Commitment - Sign and distribute.	DB	25.07.17	Complete	18.07.17
27.06.17	• Risk Register - BAF - increase Workforce rating to 20. • Link BAF to strategic risks. • Summarise increased/reduced risks and closed risks.	DB	25.07.17	Complete	25.07.17
25.07.17	DB agreed to send a link to the Guidance on Urgent Treatment and circulate the Severn Urgent Care network guidance as this would be of interest to board members.	DB		Completed	July 2017
27.06.17	Vacancy Levels: look at creating cross pathway roles and develop cohort of staff to work flexibly.	DB	26.09.17	To be taken forward as part of Older People's Partnership Board for South Wiltshire	26.09.17

27.06.17	Links with Primary Care and out of hospital: share notes and update September Board.	CB	26.09.17	Closed – content fed into October seminar	13/11/17
25.07.17	That the quality dashboard should be updated with overdue incidents Themes from learning from incidents should be shared with the board as part of reporting.	SJP		Complete – included in dashboard and drop down for further analysis of themes	13/11/17
26.09.17	The October Board seminar session should include a focus on winter planning to include projected impact on system flow.	DB		October seminar included Winter discussion	13/11/17

Chair's Report

VERBAL ONLY

MD Report

VERBAL ONLY

Wiltshire Health and Care Board	**For information**
Subject:	**Quality, performance and finance monthly report**
Date of Meeting:	**28 November 2017**
Author:	**Sarah-Jane Peffers, Lisa Hodgson, Annika Carroll**

1. Purpose

1.1 To provide an overview of the main issues arising from review of information about the quality and performance of Wiltshire Health and Care services and alert and advise the Board to issues by exception.

2. Issues to be highlighted to Board

2.1 The quality and performance dashboards are attached for the Board's information. From analysis of this information and triangulation with other sources of information and intelligence, the following issues are highlighted to the Board in relation to the quality of services:

ADVISE	• Due to operational capacity there are a number of NICE guidelines (19) that have not been reviewed and a response/ action assigned within the expected timeframe. WHC is seeking advice from other community providers to identify if changes can be made to the current process of assigning and evaluating guidance. • Due to operational capacity there are a number of Clinical audit that remain incomplete (14). WHC is seeking advice from other community providers to identify if changes can be made to the current process of completing and evidencing audit. • Duty of Candour targets have not been met across the first two stages (5). Quality Assurance administrator to spend targeted time with hotspot areas. • Falls report completed • In-patient falls assessment has not reached expected target for 2 months in August and September. However, the October performance dashboard does identify the target has been met.
ALERT	No alerts to be reported to the board
ACTION	There are no issues on which Board action is required.

2.2 The following issues are highlighted to the Board in relation to the maintaining performance against required performance standards:

ADVISE	There are continuing issues relating to the availability of psychology resources, which impact on Referral to Treatment targets for learning disability services. Additional escalation with the CCG is being pursued

	to reach a final resolution of these long standing issues.
ALERT	No alerts to be reported to the board
ACTION	There are no issues on which Board action is required.

2.3 The following issues are highlighted to the Board in relation to the financial performance:

ADVISE	• Liaison VAT Consultancy has, on behalf of GWHFT, identified an increase to the already recognised additional VAT liability applicable from July 2016 to date following the HMRC ruling. This relates to the partial exemption calculation for GWHFT. As the income related to WH&C is now recognised as exempt, it reduces the amount of VAT recovery available for GWHFT. The monthly estimated provisions for the additional liability and offsetting additional funding from the CCG to cover the liability will therefore increase from November 17 (M8). The CCG have been notified in writing of the issue. • High agency usage including off-framework agencies continues, particularly within the minor injury units and the wards. Internal authorisation processes have been reviewed and amended and administrative support is actively being sought to ensure effective and timely roll-out of Allocate v 10, which will support effective rostering. Skill-mix reviews are being undertaken with Ailesbury ward prioritised.
ALERT	No alerts to be reported to the board
ACTION	There are no issues on which Board action is required.

3. Recommendation

3.1 The Board is invited to note the contents of this report.

Wiltshire Health and Care LLP
Financial Position M7, October 2017

WH&C LLP Profit and Loss Account - October 2017

	M7 (October 2017) £'000	FOT as at M7 £'000
Turnover	**25,079**	**43,385**
Staff	(135)	(288)
Contracted Services	(24,837)	(42,877)
Other Administrative Exps	(62)	(219)
Total Expenses	**(25,034)**	**(43,385)**
Profit/(Loss)	45	0

WH&C LLP Balance Sheet as at October 2017

	M7 (October 2017) £'000
Current Assets	
Debtors	3,792
Cash at Bank	1,193
Creditors	(4,940)
Net Current Assets	45
Net Assets	45
Profit and Loss Account	45

WH&C LLP Statement of Cashflows

	M7 (October 2017) £'000
Profit/(Loss)	45
Movements in:	
Debtors	(3,333)
Creditors	3,984
Net in/(out)flow	696
Opening Cash Balance	498
Closing Cash Balance	1,193

The LLP reports a year to date surplus of £45k as at M7, October 2017.

The favourable position is due to a vacancy at Clinical Director level and lower than planned clinical services recharges.

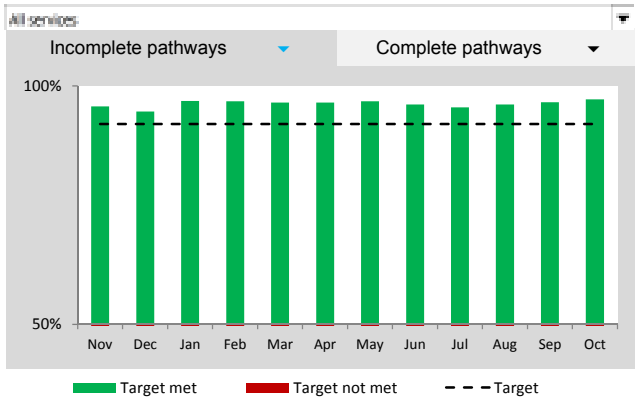
The forecast outturn for the financial year remains a breakeven position as at M7.

The turnover reflects contracted values with commissioners for 2017/18 adjusted for CQUIN risk and a provision for funding to cover the confirmed additional VAT liability, for which the final value is yet to be determined by VAT advisors.

The contracted services value reflects the planned values for 2017/18 with an additional provision for the additional VAT liability.

Performance Dashboard October 2017

RTT

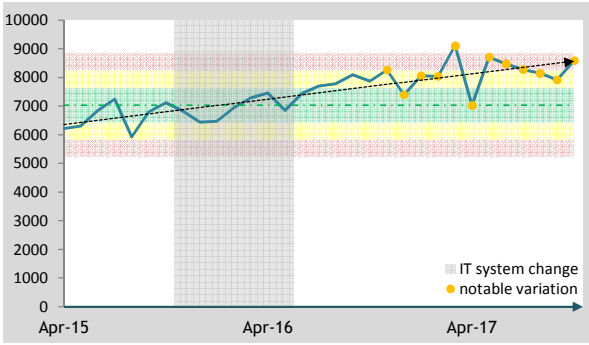


Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	93%	57
Continence - Adult	99%	3
LD	72%	11
Outpatient Physio	98%	100
Podiatry	100%	0
Wheelchair service	95%	7
WON	96%	23

LD service remains an area of concern - previously flagged to commissioners.

Activity



Referrals ↑ 14% Contacts ↑ 8%

Notable movers

Neurology Specialists	↑ 44%
Community Teams	↑ 27%
Speech and Language Therapy	↑ 20%
Fracture Clinic	↓ -8%
Inpatient Therapy	↓ -6%
Orthotics	↓ -1%

LD and Wheelchair services data excluded in this view of overall activity as not comparable pre and post system migration. Trend logic has been adjusted from previous years' reports. See explanatory notes for notable variation guidance.

Inpatient assessments

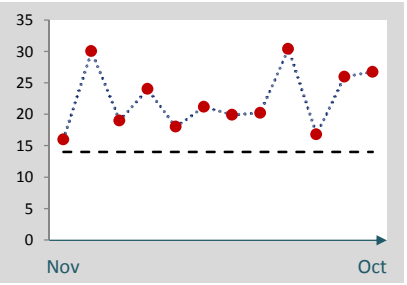
All wards

MRSA	96%
VTE	100%
VTE prophylaxis	100%
MUST	96%
PURAT	99%
Falls	99%
Dementia	94%

Overall targets met

Mean Inpatient Length of Stay

Ailesbury, Cedar, Longleat	31.7
Mulberry	53.0
Step up	29.6
Step up excluding delays	26.7



LoS heavily influenced by delayed days which routinely account for more than 20% of our ward capacity. For more detail around our LoS see the inpatient data sheet.

Discharge timings

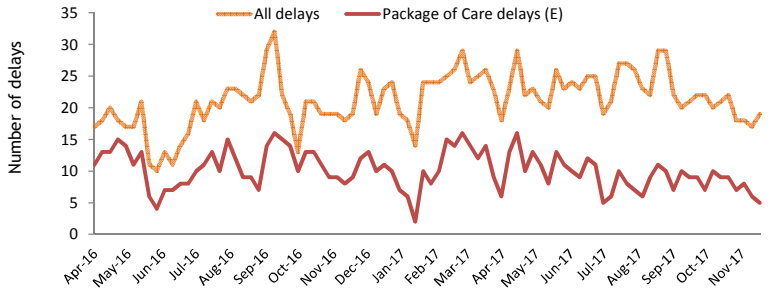
34% midday

7% weekend

excludes transfers to hospital and deaths

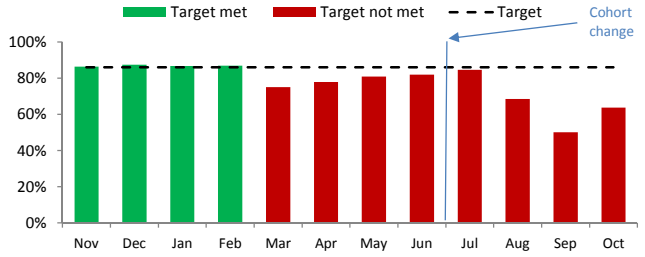
Care providers including homes are reluctant to take patients at weekends.

Delayed Transfers of Care



POC (E) delays now shown separately in trend data above. We are still awaiting acute delay data for Wiltshire patients from CCG/CSU to further assess impact of Home First pathway. Following DToC counting workshop we may see increase in POC (E) delays that would previously have counted as Housing delays.

Community teams 90 day reablement



In month 64% FYTD 78%

Patients still at home 90 days after referral to team

Data quality concerns

It is an ongoing challenge to identify the correct cohort for this data - now looking at Home First patients. Very small numbers in cohort - expecting numbers to increase in coming months.

End of life support

In month	FYTD
100%	95%

This month

15 of 15

patients were supported by the community teams to die in their place of choice

Strong performance year to date

Funding reviews*

In month	FYTD
CHC 3 month	
Completed 0	N/A
Due 0	
CHC Annual	
Completed 0	N/A
Due 0	
FNC	
Completed 0	N/A
Due 0	

CHC and FNC reporting delayed this month

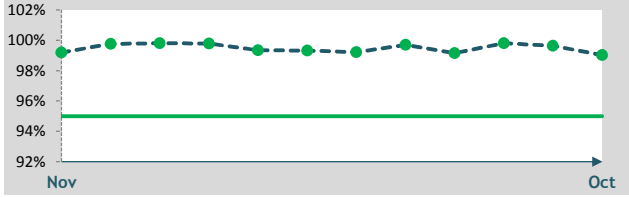
MIU waiting times

median 20 minutes

95th centile 124 minutes

MIU performance

Arrival to departure 4 hour stay	Left without being seen	Transfers to acute
99%	5%	5%



Performance on 4 hour stay and patient feedback remains strong. Data challenges remain around patients left without being seen and transfers to acute. Significant operational pressures are not reflected in the data.

Explanatory notes for our summary measures

RTT

RTT is the Referral to Treatment waiting times period for patients accessing our services.

Complete pathways are waiting periods that have ended in the month. Our target is to see at least 95% of patients within 18 weeks of their referral.

Incomplete pathways are waiting periods that are still ongoing at the end of the month. Our target is to have at least 92% of patients waiting under 18 weeks.

Activity

We routinely monitor two activity measures.
1. The number of patient contacts for each service
2. The number of referrals into each service.

Patient contacts are contacts involving direct contact with the patient - either face to face or by telephone. Our services will often record other activity relating to the patient's care that does not involve direct patient contact. These contacts are excluded from these measures.

The percentage growth shown is calculated from the slope of the trend line. The three services with the highest growth rate, and three with the lowest growth rate are shown as notable movers.

Control logic is used on the chart to indicate when variation is significant.
Coloured horizontal bands on the chart represent multiples of standard deviation (sd) from the mean. The green band represents the mean ±1 sd, amber represents the mean ± 2 sd ,and red represents the mean ± 3 sd.
Points of interest are shown on the chart when they meet at least one of the following criteria:
7 or more consecutive points above the mean, 1 point beyond 3 sd from the mean, 2 of 3 consecutive points greater than 2 sd above or below the mean, 4 of 5 consecutive points greater than 1 sd above or below the mean.

Inpatient assessments

We aim to complete a number of assessments for our inpatients within a certain time from admission.

Our targets are as follows:
MRSA: 95% of inpatients to be assessed within 24 hours
VTE: 95% of inpatients to be assessed for Venous Thromboembolism risk within 24 hours of admission, and to receive prophylactic treatment where appropriate.
MUST: Malnutrition Universal Screening Tool to be completed within 24 hours of admission.
PURAT: 95% of inpatients to be risk assessed for Pressure Ulcers within 2 hours of admission.
Falls: 95% of inpatients to be assessed for falls risk within 4 hours of admission. We report all the above as a % of inpatient admissions in the month.
Dementia: 90% of inpatients to be receive dementia screening within 72 hours of admission. We report this as a % of inpatients discharged in the month.

Mean inpatient length of stay

The average length of stay (in days) for those patients being discharged in the month.
We have 4 community wards. Our three rehabilitation wards Ailesbury (Savernake hospital), Cedar (Chippenham) and Longleat (Warminster) have an average length of stay target of 20 days. Our specialist stroke ward, Mulberry (Chippenham hospital), has an average length of stay target of 30 days.

Ailesbury and Longleat ward also admit 'step-up' patients - these are patients referred from their GP, A&E or ambulance service rather than on discharge from another hospital. We have a target average length of stay of 14 days for these patients. We also report the average length of stay for these patients adjusted to exclude and days for which the patients was a delayed discharge.

Discharge Timings

Here we report the percentage of patients discharged from our inpatient wards before midday against a target of 50%, and the percentage of weekend discharges against a target of 15%.

We only include 'onward' discharges in this data - we exclude deaths and those being transferred back to acute hospitals.

The data shown is for the most recent reporting month only.

Delayed Transfers of Care

A delayed transfer of care occurs when an inpatient is ready to leave hospital but is still occupying an inpatient bed. We report the reason for the delay as categorised by NHS England.

In line with national requirements, we report two measures:

1. The number of delays at midnight on the last Thursday of each month (target is to have delayed patients occupying less than 20% of total ward capacity)

2. The number of bed days lost in the month to these delayed patients.

Community reablement

This measure looks at the residence of a patient 90 days after referral in to our community teams for short term support following a discharge from hospital. It helps quantify the effectiveness of the Community teams in supporting patients to stay in their homes.

We currently have a target of 86% for this measure.

End of Life support

We report the percentage of end of life patients supported in the community that have died in their place of choice.

Funding reviews

Each month we are asked to complete a number of Continuing Health Care (CHC) and Funded Nursing Care (FNC) assessments on behalf of Wiltshire CCG. Here we report how many are completed within 28 days of the due date. We report this measure one month in arrears.

MIU waiting times

The median (middle) wait in minutes from arrival at the Minor Injury Unit to the time of being seen.

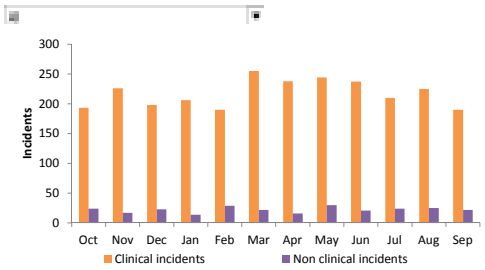
The 95th centile shows the maximum time that 95% of attendees had to wait.
Both measures for the current reporting month only.

MIU performance

We have two Minor Injury Units - one in Chippenham and one in Trowbridge.
We measure the time between each patient's arrival at the Minor Injury Unit and the time they depart. We report the percentage of patients that have an arrival to departure time of under 4 hours against a target of 95%.
We report the number of patients leaving the unit without being seen as a percentage of all attendances. We have a target of no more than 1.9% for this.
We report the number of patients transferring to an acute hospital as a percentage of all attendances. We have a target of no more than 5% for this.

Quality Dashboard September 2017

Incidents

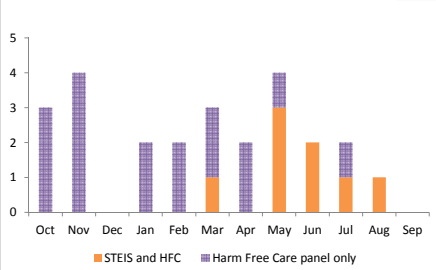


Overdue incidents 55

All services

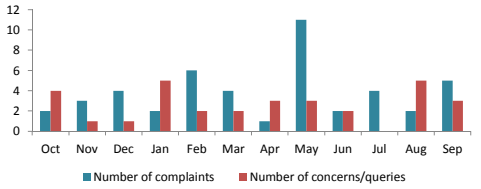
Actual impact	
1-Near Miss	5
2-None (No Harm)	108
3-Low	74
4-Moderate	24
5-Severe	5
6-Death	0

SIRIs excluding pressure ulcers



Complaints/Concerns

Response compliance 100% Open ombudsman cases 0



No overdue responses in September. Complaints routinely below benchmark level

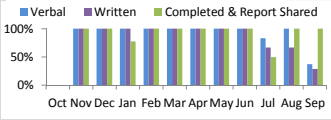
RIDDOR

Financial Year to Date

2

RIDDOR report(s)

Duty of Candour compliance

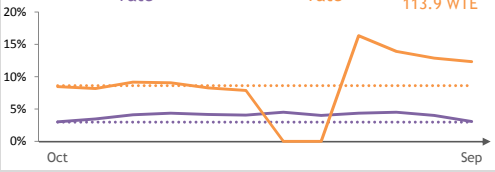


National Mandatory Audits - 1 completed in month

	Completed	Missed
Audit uploads	100%	0

Sickness/Vacancy

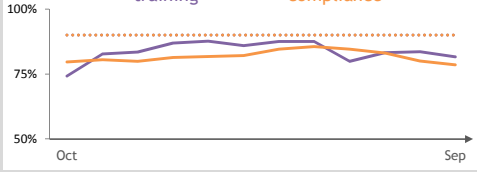
Sep-17 Sickness rate 3.09% Vacancy rate 12.33% 113.9 WTE



Sickness is 1% above same time last year. This is due to management of long term sickness.

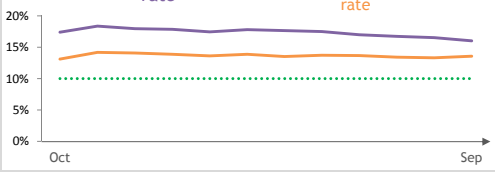
Training/Appraisals

Sep-17 Mandatory training 82% Appraisals compliance 79%



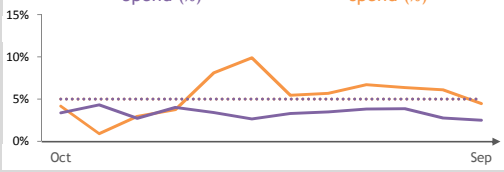
Turnover

Sep-17 Turnover rate 16.03% Voluntary turnover rate 13.58%



Bank/Agency spend %

Sep-17 Bank Staff Spend (%) 2.51% Agency staff spend (%) 4.49%



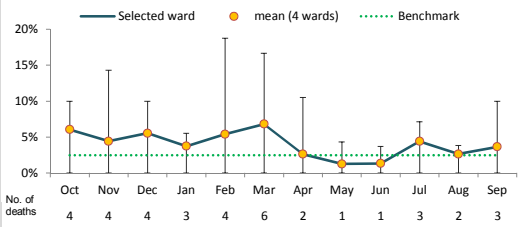
Infection Prevention & Control

	In month	Prev 12 months
MRSA incidence	0	0
C diff incidence	0	0
E coli incidence	0	0
Bed days lost to norovirus	0	17

Compliant with all targets. Bed days lost to norovirus were on Ailesbury ward in October 2016. For information there has been x1 C.Diff incidence reported in

Deaths

3 death(s) in month 3.7% of discharges

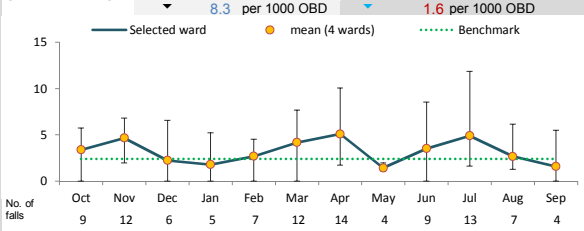


Palliative care deaths are excluded from Apr 17 (in line with National benchmarking definition)

Falls

21 fall(s) in month 8.3 per 1000 OBD

4 Fall(s) with harm 1.6 per 1000 OBD

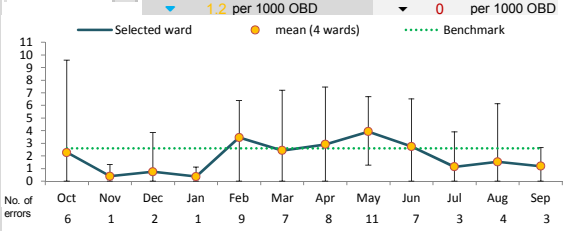


The Quality team undertook a deep dive into the 40 falls reported in April. The key findings will be published this month.

Medication errors

3 error(s) in month 1.2 per 1000 OBD

0 Harmful error(s) 0 per 1000 OBD

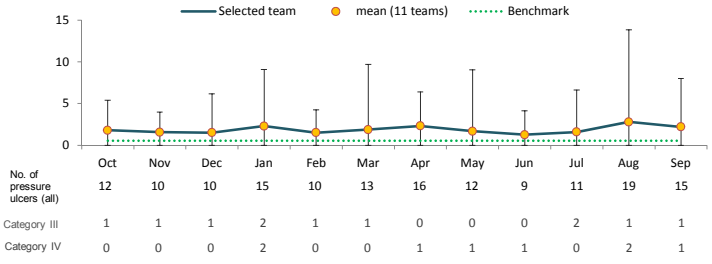


Please note: There is no benchmarking value for medication errors with harm

Medication errors now included on the community teams and specialist services sections within this dashboard.

Avoidable Pressure Ulcers

15 avoidable pressure ulcers acquired in month 2.21 per 1000 caseload

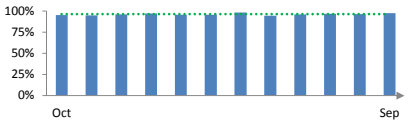


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
No. of pressure ulcers (all)	12	10	10	15	10	13	16	12	9	11	19	15
Category III	1	1	1	2	1	1	0	0	0	2	1	1
Category IV	0	0	0	2	0	0	1	1	1	0	2	1

This graph shows the total verified Category III and IV avoidable pressure ulcers.

Safety Thermometer

Percentage of Harm Free Care (new harms)

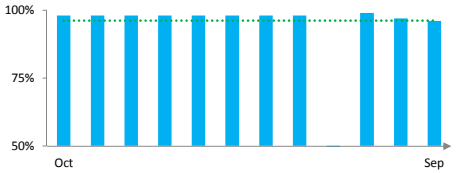


Community Wards	100.00%
Community Teams	96.22%
Wards and Teams combined	97.42%

Improvement in return for September - see community teams and inpatients tabs. The quality team continue to work with teams to improve compliance.

Friends and Family Test

Show response numbers



96%

recommend score

There is an increase in the number of responses, however a drop of 1% in the recommended score in September The quality team are scoping new ways of collating feedback to improve the response rate, i.e. mobile working. There has been no resolution to the reporting error in June;

Inpatient assessments

	Aug-17	Sep-17
Early Warning Score	100%	95%
VTE assessment	100%	99%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	94%	92%
MUST assessment	100%	99%

Explanatory notes for our summary measures

Incidents

Number of incidents (causing harm or otherwise) also shown as a rate per 1,000 WTE budgeted staff.
We monitor this to establish the overall rate of incidents reported across our organisation.
High rates do not necessarily indicate genuine patient safety issues but may be due to high reporting. Triangulation with the safety thermometer score for Harm Free Care (new harms) is recommended.
The number of overdue incidents at the end of the month is shown. The arrow illustrates the change from the preceeding month.

SIRIs excluding pressure ulcers

New Serious Incidents Requiring Investigation (SIRIs) reported per month. This figure excludes SIRIs relating to all grades of pressure ulcers - as these are reported separately.
The figure is split into those reported to STEIS and reviewed at Harm Free Care panel versus those reviewed at Harm Free Care Panel only.

Complaints

Number of formal complaints and rate per 1000 WTE budgeted staff, used to monitor the overall level of satisfaction, or otherwise with our organisation's services. Should be viewed in context with Friends and Family Test recommend score.

We also monitor number of concerns, comments and queries raised by PALS.

RIDDOR

The number of work related accidents reported under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)

Duty of Candour

We have an ethical duty of openness, and we monitor our compliance with the stages of Duty of Candour when dealing with incidents.

Audits

The number of completed audit uploads and missed uploads so far this year.

Sickness/Vacancy

WTE lost to sickness absence in the month (short and long term), expressed as a % of total WTE staff in post.

Vacancy rate - difference between funded establishment and actual establishment, expressed as percentage.

Training/Appraisals

Percentage of staff compliant with mandatory training.

Percentage of current staff with appraisals completed.

Turnover

Total number of leavers in month expressed as a percentage of average number of staff in month.

Bank/Agency spend %

Pay spend on temporary bank staff providing clinical services expressed as a percentage of total pay spend.

Pay spend on temporary agency staff providing clinical services expressed as a percentage of total pay spend.

Infection Prevention & Control

Incidences of MRSA, C.difficile and E. coli occurring on our community wards.
Blood culture contamination incidences and bed days lost to norovirus are also given.

Deaths

Number of expected or unexpected deaths in inpatient community hospital beds, as a percentage of the total number of discharges.
In the absence of HSMRs used for acute trusts, we use this to understand death rates in our wards.
Chart shows rolling 12 months worth of data.

Falls

The number of patient falls (all and those causing injury) occurring on our inpatient wards. Presented as a number and also as a rate per 1000 Occupied Bed Days (OBD) to allow comparison across the four wards and with the published community benchmarking figure.
Chart shows rolling 12 months worth of data.

Medication errors

The number of medication errors (all and those causing harm) occurring on our inpatient wards. Presented as a number and also as a rate per 1000 Occupied Bed Days (OBD) to allow comparison across the four wards, and with the published community benchmarking figure.
Chart shows rolling 12 months of data.

Avoidable Pressure Ulcers

Wards: Rate of New Grade 2, 3 and 4 Avoidable Pressure Ulcers acquired whilst under our care in a Community Hospital setting per 1,000 occupied bed days.

Teams: Rate of New Grade 2, 3 and 4 Avoidable Pressure Ulcers acquired whilst under our care in a Community setting per 1,000 patients (on caseload)

Charts show rolling 12 months worth of data

Safety Thermometer

The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that providers can measure and monitor local improvement and harm free care over time.
Percentage of harm free care (new harms) is monitored as per the national tool calculations.

Friends and Family Test

Friends and Family test % of responses indicating Extremely Likely or Likely to recommend service. This is a national tool and provides us with a simple metric to track changes in user experience over time. Should be viewed in conjunction with complaints and concerns data.

Inpatient assessments

We have a number of inpatient assessments we aim to carry out on admission.
Falls assessment (target of 95% within 4 hours of admission), EWS (95% within 4 hours) VTE (95% within 24 hours, and to receive prophylactic treatment where indicated and appropriate).
Performance below target for 2 consecutive months will trigger further reporting.

We also monitor the number of Hospital Acquired Thrombosis.

Wiltshire Health and Care Board	**For information**
Subject:	**Falls Report**
Date of Meeting:	**28 November 2017**
Author:	**Sarah Jane Peffers**

1. Purpose

1.1 To report on the outcome of a review of falls within inpatient settings which have been the subject of a detailed review.

2. Background

2.1 It was agreed at the June Board meeting that a report would be presented to the Board on the outcome of an audit being carried out on falls. This was originally intended to be presented in September. A progress report was presented in September in lieu of the full report, which is attached.

3. Discussion

3.1 The Executive summary (pages 4 and 5 only) provides an overview and summary of the recommendations for follow up action. The full report is also provided for information. The report is also being shared with the quality team within the CCG.

4. Recommendation

4.1 The Board is invited to note the contents of the review and recommendations for further action.

Falls Report

November 2017

Leads:

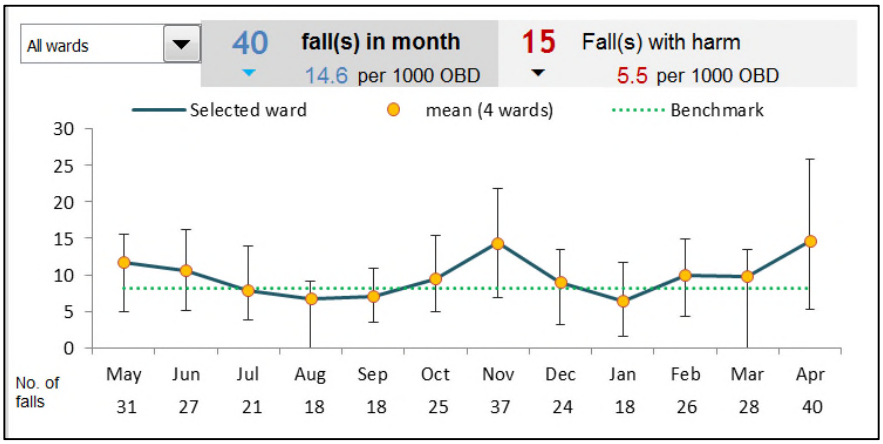
- Sarah-Jane Peffers, Head of Quality
- Caroline Wylie, Deputy Head of Quality
- Kat Hitch, Safeguarding Adults Lead
- Kayleigh Gullis, Quality Governance Facilitator

Contents

EXECUTIVE SUMMARY

This paper outlines the findings from the recent falls audit (July 2017) and the in-depth analysis (deep dive) of all the falls that occurred in April 2017. The development of the quality dashboard and the inclusion of benchmarking data have enabled Wiltshire Health and Care (WHC) to use data intuitively and seek further information or undertake greater scrutiny of the data.

Falls data presented in June 2017 identified an increase in falls across the 4 community in-patient ward areas in April 2017.



Further scrutiny of all falls in April has been undertaken and full details can be found in the main body of the report. Key findings highlighted:

- Patients admitted to community in-patient wards are complex and have multiple co-morbidities
- Majority of falls caused no harm to the patient, however this relates to physical harm not necessarily the ham caused psychologically; for example, the impact on self confidence
- The highest proportion of falls were un-witnessed falls, found on fall
- There is assurance from a safeguarding perspective that only 2 falls in this sample resulted in moderate or above harm, however, these incidents potentially should have been reported as safeguarding concerns
- The majority of patients that fell in April lacked capacity to make informed decisions about their care and treatment, and their in-patient stay
- 43% of patients were eligible for a Deprivation of Liberty Safeguards Application but these were not made
- Poly-pharmacy, a number of patients were on a high number of drugs (average 11)
- It would appear that both Delayed Transfers of Care (DTOC) and Length of Stay (LOS) is having a significant effect on patients who are vulnerable to falls
- More falls occur on a Saturday and in the afternoon
- There is inconsistency across the 4 wards with interventions occurring after a fall has happened, this includes; completion of a SWARM, Intentional-rounding, observations
- There is an overwhelming amount of documentation expected to be completed by ward staff and there is a lack of uniformity in the documentation across the wards.

To complement the falls deep dive report, a clinical audit was undertaken. The audit tool used was adapted from the Royal College of Physicians (RCP) National In-patient Falls audit. WHC has not previously been involved with this national audit because its focus is on acute wards only. However the overarching criterion reflects the community in-patient approach to falls risk, prevention and management and is in line with relevant NICE guidance (CG161 and QS86).

This audit offered a similar review of ward documentation, but reviewed all in-patients (not just those who had experienced a fall), and included a comprehensive observation of the patient environment to establish whether precautions are in place to prevent falls. In total 83 patients were audited across the 4 in-patient wards

Key findings highlighted:

- The majority of patients admitted to the ward are elderly with an average age of 85 years.
- A high proportion of patients were admitted due to a previous fall
- There is an inconsistent approach across all wards to the amount of falls documentation completed, although some wards have scored 100% in some areas
- All 4 wards consistently score high on the assessment, review and provision of mobility support
- There is limited documentation to identify if written or verbal information has been given about falls prevention and risk
- The wards are very aware of the importance of a safe environment and adaptations to support a patients mobility and safety
- The audit reflects the on-going challenge with delayed transfer of patients
- Poly-pharmacy; a number of patients were on a high number of drugs (average 10)

It is clear that there are a number of consistencies between the two reports which require attention; Adoption of prevention strategies, documentation, recording keeping, involvement of families and carers and the impact of delayed transfers of care.

Also to note; the majority of the findings highlight a need for a system wide approach both within WHC and with wider system partners.

Key recommendations

1. Streamline documentation and process
2. Seek support from Wiltshire CCG and clarification and timescales on the likelihood of moving to S1
3. Examine and agree what changes/ improvements are managed within the operational teams and what additional resource is required
4. To match the skills and resourcing to the needs of the patients. To include;
    a. Training needs analysis
    b. Skill mix review
    c. Review of prevention strategies
    d. Multi-disciplinary review and assessment
    e. Increasing the knowledge and confidence of MCA/ DOLS
    f. Assess close monitoring support requirements and processes
    g. Review of equipment to support falls prevention and active rehabilitation

INTRODUCTION

Falls and fall related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than 2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. (NICE Guidance: Falls in older people: assessing risk and prevention, CG161, June 2013)

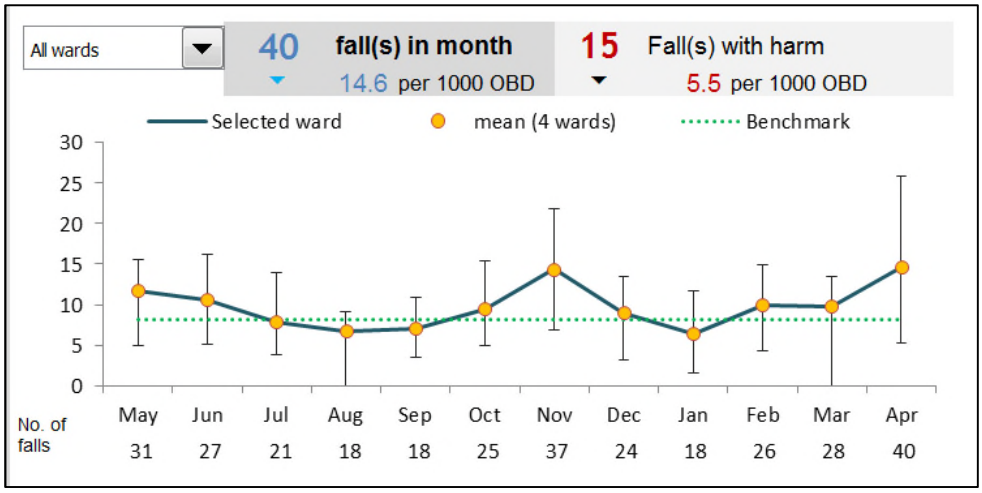
Evidence from the Royal College of Physicians and NHS Improvement suggests that there is a capacity to reduce the number of falls by up to 25%-30% through multifactorial interventions.

The development of the quality dashboard and the inclusion of benchmarking data have enabled Wiltshire Health and Care (WHC) to use data intuitively and seek further information or undertake greater scrutiny of falls data. This has led to further discussions and actions to try to identify if any additional or revised interventions could help support a reduction in falls across the 4 community in-patient wards. This paper outlines the findings from the recent falls audit (July 2017) and the in-depth analysis (deep dive) of all the falls that occurred in April 2017.

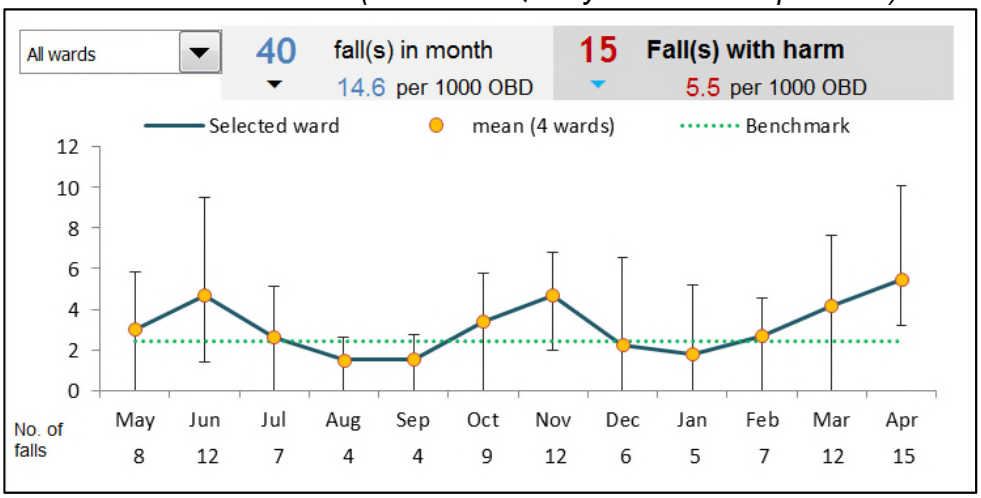
DEEP DIVE

In April 2017 there was a higher than expected number of falls occurring in the Community Inpatient Wards, in comparison to both national and local benchmarking data.

Number of Falls (Data from Quality Dashboard April 2017)



Number of Falls with Harm (Data from Quality Dashboard April 2017)



AIM

To identify if there were any further interventions/assessments that could have been undertaken that would of reduced the likelihood of a person falling in our care.

OBJECTIVES

- To review each case note to identify the following:
- Whether incidents were reported appropriately
- Accuracy and completeness of documentation, including:
- Completion of assessment tools
- Completion of care plans
- Review of medications
- Practicable application of clinical reasoning and escalation
- Practical application of the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLS)
- To recognise the trends and themes across the four wards
- To identify if there any gaps in knowledge and use of processes and policies
- To assess the environmental to recognise potential contributory factors

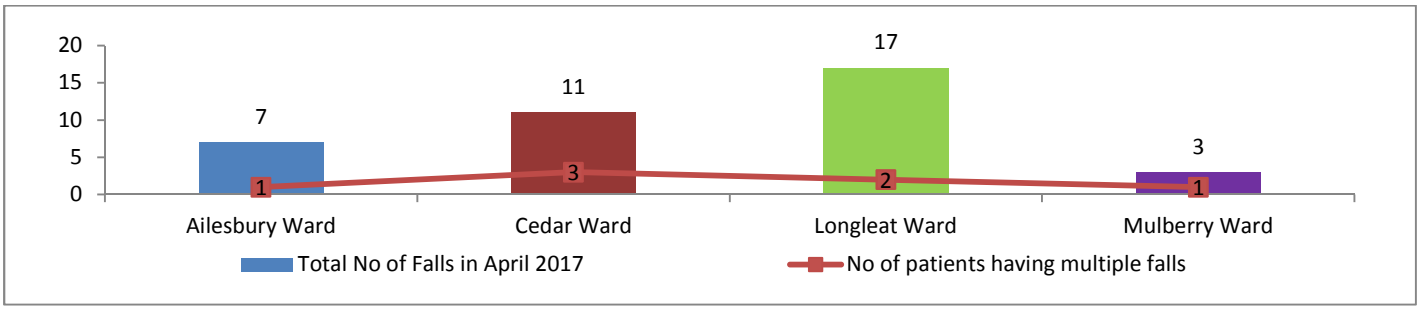
METHODOLOGY

- Retrospective analysis of clinical incidents and case notes of all the patients that fell during April 2017
- Environmental review of inpatient areas
- The analysis was undertaken by the Deputy Head of Quality, Safeguarding Adults Lead, and Quality Governance Facilitator to ensure consistency and impartiality
- Information was collected during July – September 2017

SAMPLE

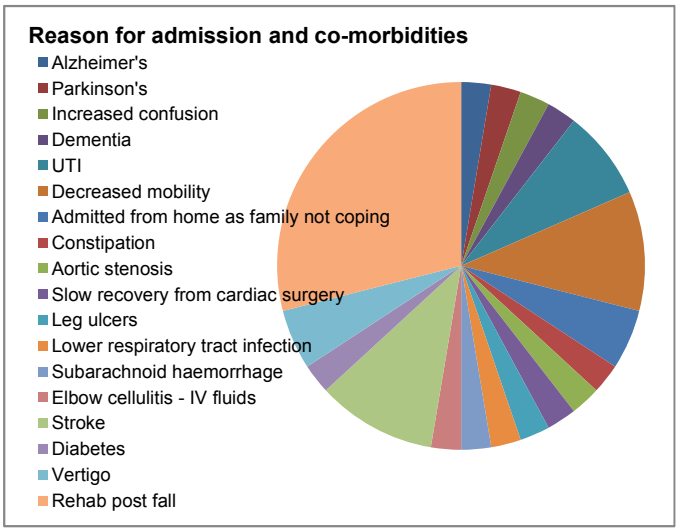
There were a total of 41 reported falls in April 2017 which equates to 25 patients. However, 3 incident reports were excluded due to the following reasons; 1x duplicated clinical incident report and 2x confirmed collapse. Therefore the total number of falls is 38 which equates to 23 patients.

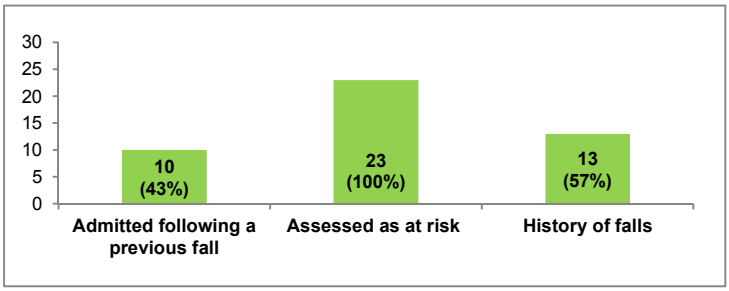
The graph below identifies the total number of falls by ward and the total number of patients who experienced multiple falls. 7 patients had repeated falls, equating to 22 falls.



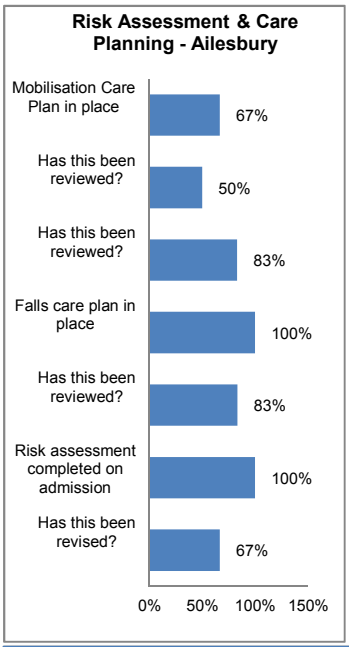
	Ailesbury Ward	Cedar Ward	Cedar Ward	Cedar Ward	Longleat Ward	Longleat Ward	Mulberry Ward
	1 patient had 2 falls	**1 patient had 5 falls**	**1 patient had 2 falls**	**1 patient had 2 falls**	**1 patient had 7 falls**	**1 patient had 2 falls**	**1 patient had 2 falls**
Was the patient a DTOC at time of fall	No	No	No	No	Yes – 4 falls	No	No
Was the patient eligible for DoLS?	Yes	Yes	Yes	Yes	Yes	No	Yes
Was a DoLS application in place?	No	No	Yes	No	No	NA	No
Was close support required?	Yes	No	Yes	No	Yes	No	No
Was close support provided?	Not in April	NA	No	NA	No	NA	NA
Comments		This patient had another 3 falls in April which were not reported through an IR1					This patient had another fall in April which was not reported through an IR1

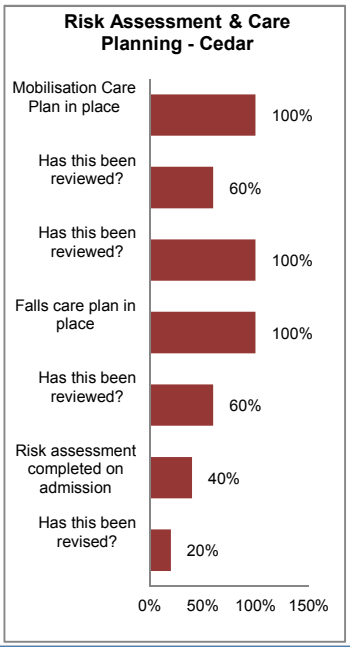
RESULTS – CLINICAL INFORMATION:

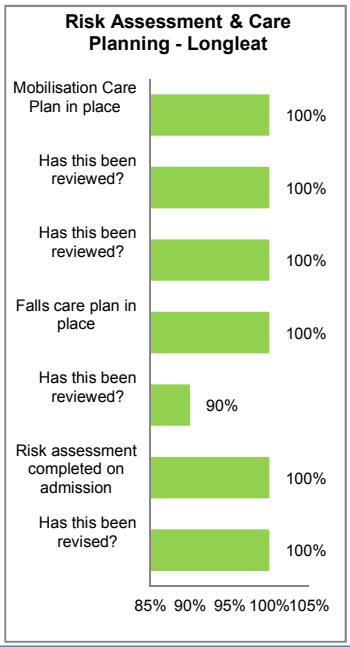


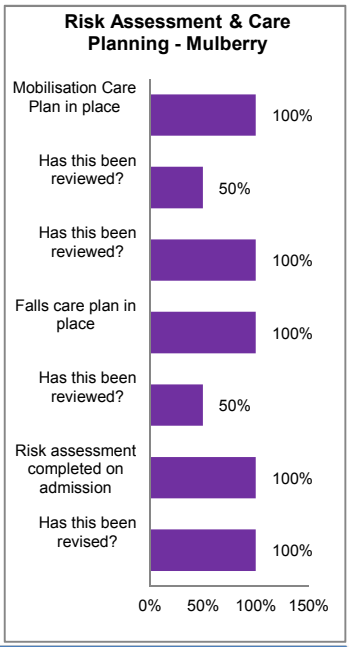


The pie chart recognises the complexity and co-morbidities of the patients admitted to our inpatient wards. The majority of patients were admitted for rehab. The bar chart clearly identifies that the deep dive cohort were at risk of falls.

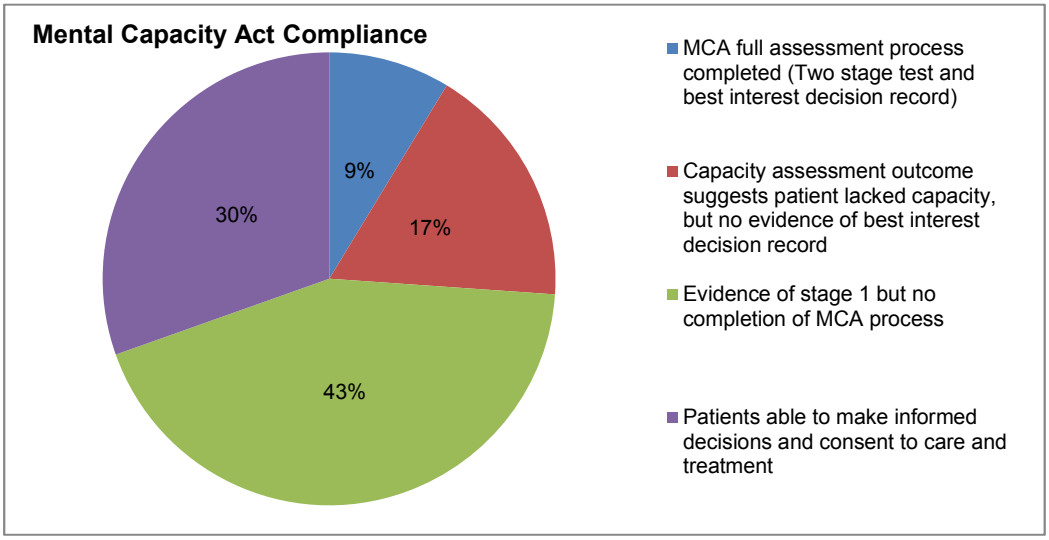




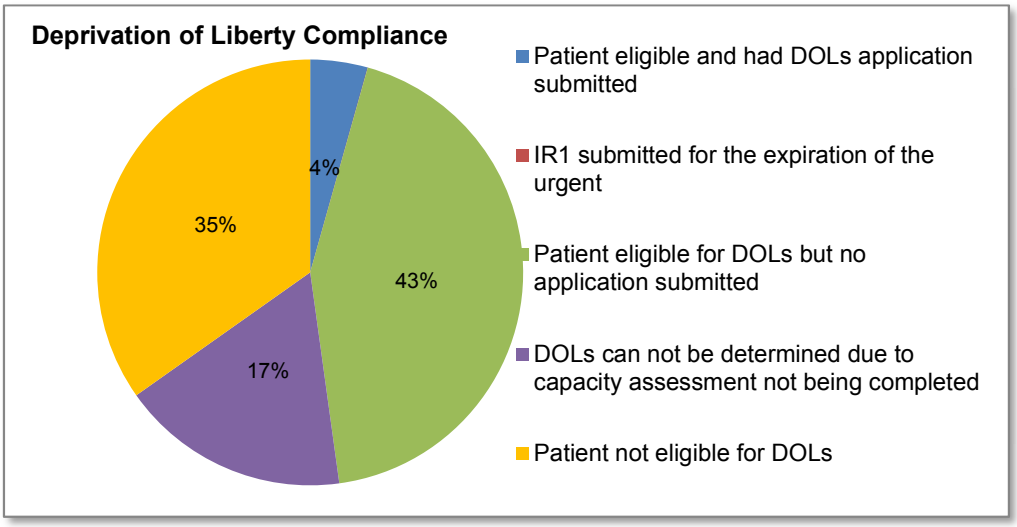




There is a varying approach to care planning across the inpatient wards.

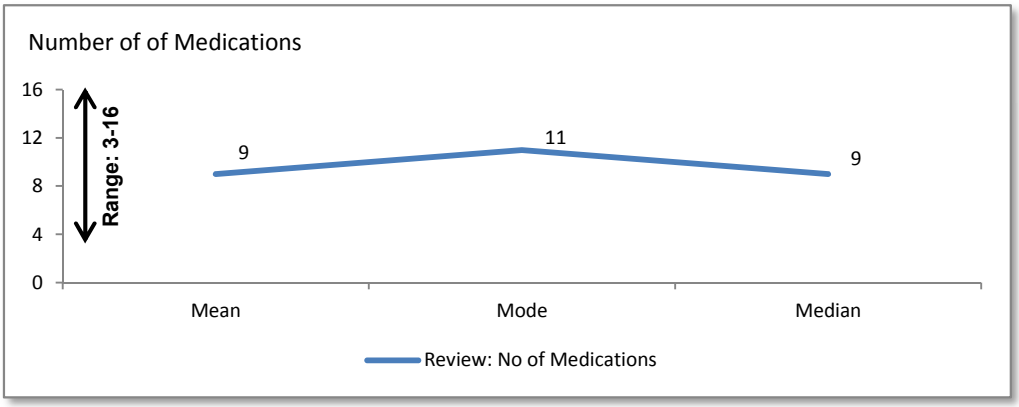


The majority (70%) of the patients who fell in April lacked capacity to make informed decisions about their care and treatment, and their inpatient stay.



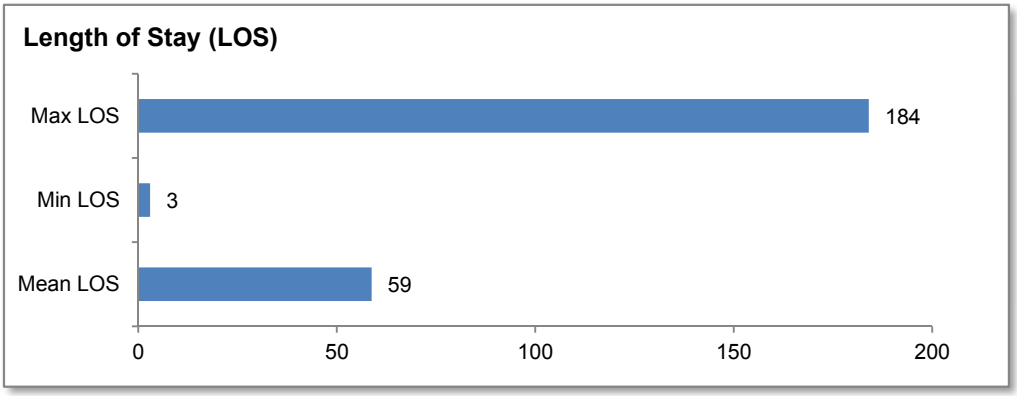
43% of patients were eligible for a DoLS application but these were not made.

Therefore WHC were not meeting legal compliance with the MCA and CQC regulatory Safeguarding standards.



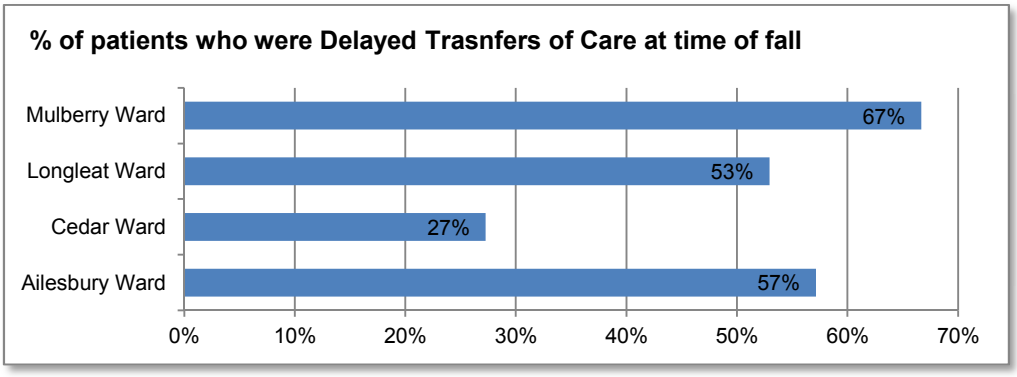
Evidence suggests that several types of drugs are associated with a significant risk of falls.

There was high use of poly pharmacy, with some drugs known to cause muscle weakness, lack of balance, drowsiness, dizziness and tiredness.



WHC overall length of stay (LOS), in April 2017 was an average of 27.4 days. The target is 20 days

The chart shows the varying LOS, with the mean LOS of those patients who fell in April 2017 being 59 days



This demonstrates the majority of patients sustaining falls are delayed transfer of care (DTOC).

RESULTS – STAFFING

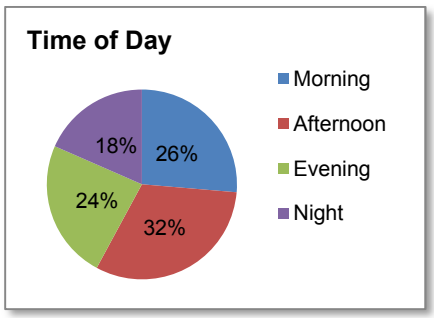
The table below identifies which shifts were missing a member of staff at the time of a patient fall

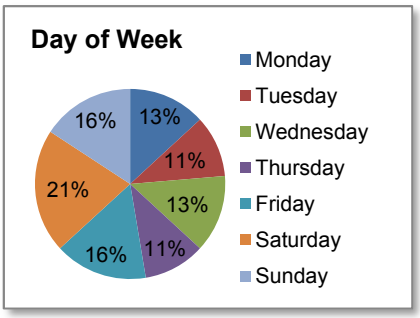
Early Shift:	07:15-15:15
Late Shift:	12:45-20:45
Night:	20:15-07:45
Core:	08:30-13:30
Handover Period:	12.45-15.15

12 falls occurred on shifts where the staffing numbers were lower than the agreed skill mix

Ailesbury Ward	
1x patient fell at 14:00 on 06/04/2017	This shift was missing: • 1x Physio during core hours • 1x Registered Nurses during early shift • 1x Registered Nurses during late shift
Cedar Ward	
1x patient fell at 13:40 on 05/04/2017	This shift was missing: • 1x Healthcare Assistant during late shift
1x patient fell at 16:00 on 05/04/2017	This shift was missing: • 1x Healthcare Assistant during late shift
1x patient fell at 21:00 on 22/04/2017	This shift was missing: • 1x Healthcare Assistants during early shift • 1x Healthcare Assistants during late shift • 1x Healthcare Assistants during night shift
Longleat Ward	
1x patient fell at 13:55 on 09/04/2017	This shift was missing: • 1x Healthcare Assistants during early shift • 1x Healthcare Assistant during late shift
1x patient fell at 05:05 on 10/04/2017	This shift was missing: • 1x Healthcare Assistants during night shift
1x patient fell at 14:30 on 15/04/2017	This shift was missing: • 1x Healthcare Assistants during early shift
1x patient fell at 09:00, 15:15 and 21:20 on 23/04/2017	This shift was missing: • 1x Healthcare Assistants on short late shift
1x patient fell at 23:50 on 24/04/2017	This shift was missing: • 1x Healthcare Assistants during early shift • 1x Healthcare Assistants during late shift • 1x Registered Nurse during night shift
1x patient fell at 05:45 on 27/04/2017	This shift was missing: • 1x Healthcare Assistants on short early shift • 1x Registered Nurse on late shift
1x patient fell at 21:40 on 29/04/2017	This shift was missing: • 1x Healthcare Assistants on short late shift
Mulberry Ward	
1x patient fell at 16:00 on 07/04/2017	This shift was missing: • 1x Healthcare Assistants during late shift

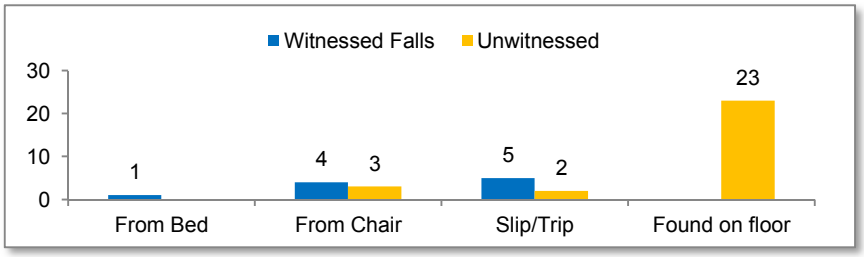
RESULTS – POST INCIDENT

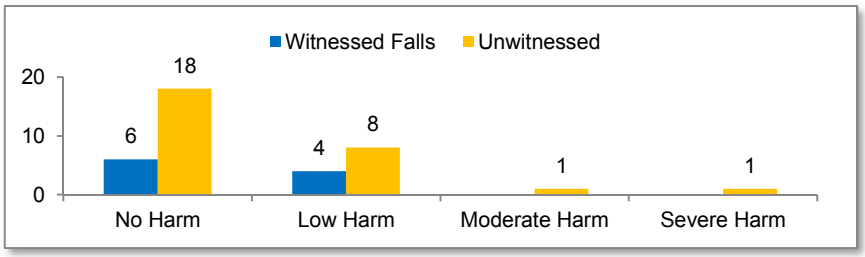




More falls occur on a Saturday and in the afternoon, however there is no apparent correlation between time and day of fall.

- Morning – 06:00-12:00
- Afternoon – 12:00-18:00
- Evening – 18:00-22:00
- Night: 22:00-06:00

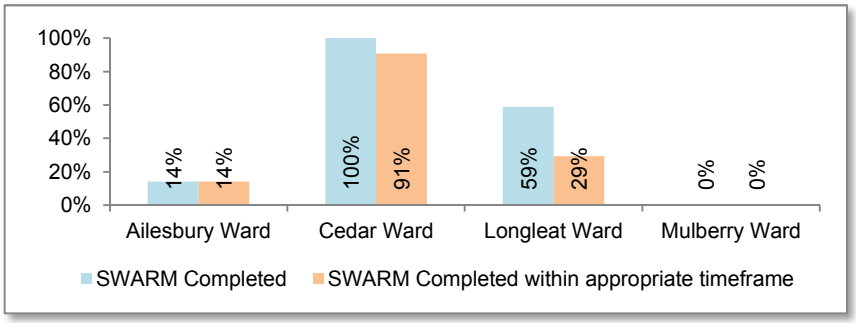




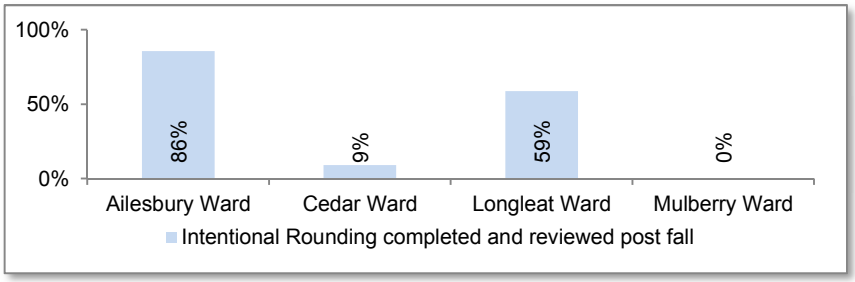
Highest proportion of falls was unwitnessed falls found on floor.

Majority of falls caused no harm to the patient.

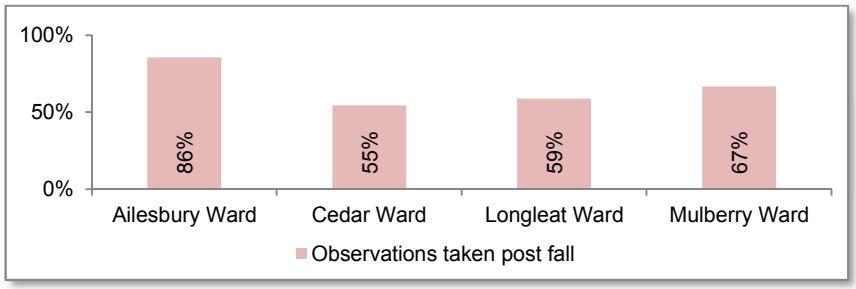
Those falls causing moderate to severe harm were un-witnessed.



There is inconsistency across the 4 wards, however there is near perfect rate of compliance on Cedar Ward.



There is inconsistency across the 4 wards; however there is high compliance on Ailesbury Ward.



There is a variation across the 4 wards with compliance and where information was recorded.

I.e. care record, SWARM and observation chart

KEY DISCUSSION

Clinical Information
Patients admitted to community in-patient wards are complex, have a high risk of falls from admission and are often on multiple medications which increased their risk of falls. This identifies the importance of appropriate, timely assessment and planning to ensure that care delivery meets the individual patient needs and potentially reduces the risk of falls or further falls.

There was recognition that all patients reviewed were at risk of falls; however it is not apparent in all cases that preventative measures are put in place at the beginning of the patient's journey.

LOS/DTOC
It would appear that DTOC and LOS is having a significant effective on patients who are vulnerable to falls.

Documentation
There was evidence of reasonably good recording within the nursing daily record of care. However, review of the documentation has identified that the current clinical documents do not support the delivery of patient centred care, completion and review. This may be due to;

- The overwhelming volume of documents
- Appropriateness of the current falls assessment which does not include a medication review
- Duplication and segregation of documentation between the clinicians
- Lack of consistency across all 4 wards
- Poor quality of documents due to over photocopying
- Some of the documents were from other organisations not related to WHC or the partnership
- Use of out dated documents
- Staffs understanding of the value and purpose of the document
- There is too much focus on 'tick boxes' and pre population of forms

MCA/DOLS
There is currently not a consistent approach to the application of MCA and DOLS and therefore patients are not having their rights upheld. Better application of MCA and DOLS could have a positive impact on patient's length of stay by prioritising those patients who are at risk within the hospital environment.

Safeguarding
There is assurance from a Safeguarding perspective that only 2 falls in this sample resulted in moderate or above harm. These incidents potentially should have been reported as Safeguarding Concerns. Further work needs to be undertaken following this deep dive for Wiltshire Health and Care to determine clear indicators that require a fall to be reported as a Safeguarding Concern under the requirements of S42 of the Care Act (2014).

Consent
Fundamental to good quality patient centred care is the establishment of patient consent to be both accommodated to receive care and treatment and the delivery of that care and treatment. The current inpatient paperwork is not supporting staff to record consent for these elements. Recording of consent to care/treatment or therapy was limited to a reference that "consent was gained or obtained". There was no specification as to information discussed with the patient about their admission/stay and/or the care and treatment plans being delivered which would evidence better legal compliance in relation to consent and informed decision making.

SWARM
It is recognised that currently there is inconsistency in the use of the SWARM template and the IR1 falls questionnaire. Some wards consider the falls questionnaire to be a replacement of the SWARM and at times neither a falls questionnaire nor a SWARM had been completed.

Intentional Rounding (IR)
There is broad consensus that the current IR tool does not improve the safety of patient care and therefore does not prevent further falls from occurring.

Observations
Observations are an essential assessment which should be carried out at prescribed intervals according to patient need; this includes an initial assessment and post fall. It was noted during the review, that observations were not being repeated when a concern or out of parameter result was identified. When a timeframe for observations was prescribed these were not consistently followed.

Close Support
Close support monitoring was identified for a number of cases. However the current proforma adopted by GWH is not always utilised across the wards and therefore additional workforce requirements are either not identified or alternative less restrictive options are not always considered. Incident reporting did not reflect any resource shortfall or the risk to patients by not having this support available.

FURTHER DISCUSSION

It would appear that more falls occur on a weekend and in the afternoons. A common sense interpretation would suggest this could relate to visiting hours. Restricted visiting hours was recognised as an area of improvement in the recent CQC inspection.

There was clear evidence that suggested that some patients were not appropriate admissions for the community inpatient wards. This was often due to poor/incomplete information being given from referral agency.

Incident reporting has been recognised as an area of development and this deep dive has re-enforced the necessity to progress quality improvement in this area. Areas of significance were missing incident reporting when errors or omission have occurred, for example; missed medications and occurrences of falls. Also incidents forms were not completed when staffing numbers were not at the expected level, this included the requirement for close support. It is felt that the current system does not support the ease of reporting.

FALLS CLINICAL AUDIT

INTRODUCTION
It has been noted by Wiltshire Health and Care (WHC) that the Community Inpatient Wards do not participate in the mandatory Royal College of Physicians (RCP) National Inpatient Falls audit as the audit focuses on acute wards only. However, it was felt the audit tool could be adapted and used in a community in-patient setting. The completion of this audit would identify if the community wards are complaint with the relevant NICE guidance. The audit was carried out during July 2017.

AIM
To determine compliance against the NICE guidelines with assessing risks and preventing falls in older people.

OBJECTIVES
1. To identify whether assessments are being completed

2. To observe the patient environment to establish whether appropriate precautions are in place to prevent falls

METHODOLOGY
- The Ward Physiotherapist was requested to audit **all** patients on the ward, on a specific day between the 3rd and 14th July 2017 (Only Longleat completed the audit in this time period)

- Data was collected by looking through health records and patient environment observations

- Data was analysed and a draft report was developed by the Quality Governance Facilitator

- The audit report was finalised by the Inpatient Services Manager and Head of Quality

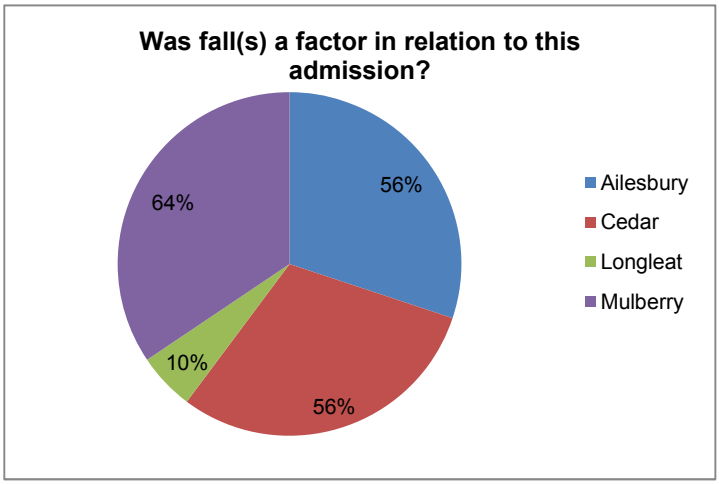
SAMPLE
In total 83 patients were audited across the x4 Inpatient Wards
- Ailesbury Ward – Audited x25 patients on 5th August 2017
- Cedar Ward – Audited x16 patients on 11th July and 10th August 2017
- Mulberry Ward – Audited x20 patients on 28th July 2017
- Longleat Ward – Audited x22 patients on 4th July 2017

Age of patients – Mean: 80, Most: 85, Median: 83

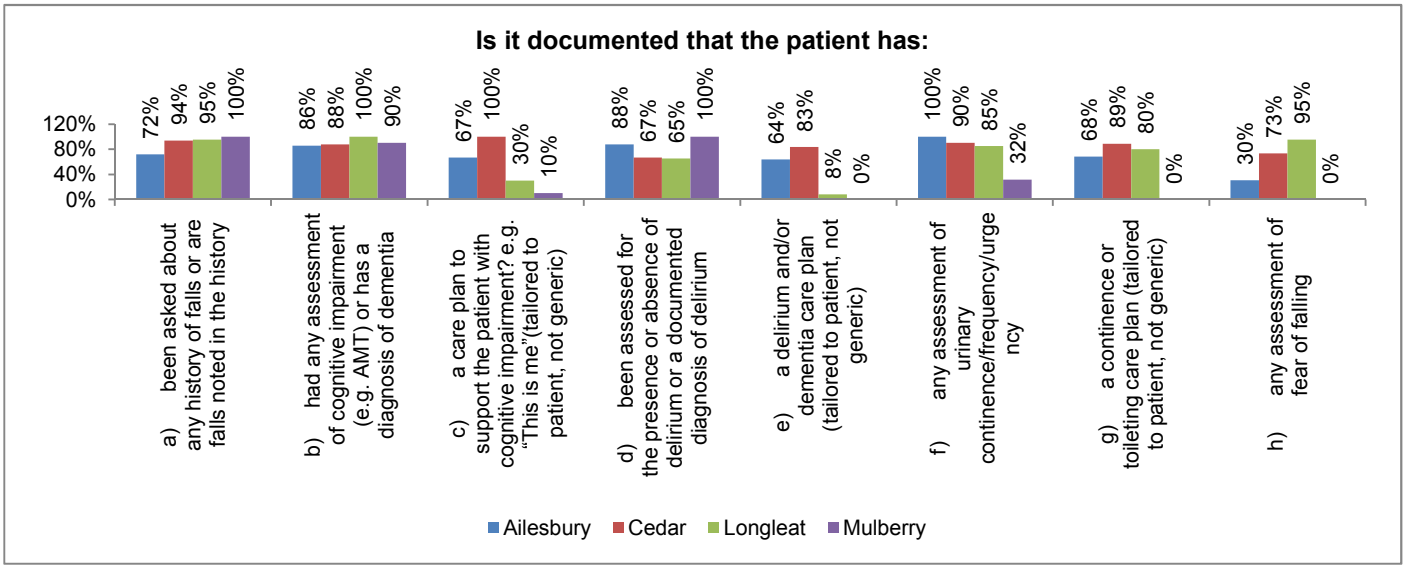
Gender – 32x Males, 51x Females

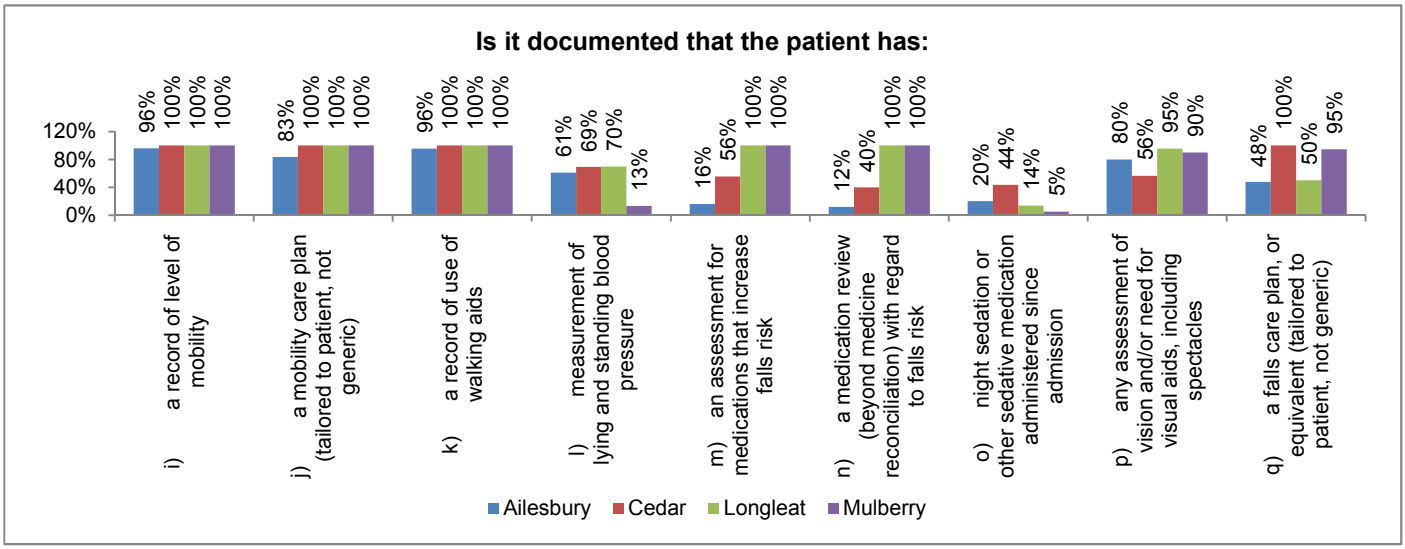
CAVEATS
Cedar Ward audited 5 patients on the 11th July, not all patients on the ward. The Cedar Ward Manager and Ward sister audited a further 11 patients on the 10th August to ensure the all patient beds were audited in total. Please note – two beds were closed during this audit on Cedar Ward.

RESULTS: SECTION 1 - EVIDENCE OF ASSESSMENT AND INTERVENTION

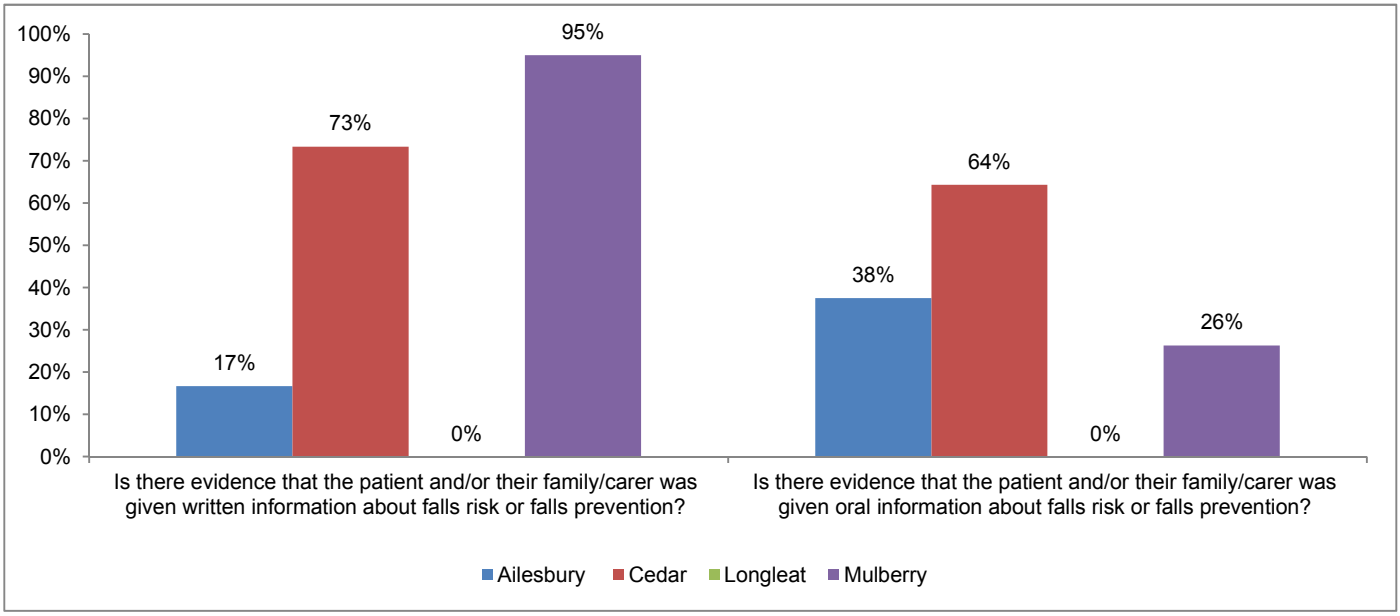


The majority of patients admitted on Ailesbury, Cedar and Mulberry were admitted due to previous fall(s) when this audit was undertaken.



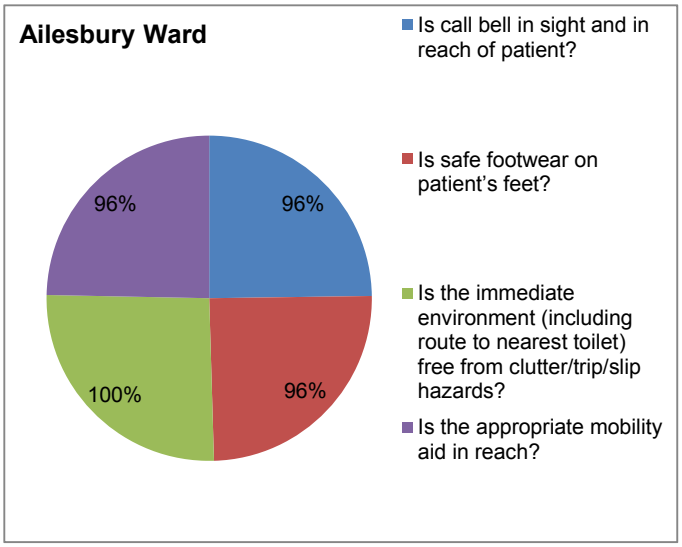


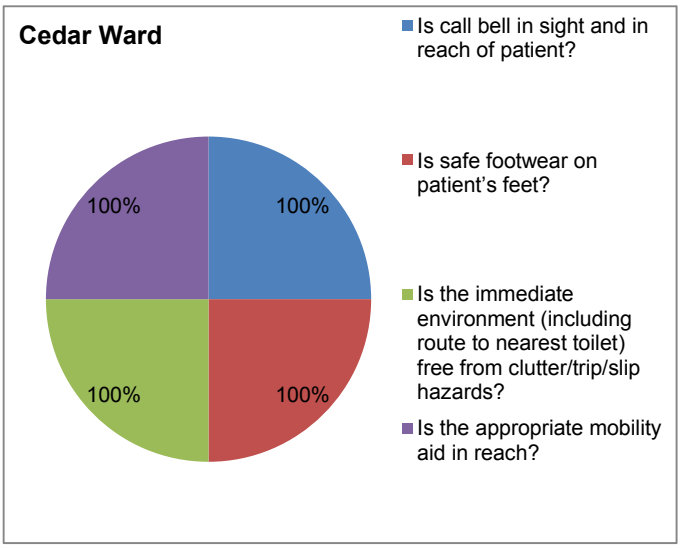
There is an inconsistency in the completion of the falls assessment. However there are some areas of notable practice in some wards and the assessment, planning, review and provision of mobility is consistently high across all 4 wards

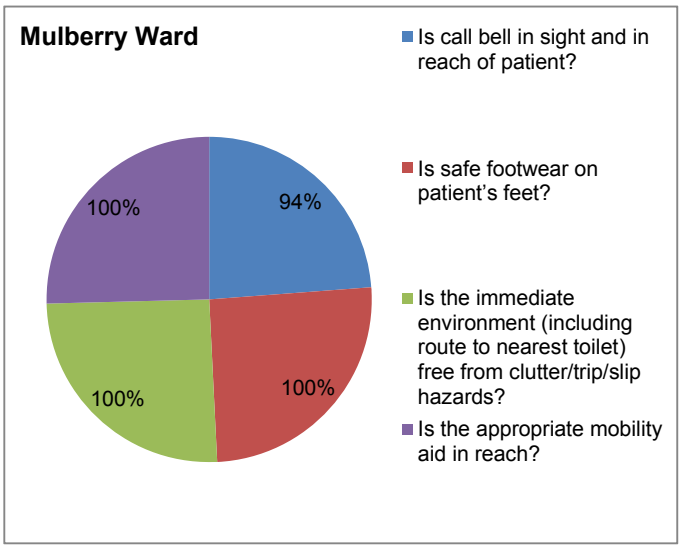


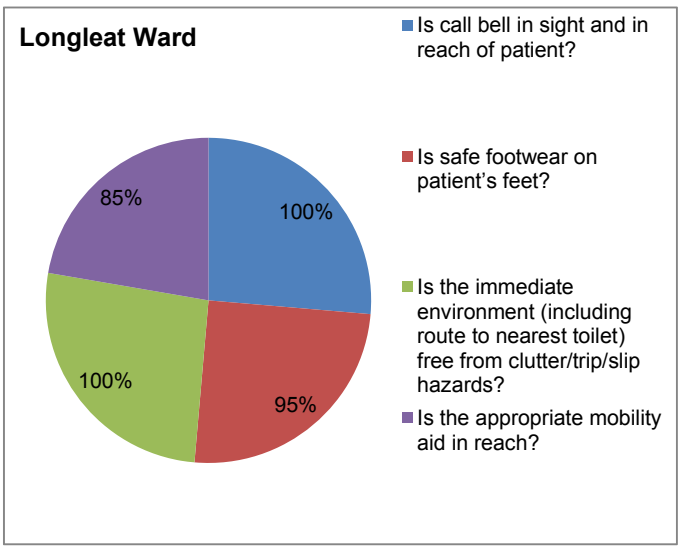
There is inconsistent recording of written information and verbal conversations held relating to falls prevention and falls risks

RESULTS: SECTION 2 – BEDSIDE / PATIENT ENVIRONMENT OBSERVATION

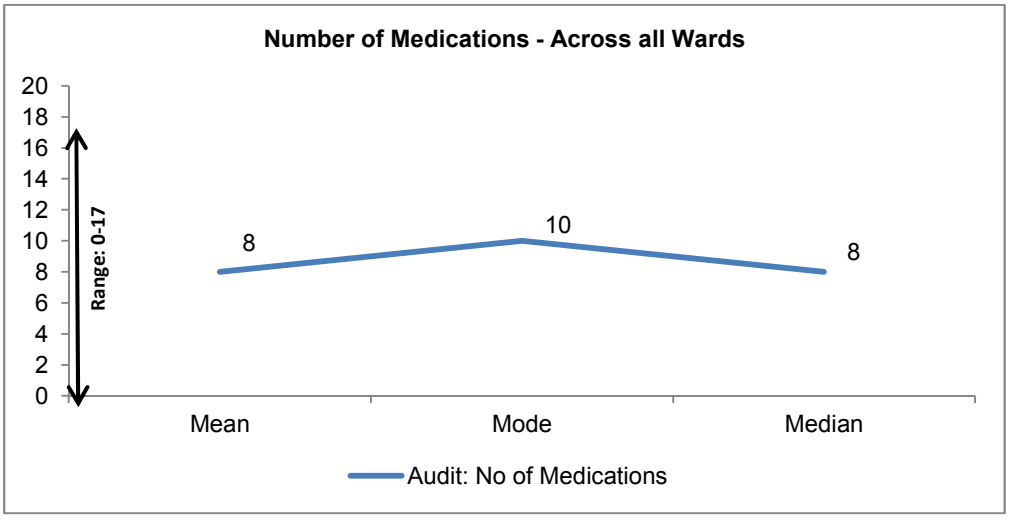




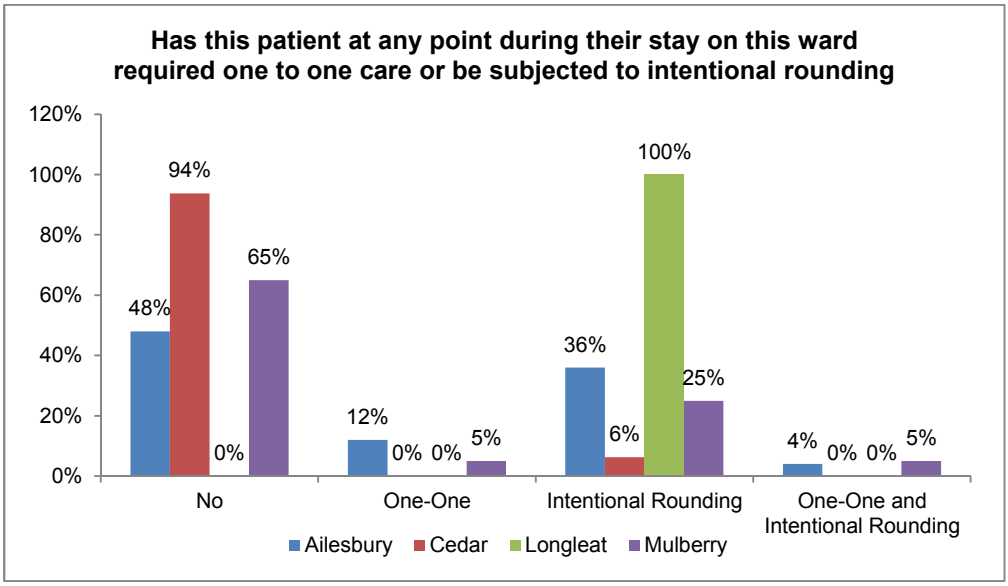




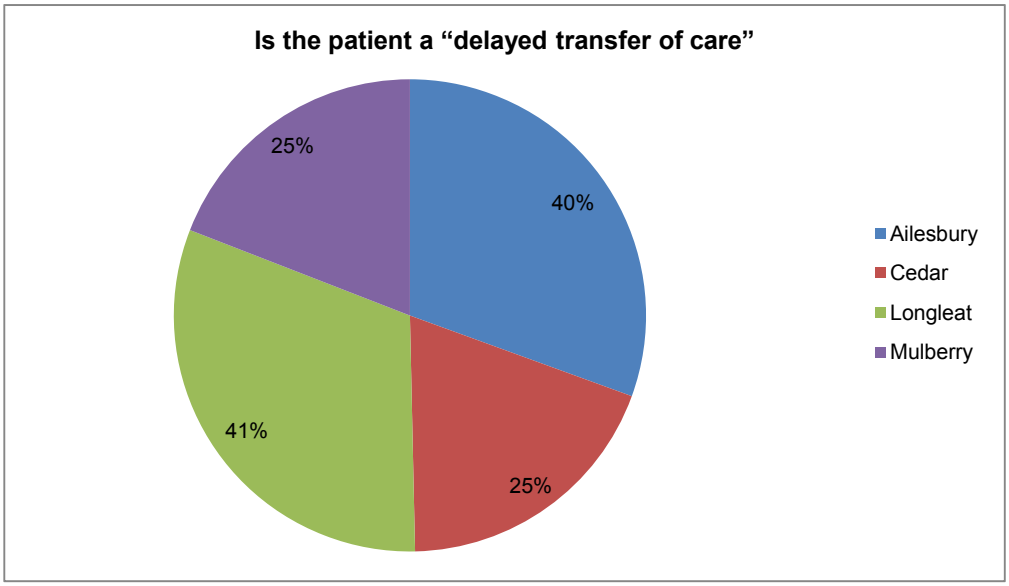
All 4 wards have scored high in this domain, this highlights the importance placed on ensuring the provision of a safe environment and providing the right equipment to try to prevent falls from happening. These findings are different to the deep dive, this may highlight that preventative approach is being adopted, but the recording of interventions is limited.



There is a high use of poly pharmacy. The audit shows both Longleat and Mulberry ward have scored 100% on assessing patient's medication.



Limited use of close support and a varying approach to the use of intentional rounding



The audit reflects the on-going challenges with delayed transfer of patients

RECOMMENDATIONS

1. Streamline documentation and process
2. Seek support from Wiltshire CCG and clarification and timescales on the likelihood of moving to S1
3. Examine and agree what changes/ improvements are managed within the operational teams and what additional resource is required
4. To match the skills and resourcing to the needs of the patients. To include;
    a. Training needs analysis
    b. Skill mix review
    c. Review of prevention strategies
    d. Multi-disciplinary review and assessment
    e. Increasing the knowledge and confidence of MCA/ DOLS
    f. Assess close monitoring support requirements and processes
    g. Review of equipment to support falls prevention and active rehabilitation

Wiltshire Health and Care Board	**For information**
Subject:	**CQC Action Report**
Date of Meeting:	**28 November 2017**
Author:	**Victoria Roper**

1. Purpose

1.1 To provide the Board with a copy of the Action Report returned to the CQC on 31 October 2017.

2. Background

2.1 Following the CQC inspection in June, Wiltshire Health and Care were advised of two actions where regulation had not been met. For these two, the CQC issued us with a report template for our completion by 31 October, to advise them of our progress and planned actions to address those issues. The full report and appendix is embedded below for your information. It was submitted to CQC on 31 October 2017.

3. Recommendation

3.1 The Board is invited to note the content of the report on actions submitted to the CQC.

Report on actions you plan to take

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

Account number	1-2642739822
Our reference	INS2-3486940824
Provider name	Wiltshire Health and Care LLP

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures. Treatment of disease, disorder or injury.	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
	How the regulation was not being met:
	The organisation was unable to provide the Commission with the complete set of information as specified by this Regulation.

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

A complete set of evidence has been compiled in line with the requirements set out in Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors, and the Chair has signed a declaration that she is satisfied that all members of the Board are fit to hold those roles. This declaration is attached.

A database to monitor compliance on an annual basis has also been developed to ensure the declaration of fitness is renewed every year.

Who is responsible for the action?	Douglas Blair

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

The database includes dates for renewal of annually required updates and also will highlight any gaps in evidence.

A newly appointed Board Secretary will be responsible for maintaining this, but in the meantime, until her commencement in post, Douglas Blair (MD) will be responsible for this.

Who is responsible?	Douglas Blair

What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resources required to meet the regulations in the short term as this has already been achieved. A Board Secretary is being appointed who will monitor annual compliance and review policy as required.	
Date actions will be completed:	All necessary evidence on file: 31st October 2017 New resources in place and arrangements fully embedded: 31 January 2018

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is no direct impact on patients in the short term as Board members have been assessed as 'fit and proper' in line with the Regulations. The organisation does need to evidence its continued assurance of Board members' fitness to sit on the Board, to ensure that all Board level decisions are taken by people of good character whose interest is to improve patients' experience and quality of care over the longer term.

Completed by: (please print name(s) in full)	Victoria Roper Douglas Blair
Position(s):	Project Manager Managing Director
Date:	25/10/17

Regulated activity(ies)	Regulation
Diagnostic and screening procedures. Treatment of disease, disorder or injury.	Regulation 17 HSCA (RA) Regulations 2014 Good governance
	How the regulation was not being met:
	The organisation was not able to provide assurance of the provision of safe and quality care due to a lack of good governance in the minor injury units. There was a lack of regular team meetings, low rates of incident reporting, few routine audits undertaken, and overall governance. Some staff had too many responsibilities to be enabled to devote quality time to everything they were required to deliver. The organisation was not able to provide assurance it was assessing and monitoring the safety and quality of care effectively through good governance at the board and sub-committees of the board. There was insufficient evidence to show improvements to care had been made from incidents and near misses. Minutes from governance meetings did not demonstrate where learning had made a difference. There was an improving but still inconsistent approach to risk management. A lack of governance due to some committees not meeting until very recently had left gaps in assurance. There was a lack of evidence provided to the board to show there had been learning from complaints, and little patient engagement to ensure that patients play a part in influencing how the organisation evolved. The investigation of serious incidents did not always identify the root cause of the incident and the action plans did not always capture or address the failings in care. There was a lack of good audit work to demonstrate to the board that patients were receiving good outcomes. Some audits were inconsistent across services.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Lack of good governance in MIUs - lack of regular team meetings, low rates of incident reporting, few routine audits undertaken, and overall governance. In MIUs, regular (bi-monthly) team meetings have been scheduled and held, All staff have an influence on the setting of the agenda. To ensure every member of staff recognises what has been discussed and agreed, minutes are taken and shared. Individual acknowledgement of the minutes being read is expected and this is monitored by the Head of Service. Standing agenda items include the themes and learning from incident reporting. There is a specific action plan to support improved governance arrangements within MIUs, including: • Assurance of medicines management, including monitoring stock and use by dates • Assurances of control for the safe and effective use of PGDs, including version control, sign	

off by staff as read and understood, and a review of the training requirements of the PGD for emergency contraception.

- Improved clinical and management supervision through the development of a defined structure, with a pending action to enable protected time for this to be undertaken. All staff have now had children's safeguarding supervision, with the children's safeguarding lead working regularly within each MIU.
- Development of a local risk register.
- Improved understanding of the service's quality and safety performance at a local level through the team meetings – encouraging local ownership of the information available in the Quality and Performance dashboards.
- Training staff in Intermediate life support for paediatrics and adults in line with College of Emergency Medicine recommendations.

Some staff had too many responsibilities to be enabled to devote quality time to everything they were required to deliver.

Since the CQC inspection and the Clinical Director post recently becoming vacant, WHC's Executive Committee, alongside the Managing Director and Chair are considering the overall governance and senior leadership structure and will have regard to the CQC's findings in relation to the loading of senior leadership portfolios. The new structure will be agreed in Q4 of 2017/18, for implementation in 2018/19.

Assurance of assessing and monitoring the safety and quality of care effectively through good governance at the board and sub-committees of the board.

A further review of the structure of Board meetings and sub committees has been commenced and will be completed in Quarter 4. In addition, the supporting structure of operational and governance meetings is being reviewed. This includes the introduction of additional performance and quality review at operational level, under the leadership of the new Chief Operating Officer. This will improve the alignment and triangulation of information between performance, quality (including workforce) and finance at all levels throughout the organisation.

Insufficient evidence to show improvements to care had been made from incidents and near misses. Minutes from governance meetings did not demonstrate where learning had made a difference.

The Quality Assurance Committee is accountable for offering assurance to the Board that all incidents and near misses have been reviewed and learning and service development have been agreed and implemented with clear evidence to show the learning and development. This information and assurance will be generated from discussions and actions from the sub-groups. These groups will have responsibility for their specific areas, for example, Medicines incidents will be discussed at the Medicines Governance group. From November 2017, all minutes will reflect these discussions and highlight the improvements to care identified from learning.

Improving but still inconsistent approach to risk management

The identification and management of risk will be a standing agenda item for all sub groups and Quality Assurance Committee from November 2017.

A lack of governance due to some committees not meeting until very recently had left gaps in assurance.

The governance committees that had been established from 2017/18 onwards (and therefore had only met very recently at the time of the inspection) are now fully established.

A lack of evidence provided to the board to show there had been learning from complaints

The quality dashboard is being adjusted so that themes and learning from complaints are identified within it, this will be evident from November 2017. The dashboard is made available to the Board on a monthly basis.

Little patient engagement to ensure that patients play a part in influencing how the organisation evolved

WHC is developing a Public and Patient Engagement plan, as planned in the Delivery Plan for 2017-19. Discussions have started with Healthwatch to gain their support and the Head of Quality is in liaison with other community providers, namely Bristol Community Health, to seek advice and guidance on how they have successfully developed and implemented a comprehensive public and patient engagement approach. In the meantime, all opportunities are being taken to involve patients and carers in developmental work. For example, volunteer representatives from Healthwatch presented to a workshop held in October 2017 to develop a frailty strategy.

The investigation of serious incidents did not always identify the root cause of the incident and the action plans did not always capture or address the failings in care.

WHC has invested in Serious Incident training for all staff involved in the completion of the Root Cause Analysis process. This is accredited training delivered by an external provider (Sancus Solutions) the training is expected to start in January 2018. A recent internal workshop (held on the 24/10/2017) identified where improvements can be made in the management of incidents and how WHC should response to Serious Incidents. The outcomes of the workshop are being translated into proposed changes to the process. These proposals will be shared with the Quality Assurance Committee, with changes being implemented from December 2017. On-going actions will be monitored at the Harm Free Care Panel and a monthly report will be scrutinised by the Quality Assurance Committee.

A lack of good audit work to demonstrate to the board that patients were receiving good outcomes. Some audits were inconsistent across services.

WHC have agreed a new process for the management of clinical audit. This is already being monitored at the monthly Quality Assurance Committee.

Who is responsible for the action?	Sarah-Jane Peffers

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
The improvements will be monitored through the Quality Assurance Committee. The continual embedding of the quality dashboard and the revised governance structure will mean continual monitoring and development is sustained. This will be evidenced in minutes from all groups and the highlight reports to the Quality Assurance Committee and the Board	
Who is responsible?	Sarah-Jane Peffers
What resources (if any) are needed to implement the change(s) and are these resources available?	
The evaluation of the current arrangements may reflect the need for additional resource. Currently this is unknown. However WHC is committed to ensuring effective governance arrangements are in place and this includes additional resource where required.	
Date actions will be completed:	1 April 2018 for all aspects.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
These actions are about the continuing improvement of governance structures and processes and procedures. While these arrangements continue to improve, people who use the services will continue to benefit from high standards of care from our committed service teams.

Completed by: (please print name(s) in full)	Jo Lawton Victoria Roper Sarah Jane Peffers
Position(s):	Head of Service (MIU) Project Manager Head of Quality
Date:	

Wiltshire Health and Care LLP: Board Assurance Framework

Strategic Risk No.	Date created	Description of Strategic Risk	Inherent risk score			Controls in place	Residual risk score			Further action required	Target risk score			Oversight	Current linked risks
			S	L	Risk Score 5x5 matrix		S	L	Risk Score 5x5 matrix		S	L	Risk Score 5x5 matrix		
1	15/05/2017	**Capacity for change**: Change capacity and capability insufficient to match the breadth and scope of change programmes	3	3	9	• Outline project plans set out in Business Plan • Project architecture including PIDs and checkpoints • Monthly monitoring of change programme at Executive Committee • Quarterly change report to Board	3	2	6		2	1	2	Board and Exec Committee	LLP CORP 15,16
2	15/05/2017	**Workforce**: The availability, skills mix, competition, transferability and training of workforce does not match current and future service needs	4	5	20	• Workforce strategy • Attendance at recruitment fairs/ universities • Participation in STP wide workforce stream	4	4	16	As part of workforce strategy, workforce plans to be put in place for each service area	2	2	4	Board and Exec Committee	SERVICE 1786, 1567, 1847, 1878
3	15/05/2017	**Regulation**: Failure of governance results in lack of compliance with regulatory standards and/or legal requirements.	3	3	9	• Agreed governance structure • Scrutiny by Board and sub committees	3	2	6	Establishment of audit and assurance committee Permanent appointment of Board secretary role	3	1	3	Audit and Assurance Committee	LLP CORP 10,20
4	15/05/2017	**Reputation**: A single major failure or series or smaller failures adversely affect the Wiltshire Health and Care brand.	3	3	9	• Scrutiny of performance and quality to reduce likelihood of failure • Communication of positive changes being pursued by Wiltshire Health and Care • Communication support to respond to unforeseen external interest.	3	2	6	Additional communications resource for LLP, to promote positive changes and successes	3	1	3	Board Audit and Assurance Committee	LLP CORP 18
5	15/05/2017	**Investment**: Insufficient financial headroom in contracts to create capital expenditure means opportunities to invest are limited, and opportunities to invest to save cannot be realised	3	4	12	• Financial plan and savings programme in Business Plan • Contractual negotiations on growth funding on annual basis • Participation in STP infrastructure stream	3	3	9		2	1	2	Board and Exec Committee	LLP CORP 1,21,22,23 SERVICE 1885
6	15/05/2017	**System vision**: Lack of commissioning clarity on future direction, for example plans for the creation of accountable care systems, has an adverse impact on the future direction and development of the LLP	3	3	9	• Participation in and contribution to STP • Involvement in development of Wiltshire Accountable Care systems	2	3	6		2	2	4	Board	
7	15/05/2017	**Partnership strategy**: Lack of alignment between views of partnership members adversely affects the setting and delivery of long term strategy	2	2	4	• Annual Members Meeting • Member Board representative role on Board	2	1	2		2	1	2	Board	
8	15/05/2017	**Integration**: Commissioning and/ or tendering decisions do not align with long term direction of LLP to integrate services.	2	3	6	• Ongoing Participation in and contribution to STP • Membership of Part 2 of Wiltshire Joint Commissioning Board	2	2	4		2	2	4	Board and Exec Committee	
9	15/05/2017	**System performance**: Broader system issues and performance affect effectiveness of Wiltshire Health and Care services, for example Delayed Transfers of Care.	3	4	12	• Representation on 3 A&E Delivery Boards • Development of changes, such as HomeFirst, designed to have impact on broader system issues	3	3	9		2	2	4	Board	SERVICE 1568, 1846, 1915
10	15/05/2017	**Patient and public engagement**: Current and/or new services do not meet needs due to insufficient patient and public engagement	3	3	9	• Sources of patient feedback • Development of Patient and Public Engagement Plan	2	3	6	Development of full patient and public engagement plan, in line with Business Plan	2	1	2	Board	

Wiltshire Health and Care LLP: Corporate Risk Register

Risks Opened in Month	**1**
Risks Closed in Month	**0**
Risk scores increased	**0**
Risk scores reduced	**0**

Severity	Likelihood
1 - Negligible	1 - Rare
2 - Minor	2 - Unlikely
3 - Moderate	3 - Possible
4 - Major	4 - Likely
5 - Catastrophic	5 - Almost certain

1-4	Insignificant
5-9	Low
10-15	Medium Risk
16-24	High
25	Extreme

Risk/ Issue No.	Status Open / Closed	Current risk score			Direction	Target risk score			Description of Risk	Date raised	Raised by	Mitigations	Updates	Owner	Link to strategic risk
		S	L	Risk Score 5x5 matrix		S	L	Risk Score 5x5 matrix							
1	Open	3	3	9	=	2	1	2	Risk of additional VAT costs falling to Wiltshire Health and Care due to new contract.	24/11/2015	CS	• Financial VAT risk covered by assurance received 24/6/16 from CCG that VAT costs incurred as a result of the structuring of LLP and contract will be met by CCG. • VAT decision/clarity being sought from HMRC	• Update 12/9/16: Liasion submitted request to HMRC in August, awaiting outcome. • Update 19/1/17: HMRC response negative on COS VAT recovery. Appeal being lodged through GWH. CCG informed. Risk scoring kept the same as, although risks due to other unforeseen are reducing as year progresses, VAT risk is being realised, and reliant on mitigation from CCG. • Update 21/3/17: HMRC appeal lodged. Risk will materialise for 2016-17, covered by CCG, while appeal is processed. • Update 20/4/17: Wording of risk adjusted to reflect VAT position is remaining issue due to new contract - other finanical risks covered in additional risks added to register. • Update 20/9/17: Risk score raised to reflect HMRC outcome increases likelihood of risk. • Update 13/11/17: Additional VAT implication identified and costed for 2016/17 linked to partial exemption calculations within GWH. This will fall to LLP but should be covered by assurance from CCG.	AC and DB	Investment
15	Open	3	4	12	=	2	3	6	Recruitment challenges affect pace of change.	19/05/2016	DB	• Recruitment plans include proactive recruitment events. • Develop further opportunities for rotations etc to increase attractiveness of working in community services.	• Update 11/11/16 : Risk reduced to 6 as initial response to recruitment of RSWs shows reduced risk. • Update 19/1/17: Good level of recruitment to RSWs posts, but delay to ESD due to recruitment. Risk level unchanged. • Update 15/6/17: Likelihood score raised as continuing delay in relation to ESD in South and RSWs not yet fully recruited.	DB	Capacity for Change
16	Open	3	3	9	=	2	2	4	Limited change management/project management capacity limits pace or realisation of benefits.	19/05/2016	DB	• Increase project resources in core team • New project management process introduced • Appointment of Chief Operating Officer	• Update 12/9/16: Risk score raised on 12/9 as change capacity is being stretched. • Update 21/3/17: Draft business plan includes proposed additional change resource. • Update 15/6/17: Appointment of Chief Operating Officer to increase operational leadership capacity.	DB	Capacity for Change

Risk/ Issue No.	Status Open / Closed	Current risk score			Direction	Target risk score			Description of Risk	Date raised	Raised by	Mitigations	Updates	Owner	Link to strategic risk
		S	L	Risk Score 5x5 matrix		S	L	Risk Score 5x5 matrix							
18	Open	2	3	6	=	2	2	4	External partners /commissioners question Integration/ pace of change	19/05/2016	DB	• Communications on changes • Use of new branding	• Update 19/1/17: Reworded risk to reflect current reputation risk on integration. Lack of dedicated communications resource becoming a barrier • Update 21/3/17: Draft business plan includes proposed additional comms resource. • Update 20/4/17: Preparing for publication of ratified business plan to increase communication of plans and priorities. • Update 21/6/17: Delivery plan published on website.	DB	Reputation
20	Open	2	3	6	=	2	2	4	There is a risk that the transfer of the community estate from GWH to NHSPS, could destabilise the existing arrangements for EFM support for WHC delivered services, jeapordising service delivery and compliance with regulations.	28/04/2016	VH	• Work with the CCG to flag EFM issues. • GWH to continue to provide soft FM • Lead detailed checks with NHSPS and GWH to check whether any functions have been overlooked in TUPE process	• Updated 19/1/17: Specific detailed risks described in Board paper 24/1/17 • Update 21/3/17: Timeline for transfer slipped allowing more time to prepare. CCG not supporting transfer until EFM issues have been resolved. Risk score reduced to reflect this. Risk reworded to focus on EFM risk only. • Update 20/4/17: Likley timeline for transfer for transfer for most properies now 1 July. Interim arrangement agreed between CCG and GWH to continue provision of EFM services which mitigates immediate risk. • Update 15/6/17: Risk score unchanged in relation to regulation compliance but linked operational service risk has increased due to lack of robust process for transfer • Update 18/7/17: No major operational issues reported in first fortnight. Risk being kept under review. • Update 11/11/17: transfer of Hard FM function has had no effect on patient care. Soft FM services remain in interim solution, so risk continues in relation to potential change.	VH	Regulation
21	Open	2	3	6	=	2	1	2	Knock on consequence of transfer of community estate is disruption/lack of capacity to administer medical records, leading to information governance risk	19/01/2017	VH	• Project established to redesign medical records approach • Negotiation with NHSPS to retain access to receptionist resource • Extraction of financial value and resource related to medical records from wider estates costs to support	• Updated 19/1/17: Risk described in Board paper 24/1/17 • Update 21/3/17: Timeline for transfer slipped allowing more time to prepare. Risk score reduced to reflect this. • Update 20/4/17: Update as for Risk 20. • Update 15/6/17: Risk score raised as potential for disruption but impact not as high as for Risk 20. • Update 11/11/17: Update as for Risk 20	VH	Regulation

Risk/ Issue No.	Status Open / Closed	Current risk score			Direction	Target risk score			Description of Risk	Date raised	Raised by	Mitigations	Updates	Owner	Link to strategic risk
		S	L	Risk Score 5x5 matrix		S	L	Risk Score 5x5 matrix							
21	Open	3	4	12	=	2	1	2	There is a risk that the transfer of the community estate from GWH to NHSPS, could increase costs for the LLP, due to rents from NHSPS being higher/ multiple additional costs being uncovered.	21/03/2017	DB	• Estates strategy will plan for shrinking use of estate wherever possible to reduce exposure. • Financial risk covered by CCG recognising risk during bid and undertook to seek additional funds if transfer increased costs to local	• Update 21/3/17: Risk added to focus only on financial impact • Update 15/5/17: Specific aspect of risk related to phasing of transfer: CCG being reminded of commitment to cover all costs. • Update 15/6/17: Increased risk score to 12 from 4, in recognition of attempts by CCG not to honour commitment they have made • Update 18/7/17: Risk level unchanged - meetings	DB	Investment
22	Open	2	2	4	=	2	1	2	Risk that high agency expenditure on Ailesbury Ward and Trowbridge MIU gives rise to an overspend against the budget. This puts the financial position and saving plans at risk.	20/04/2017	DB	• Agency reduction plans being developed and implemented to support reduction in high use areas in line with the recruitment strategy. • Monitoring of costs at	• Update 20/4/17: Risk added to recognise risks specific to 2017/18 financial plan, and that any impact will fall on LLP. • Update 18/7/17: Score kept unchanged - reduction in agency costs overall in June, but risk of overspend remains.	DB	Investment
23	Open	2	2	4	=	2	1	2	Risk of unforeseen cost pressures falling to LLP due to inaccuracy in coding of costs between financial ledgers used by delivery arm.	20/04/2017	DB	• Quarterly I&E and Balance Sheet reconciliations between the two ledgers to be carried out and regular analysis of service lines to ensure costs are accurately captured • Financial reporting provides monthly position in both LLP and delivery arm	• Update 20/4/17: Risk added to recognise risks specific to 2017/18 financial plan, and that any impact will fall on LLP.	DB	Investment
24	Open	3	1	3	=	1	1	1	Transfer of estates means LLP is tenant - consequential increase in risk of public liability claims exceeded insured risk. Risks heightened during 'Tenants at Will' period, when no lease in place to specify tenants' responsibilities	18/07/2017	DB	• Increase in public liability insurance	• Update 20/9/17: Risk remains as no lease yet in place with NHSPS.	DB	Regulation

Wiltshire Health and Care: Service delivery risks (score of 12+)

Summary this month

Low Risk	1-3	2
Moderate Risks	4-7	12
High Risks	8-15	25
Extreme Risks	>16	3
Total		42

Risks Opened in Month	2
Risks Closed in Month	1
12 and above risks	10

Risk Register Report

Risk Ref	Source of Risk	Directorate	Department	Date Raised	Risk description including the effect of the risk	Risk Group	Risk Type	Existing Controls	Target Consequence	Target Likelihood	Target Score	Actions required to mitigate risk
1786	Trend Analysis	Wiltshire Health And Care	Operations Management	28/02/2017	ISSUE: Recruitment and Retention challenges across various teams within WHC RISK: Insufficient staff to deliver safe, effective service CONSEQUENCE: Delivery of care is affected, appointments cancelled or re-scheduled, targets not met. Care delivery becomes task orientated and not person centred Staff morale is reduced Sickness increases Turnover increases	Well-Led	Staffing Levels	HR metrics tabulated monthly Bi-Monthly review at WHC workforce and development sub-group Assurance report reviewed by Quality Assurance Committee 1/4 scrutiny by WHC board Assurance report Recruitment plan for Ailesbury and Longleat Wards Delivery within services is reviewed on a daily basis Use of agency staff	3	1	3	Longleat no longer is a focus for vacancy levels and turnover. MIU and Ailesbury continue to have vacancies, which are impacting on safe staffing levels. Cedar Ward is now high for turnover levels

								turnover levels.			
								All areas are undertaking active recruitment and posts are within the recruitment pipeline.			
								There is an increased focus and a change in the model for recruitment should support a better service for getting staff into post Improve processes and procedures in recruitment to vacant posts to ensure vacancies are kept to a minimum			

Risk Register Report

Risk Ref	Source of Risk	Directorate	Department	Date Raised	Risk description including the effect of the risk	Risk Group	Risk Type	Existing Controls	Target Score Likelihood Consequence	Actions required to mitigate risk	
										Trainee Nurse Associate Pilot	

Risk Register Report

Risk Ref	Source of Risk	Directorate	Department	Date Raised	Risk description including the effect of the risk	Risk Group	Risk Type	Existing Controls	Target Consequence	Target Likelihood	Target Score	Actions required to mitigate risk
												Trainee Nurse Associate Pilot
1805	Trend Analysis Pattern of reports via IR1 system	Unscheduled Care	Patient Transport Services	14/03/2017	ISSUE: Arriva transport is not meeting the deadlines for pick ups and collections of patients from and to inpatient wards and outpatient areas. RISK: Patient safety if transport doesn't arrive. Risk to patient flow if transport doesn't arrive. CONSEQUENCE: System pressures, complaints, reputation and potential for patient harm	Responsive	Transfers	Escalate concerns to commissioners	3	4	12	SJP to liaise with commissioner's issue with reference to all known clinical incidents Completion of IR1s by all staff to highlight issues and monitor trends and to inform feedback to CCG and Arriva.

Risk Register Report

Risk Ref	Source of Risk	Directorate	Department	Date Raised	Risk description including the effect of the risk	Risk Group	Risk Type	Existing Controls	Target Consequence	Target Likelihood	Target Score	Actions required to mitigate risk

												Organise training
1979	Audit Report	Wiltshire Health And Care	Wiltshire Health & Care All Se	04/09/2017	ISSUE: Current MIU paperwork does not reflect safeguarding risks to children; parental responsibility is not being established consistently and therefore consent is not being ascertained correctly. RISK: Potential lack of identification of vulnerable children and provision of treatment without adequate consent CONSEQUENCE: Children are not assessed for safeguarding risk and parental responsibility is not established	Safety	Safeguarding	Change of current paperwork Childrens Safeguarding Lead allocating one working day to MIU to support staff	1	2	2	To change paperwork used in MIU for assessment of children Education around consent and parental responsibility

Risk Register Report

Risk Ref	Source of Risk	Directorate	Department	Date Raised	Risk description including the effect of the risk	Risk Group	Risk Type	Existing Controls	Target Consequence	Target Likelihood	Target Score	Actions required to mitigate risk	D

Wiltshire Health and Care Board **For decision**

Subject:	**Children's Safeguarding Declaration**
Date of Meeting:	**28 November 2017**
Author:	**Sarah Jane Peffers**

1. Purpose

Approve and adopt the Board declaration of statutory compliance and authorise the MD to sign on behalf of the Board.

2. Background

The contract between Wiltshire Clinical Commissioning Group (WCCG) and Wiltshire Health and Care includes an expectation that Wiltshire Health and Care complies with all statutory/ national guidance related to safeguarding children, which are:

- Children Act 1989
- Children Act 2004
- Working Together to safeguard Children 2015
- Care Quality Commission regulation 13: Safeguarding Services Users from Abuse and Improper Treatment- Health and Social Care Act 2008 (regulated Activities) Regulations 2014: regulation 13
- Safeguarding Children and Young people: Roles and Competences for Health Care Staff

Wiltshire Health and Care has agreed to adopt certain safeguarding children standards and performance indicators. There are ten core safeguarding children's standards which we must meet and provide the CCG with assurance against each standard. The first standard is:

- Governance and commitment to safeguarding children: The provider will ensure that their organisation is committed to safeguarding children and can demonstrate that robust governance structures and systems are in place in line with Working Together to safeguard Children (2015).

The criteria which sets out how each standard can be met states that the provider must have a clear statement of their commitment to safeguard children, which is accessible to the public. WHC's statement of commitment can be found in Appendix 1. This has been drafted in a way that recognises the current delivery structure (and the fact that operational staff are continuing to ensure compliance with GWH policies). It is proposed that this statement is updated in April 2018 to reflect the changes in delivery structure.

3. Recommendation

The Board is invited to:

- Approve and adopt the proposed Board declaration of statutory compliance and authorise the MD to sign on behalf of the Board.

- Note that the content of this declaration will be updated in April 2018 to reflect the changes in delivery structure.

Impacts and Links

Impacts	
Quality Impact	Robust Children's' safeguarding processes and procedures are pertinent to provide safe and effective care to children throughout all WHC services.
Equality Impact	Effective Children's safeguarding arrangements support the provision of safe care to all patients.
Financial implications	Compliance with legislative requirements should minimise the likelihood of harm to patients and staff and reduce the potential for prosecution and civil litigation against WHC.
Impact on operational delivery of services	Effective children's safeguarding arrangements support staff to deliver services efficiently
Regulatory/ legal implications	• Children Act 1989 • Children Act 2004 • Working Together to safeguard Children 2015 • Care Quality Commission regulation 13: Safeguarding Services Users from Abuse and Improper Treatment- Health and Social Care Act 2008 (regulated Activities) Regulations 2014: regulation 13 • Safeguarding Children and Young people: Roles and Competences for Health Care Staff
Links	
Link to business plan/ 5 year programme of change	A Quality focus- Strengthening Quality Assurance
Links to known risks	None
Identification of new risks	None

Appendix One

Wiltshire Health and Care Board

Working Together To Safeguard Children

Declaration of Statutory Compliance

The Board of Wiltshire Health and Care is assured that the following requirements are in place in line with the recommendations of the Care Quality Commission to ensure that systems and processes are established to safeguard children and young people.

Section 11 of the Children Act 2004 places a duty on every provider to have arrangements in place to ensure that the organisation and all staff working within it have regard to the need to safeguard and promote the welfare of children. Wiltshire Health and Care will:

- Do all that it can to ensure staff delivering services on behalf of Wiltshire Health and Carework within the relevant policy and procedures
- Regularly review its arrangements against these requirements and remain compliant with them.

Wiltshire Health and Care's principal philosophy is that 'safeguarding' is everybody's business:

- Wiltshire Health and Care is committed to 'safer staffing' recruitment. The recruitment arrangements for employees and other staff working on behalf Wiltshire Health and Care meet all statutory requirements in relation to Disclosure and Barring Service (DBS) checks..

- Wiltshire Health and Care has a nominated HR lead for dealing with allegations relating to children who works closely with the Local Area Designated Officer (LADO) if concerns arise.

- Staff working on behalf of Wiltshire Health and Care will work within GWH Safeguarding Children & Young People's policy which meets with the requirements of *Working Together to Safeguard Children 2015*.

- In addition to following the South West Child protection procedures, staff working on behalf of Wiltshire Health and Care will follow other GWH processes, pathways and policies to safeguard children, which include

    - Missed Appointments policy
    - Safeguarding Supervision Policy
    - Managing Allegations Against Staff and Volunteers who Work with Children Policy
    - Self-Harm pathway
    - Young People presenting with substance misuse and alcohol protocol.

- A rolling programme of Safeguarding Children's training and development is in place, including training at induction. A Training Needs Analysis is regularly reviewed to identify the requirements for Wiltshire Health and Carestaff, and develop the training to reflect the need.
- Wiltshire Health and Care has designated named safeguarding professionals in place to fulfil the requirements as detailed in *Working Together to Safeguard Children 2015*;

- The Board level Executive Lead with the responsibility for safeguarding is the Head of Quality

The Wiltshire Health and Care Safeguarding Forum (children and adults) monitors the safeguarding activities on behalf of the Board and will comply with requests to participate in the Section 11 audit for Wiltshire Local Safeguarding Children's Board's, as requested to do so.

Managing Director **Date**

Link to Wiltshire Local safeguarding Board http://www.wiltshirelscb.org/

Board Sub Committees

VERBAL ONLY

Nomination of Chief Operating Officer as Board member

VERBAL ONLY