The Royal Wolverhampton
NHS Trust

The Royal Wolverhampton NHS Trust review and gap analysis to the Kirkup report
30 July 2018

Agenda Item No: 7.4

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	30th July 18
Title:	RWT review and gap analysis to the Kirkup report
Executive Summary:	The Kirkup report published January 2018 identified widespread failings in the provision of community services at the Liverpool Community Health NHS Trust. The investigation was initiated following whistleblowing concerns raised by staff and subsequent concerns highlighted in the CQC report and a Quality, Safety and Management assurance review carried out by Capsticks Solicitors. The investigation report identified failings in the following areas: • Clinical care capability • Avoidable patient harm e.g. falls and pressure ulcers • Poor reporting culture • Inadequate investigation of incidents • Failure to act on incident themes, trends and outcomes • Failure to act on or follow up poor compliance with audit results • Harassment and bullying • Failings in multi-disciplinary teamwork • Failings in HR process implementation • Leadership and culture • Poor record keeping and records management • Imbalanced focus on CIP over quality – inadequate CIP QIA processes and clinical engagement • Ineffective reporting, escalation and follow up through the Committee reporting structure. • Poor assurance on the safety and quality of integrated services • Poor compliance with Mortality guidance for the review of deaths • Non-compliance with mediation policies • Inadequate or absent clinical assessment • Lack of oversight in serious incident reports • Poor compliance with mandatory training – with no apparent following up to improve • Staffing and management • Organisational culture and values i.e. Blame, H&B Detail on findings is added within appendix 1 along with a RWT position statement and consideration of any further action or assurance that may be needed to learn from the Kirkup report. The gap analysis shows a number of areas where work is in progress or planned, consideration should be given to the frequency for update reporting on progress.
Action Requested:	The Board are asked to receive and note the RWT position against the Kirkup findings and further actions proposed.
For the attention of the Board	This section requires a brief, focussed summary of the points of fact for the Board plus any/all of the following:
Assure	• A RWT statement is provided from subject leads who have received the report and action plan • The gap analysis will be reported and monitored to closure via the Compliance Oversight group • Within the further actions identified are proactive steps towards continuous improvement such as a Trust Culture survey, audit/evaluation of action and themes to assess improvement. • A number of findings are substantially covered by ongoing work areas in the

	Trust eg QIA review processes, VI integration processes, Risk management reporting, others items are within planned work eg Leadership framework, Culture survey, Improvement evaluation and Clinical Supervision evaluation.
Advise	• The report takes the approach of an exception gap analysis within appendix 1 containing headline summaries around key arrangements rather than an exhaustive list or statement.
Alert	• Some findings of the report (eg themes for pressure ulcers and falls, review of deaths and HR/OD policy and process implementation) are already subject to focused work which will be further assessed against these findings. • Overarching principles point to the importance of proactive assessment and redress of cultures and subcultures within organisations. • Focus needed on improvement evaluation, identifying and addressing root causes and effecting action planning/tracking.
Author + Contact Details:	Tel 01902 695114 Email maria.arthur@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	None identified at the point of producing this report
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	No adverse impact on PPC identified.
Risks: BAF/ TRR	SR1 Workforce Recruitment and Retention SR8 Failure to deliver recurrent CIP SR9 Underlying Trust deficit
Public or Private:	
Other formal bodies involved:	The Compliance Oversight group will monitor the action plan.
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details	
1	The Kirkup report has been reviewed having regard to relatable findings and recommendations for consideration at RWT and complies with good Governance and risk management practice to assess learning and improvement following National Inquiry reports. The report and gap analysis has been shared with subject leads for a position update and any future actions needed. Identified leads will take forward actions as appropriate with oversight being monitored at Compliance Oversight Group.

Appendices	
1	Appending 1 – Gap analysis.

RWT Gap analysis following the findings of the Kirkup Independent review of Liverpool Community NHS Trust

Appendix 1

Finding subject	Finding detail/context	RWT position	Further action/assurance needed by RWT	Action Lead
A. CIP QIA p2,3,	1. Grossly deficient QIA of CIP. 2. Ill-considered, overambitious CIP measures (cost control through significant staff cuts and vacancy freezes). 3. No Clinical engagement on the design or implementation of improvement programme. 4. Ongoing quality and safety impact of staff reductions were not evaluated or monitored.	1. QIAs RAG rated, reviewed and reported to QSIG. 2. RWT CIP development process includes validation by project team and clinical lead, confirm and challenge meeting, clinical lead sign off, independent QIA, FRB sign off and QIA review and reporting via risk and quality forum (QSIG).	4. Review arrangements for ongoing monitoring of QIAs.	S Evans D Hickman
B. Staff welfare and wellbeing p3,	1. Staff demoralised due to cuts. 2. Not listened to and disengaged. 3. Sickness absence increased. 4. Staff subject to a climate of fear, insecurity and bullying making them reluctant to speak up. 5. Increase sickness absence from work related stress. High levels of stress particularly in Prison staff. 6. Staff working long hours with insufficient breaks. 7. Staff survey showed a worsening position.	1,2,3,6,7 Staff survey, F&F test results, Chatback results. 5. TBC -OH staff stress results 4. HR grievance process monitoring (see F below). 2. Meet the exec engagement sessions. 2. Executive Leadership walkabouts. 2. Freedom to speak up guardian and champions.	1,2,3,6,7 Review staff survey, F&F and chatback action plans. 1 – 7 Undertake a Trust Culture survey. 4,5,6 Evaluate results from annual team stress risk assessments. 2,4 Internal Audit F2SU.	HRM/All managers M Arthur/D Locke HRMs/All managers N Mahey
C. Patient harm p3, 4	1. Increase in patient harm incidents (including falls and pressure injuries) and avoidable harm caused. Areas most affected were district nursing, intermediate care, community dentistry and healthcare in HMP Liverpool. 2. Significant harm caused to patients due to inadequate experience and capability to manage new Prison service. 3. Failure to act on indirect indications of harm i.e. increased complaints re staff attitude and communication. Work on this was said to be ongoing with little additional assurance. 4. Increase in claims and inability to defend due to	1. In 17/18 RWT has seen a 40% reduction in fall incidents although falls with serious harm have increased. 1. In 17/18 high numbers of PI incidents reported and a reduction in avoidable PIs. Community had an increased number of incidents in May and June. End of life referral data shows an increase of end of life referrals above the usual trend during May and June too, and a significant factor in a high number of pressure injury incidents. The incidents following June showed a continual reduction and a high	1. Falls collaborative interventions have been reviewed, targeted work is underway with areas reporting higher numbers of falls on a monthly basis. 1. Targeted work on PI reduction in Community. CCG are reviewing the community equipment contract, with an aim to improve delivery times and stepping down process for patients that improve. 3. Quarterly Complaint theme report.	D Hickman L Jones A Dowling

	incomplete actions by managers, lack of robust control and monitoring of action plans and interrogation of governance and quality.	proportion were unavoidable 3. Quarterly and annual patient experience report which contains complaint themes and actions taken. 4. Clinical negligence (CN) and Personal Injury (PI) claim numbers reduced in 17/18 and areas of targeted work is being identified.	4. Investigation into local action plans to address CN claim themes i.e. Treatment, Diagnosis and Surgical. Evaluate control measures to reduce STF incidents and claims with key leads e.g. Estates, Health and Safety.	M Arthur/P Archer
D. Clinical and Corporate Governance systems/process p3,	1. Failures in mandated reporting of serious incidents – some reporting discouraged. Incidents regularly downgraded in importance. 2. Lack of assurance in the Serious Incident report papers presented to Assurance Committee and TB. 3. Poor Investigation of incidents and deaths. 4. Action planning for improvement absent/invisible, not followed through or followed up. 5. Governance systems failed to identify deviation from necessary standards to correct/improve. 6. Learning from incidents and serious incidents not used effectively or shared for wider learning. 7. Lack of coherent communication from the frontline of service delivery to TB. 8. Sufficient data to identify trends and themes but analysis was poor. 9. Learning from deaths not reviewed or used to inform healthcare system reform. 10. Deaths in custody did not feature on performance dashboard reported. 11. Failure to find root causes of incidents leading to recurrence of similar events and/or staff blamed. 12. Poor quality minutes of the Assurance Committee meant inability to track issues raised and responsibility for actions. 13. TB minutes showed little appreciation or questioning around repeated incidents, underlying causes and no correlation with repeated incidents	1. NRLS report healthy reporting and no underreporting at RWT based on peer benchmark data. 2. Delays in reporting serious incidents are irregular – monitored internally and by CCG. 4. Central tracking of SUI action reported to QSIG and TB. 4. Six monthly Audit of SUI action closure. 5. Oversight monitoring in place via: Clinical audit, Policy audit, External reviews, SUI and incident monitoring, Duty of Candour, Risk register review, CQC assessment, NICE and National guidance, New procedures. 6,8 Lessons identification and sharing via: RCA table top reviews, CLIP meeting, quarterly risky business newsletter, Health and Safety newsletter, Information Governance Newsletter, Making it better alerts and lessons shared in monthly Integrated Governance reports to Directorates. 9,10Mortality processes to comply with learning from Deaths is in development. 12 All Trust committees and groups minutes with action logs. Positive feedback on minute capture.	2. Review content/template for serious Incident report to TB. 3. Review RCA training to consider human factors and guidance on identifying root causes. 4. Develop evaluation of closed action impact. 4. Develop evaluation/investigation into recurrent themes from incident and claims. 5. Clinical Audit Group to agree safety alert audits based on risk. Review information flow and closure of alert actions at Divisional level. 14. Review flow of ward to Board reporting including Performance, Risk registers, SUI outcomes, Quality indicators, Patient experience, ensuring appropriate levels of granular and oversight reporting exists. 6, 8 Review regular theme analysis via the CLIP group. 9, 10 Evaluate the operation of Mortality review systems and processes. Including review of death and SJR outcome reporting, Mortality KPI dashboard development. 14, 15 Consider further committee	M Arthur HGMs P Archer P Archer M Simcock/ HGM K Wilshere P Archer J Odum M

	and complaints or staffing levels. 14. Trust committee structure lacked clear escalation between groups, attendance inconsistent and multiple meeting names for same group was confusing. 15. Meeting structure failed to hold staff to account for delivery of action from safety incidents or risk assessments. 16. Failure to act on an Internal Audit of Trust Clinical Audit arrangement – recommendation not accepted on the belief that they were the responsibility of management teams. 17. Inconsistent application of Trust Governance processes (Dentistry, HMP operated outside mainstream governance).	14,15 Trust committee structure reviewed from Mar 18 to strengthen accountability and oversight. 16. Internal audit actions are tracked to closure. Trust Clinical audit outcomes showed improved compliance outcomes. 17. Annual Governance and Risk management audit of core Governance activities eg minuted governance meetings, risk register review, incident and SUI reporting, action tracking.	structure developments from National best practice and organisations rated outstanding.	Arthur/K Wilshere
E. Leadership/ Management issues p11, 12	1. Focus on becoming a FT and on CIP achievement. 2. Poor HR practices in Nursing and HR management. 3. Serious shortcomings in leadership of HR and Nursing Depts. 4. Lack of leadership at senior and middle levels. 5. Safety concerns and themes escalated to Board had some evidence of redress actions identified but no evidence of effective action taken to improve practice. 6. Lack of management training and poor leadership. 7. Excessively top-down management. 8. Clinical Leadership poorly developed at senior/Exec levels. 9. Non Exec Board members lacked expertise to challenge. 10. Failure of leadership replicated in the organisation resulted in failure to get a grip on governance and quality improvement. 11. Lack of senior and Exec presence in HMP. 12. Lack of professional responsibility at senior level, insufficient expertise and inadequate infrastructure	6,8 Leadership and management training programme available for staff. 4,6 Nursing Leadership facilitation and support available. 12. RWT Exec leadership succession plan. 4,6,8 Engagement with NHSI Talent management programme. 9. Evidence of non Exec challenge produced for CQC Mar 18. 11. RWT has Exec and senior support for newly acquired Primary Care Directorate. 6. Current and future training delivery plan for leadership and management training has been identified and collated into a Leadership Strategic Approach document. This work included a multi-mode analysis including capacity and demand, gap analysis, organisational analysis, and determination of the skills and behaviours required of leaders and managers at RWT. The associated	2,3,4,5,6,7,8,10 Undertake a Trust Culture survey. 6,8 A targeted approach to leadership and management training to be determined following a Trust wide training completion analysis planned for January 2019'. Further development of the 'career pathways' work and KITE site would help signpost staff to the appropriate interventions at the appropriate level. 6,8 Leadership framework under development.	M Arthur/D Locke L Nickell L Nickell/D Locke

	to manage services.	delivery plan includes both 'core', 'intermediate' and 'advanced' training offers and 'additional' leadership and management training offers. 'Core' is multi-professional and is accessed through an inclusive leadership approach. 'Additional' includes skills and knowledge pertinent to a subset of staff e.g. medical staff requiring NCAS training to be case Investigators. The Leadership Strategic Approach document includes the training offers presented in a step-wise pathway to facilitate the building on of existing skills and knowledge.
F. Human Resource Dept and Processes p3	1. HR Dept not fit for purpose caused detriment to staff and services. 2. Wrongful use of suspension sanctions. 3. Failed process for 'Freedom to speak up'. 4. HR managers failed to follow Trust disciplinary procedures. 5. Poor and delayed recruitment process - Outsourced 6. Failure to investigate suspensions.	1. Work of the HR Department is governed by the People and OD Strategy 2016 – 2020, which has been approved by Trust Board and is monitored on a monthly basis including HR metrics, which indicate organisational health. 1. The HR Department has a monthly governance meeting which reviews complaints and any serious incidents/RCAs to a set framework. 1. Stakeholder meetings are held monthly with key Trust personnel to review the service provided by the HR service. 1. HRMs' attend the monthly divisional meetings to pick up on trends and requirements. 1. Employee Voice networks have been established within the Trust to provide a forum for staff to express their views and concerns. 2. Suspension within the Trust is a very last resort sanction and there are less than 0.1% of the workforce suspended at any point. 2. Suspensions are monitored every month by the Chief Nurse for the nursing workforce Deputy Medical Director for medics and by the Deputy Director of HR for whole workforce. 2. The WODC committee (chaired by NED) reviews the level of suspensions every 2 months. 3. There are established protocols for HR working with the Freedom to Speak up Guardian within the Trust and staff concerns/casework outcomes are triangulated with staff survey results in order to focus on improvement.

3. The FTSU guardian is based within HR and has regular meetings with the Director of Workforce, Deputy Director of HR, Head of Workforce and Head of Advisory to ensure the processes are effective.
3. The Trust commissioned an internal audit of all FTSU process, policy and practice within the Trust specifically to review effectiveness and the interface with HR and effectiveness of those processes were included.
3. There is a network of contact links for FTSU and these are linked in with the Trust's Employee Voice – Every Voice Matters Campaign, in addition they are linked with Cultural Ambassadors within the Trust.
4. The Trust has a Fair Blame disciplinary process which is administered in partnership with Staff Side. This has reduced the amount of time spent on investigation and disciplinary action and has considerably reduced the stress to employees caught in a disciplinary process.
4. There is a full training course available over 400 managers received the training and the HR Team have intensive training in all the core HR policies and procedures including both the technical aspects and the softer skills associated with deploying these effectively.
4. The number and detail of ER cases including time to resolve are monitored in detail as part of a weekly HRM meeting with the Head of Advisory Services, there is an established supervision structure which includes 1:1 and 2:1 case reviews for learning.
4. The Deputy HRD monitors the casework in detail each month.
4. All policies are co-produced with stakeholders including managers and staff side and other employee representatives in order to ensure they are workable and adhere to the Trust values. Each policy change comes with comprehensive training and skills development and there is a formal Stakeholder review of the impact after 12 months of operation.
5. The Trust is centralising all resourcing from 1st September 2018 (currently just nursing and medical staffing is centralised)
5. The Trust has invested in TRAC an applicant tracking system which has improved recruitment metrics as a core implementation outcome – including time to recruit.
5. The Trust is part of the national pilot on Streamlining and aims to further improve processes and empower managers within the Trust to enhance the quality of recruitment.
6. Every suspension within the Trust takes place only following full HR review and with HR present.
6. Suspension within the Trust is a very last resort sanction and there are less than

		0.1% of the workforce suspended at any point. 6. Suspensions are monitored every month by the Chief Nurse for the nursing workforce Deputy Medical Director for medics and by the Deputy Director of HR for whole workforce. 6. The WODC committee (chaired by NED) reviews the level of suspensions every 2 months.		
G. Service acquisition p3	1. Trust expansion of geographical area covered and service type – expanded community services acquired and Prison healthcare services. 2. Staff integration difficulties, sub-culture conflicts affected staff re-deployment and worsened staff morale. 3. Poor system integration eg. incident reporting and investigation. 4. No attempt to integrate Prison service with Trust with Trust clinical Governance systems. 5. No regular monitoring and reporting back to the main governance framework. 6. The Prison Partnership Board was mainly operational rather than quality focused, RR not reviewed and managers struggled with unfamiliar data.	1,2,4 RWT has a Primary Care integration plan. All integrated practices are reporting through Datix. The directorate is having monthly governance meetings to discuss themes and trends as well as shared the primary care integrated governance report with all practices. 3,5,6 Primary Care Directorate sits with Division 3 and follows the Trust formal report routes to TB – reports include operational performance and Quality at various levels.		
H. Clinical care Capability	1. Staff training and supervision inadequate. 2. Staffing levels inadequate. 3. Skill mix inadequate. 4. Staff had little time for clinical and management supervision preventing reflective practice and learning. 5. Low mandatory training compliance.	1. An audit of Clinical supervision in practice was undertaken prior to the recent review of Trust Policy. New requirements include a minimum of 3 CS sessions per year and an individual evaluation return for each supervisee. 1. Clinical supervision occurring on an ad hoc basis. 2, 3 Nursing System framework in development. 2,3 Monthly report on staffing vacancies and due starts locations. 2,3 Calendar for monthly recruitment	1. Nurse Education will co-ordinate an annual evaluation report on the effectiveness of CS from personal and professional feedback from supervisees. Templates for returns are in the new CS policy. 1, 5 Action plan being compiled to improve mandatory training compliance which will include: examination of current compliance thresholds, training content and educational robustness, improved process for confirm and challenge meetings for SMEs to improve	L Southan L Nickell/ SME

		events based on vacancies and predicted vacancies. 2,3 Safer staffing figures reported monthly for all adult inpt areas. IQPR monitoring – published on NHS Choices. Staffing benchmarks are taken from the model hospital dashboard. 2,3 Staffing risks are identified with mitigation actions. 2,3 Staffing levels are reported to TB. Skill mix review undertaken bi annually for adult inpatient areas. Maternity (birth rate plus) and Paediatrics undertake annual skill mix reviews. The Shelford acuity model is used for adult inpatients, emergency portal, Children and young people. 1. Trust Clinical Supervision policy in place. 1. Mandatory training reported monthly. 1. Trust Supervision policy for non-consultant medical staff in place.	compliance, and, improved process for confirm and challenge around the Mandatory training topics ratification process (resulting in the mandatory training TNA)	
I. Clinical standards	1. Evidence based standards not uniformly applied. 2. Action plans significantly hampered by: - Failure to identify actual root causes. - Lack of time-trend analysis and thematic analysis. - Plans based on process actions unrelated to patient outcome. - Failure to follow up whether actions undertaken/completed. - Lack of evaluation of whether actions from incidents/themes have been successful. 3. Failures in clinical assessments, screening, poor care planning, record-keeping and communication led to messages not being received/acted upon within MDT.	1. Systems in place for cascade and response to NICE, National guidance/inquiries, Royal College reports etc and reported at an appropriate level within the trust. 2. Six monthly audits of completed SUI actions – variable compliance reported. 3. Audit and monitoring in place for some clinical assessments eg observations, VTE, documentation audits. 4. Policy Governance systems for Trust policies in place. Communication of policies via SMB, TMC, via local meeting updates and Policy briefings.	2. Refresh RCA training on root causes. 2. Review thematic analysis methods and response (inc CLIP). 2. Develop evaluation/impact audit of SUI actions for improvement. 3. Full system review of key clinical assessments. Ongoing monitoring of clinical systems to form part of local audit plans. 4. Develop Policy Governance for local Policy and procedural documents.	HGMs P Archer P Archer A Cannaby/ J Odum M Arthur

	4. Staff ignorance of policies and procedures.			
J. Culture and leadership p3, 9,	1. Lack of openness and transparency impacting Duty of Candour. 2. Failure to learn from events. 3. Reactive culture. 4. Failure to act on serious patient safety markers ie care planning, poor reporting – exposing poor reporting culture. 5. Instead of 'just culture' staff worked in a culture of blame, punishment, disbelief and fear. 6. 'Scoping meetings' where incidents and actions were discussed and reviewed, described as interrogation and frightening experience – staff felt blamed, anxious and stressed. 7. Poor focus on values for staff behaviour. The culture was one of not reporting failure.	1. Duty of Candour system in placed monitored internally and by CCG. High compliance reported in 17/18. 2,3 Trust has experience a recurrence of serious incidents and Never events – the themes have been identified. 4. Monthly monitoring of Quality metrics via IQPR, Nurse sensitive KPI, NAAS audits etc. 3,5,7 Trust has a People and OD strategy.	2. Develop action plan to address serious incident themes. 6. Review RCA tabletop/scrutiny meetings to focus on root causes and system learning. 5. Promote 'Just culture' principle within policy, processes and behaviour. 7. Consider and promote a Trust values campaign. 2,3,5,7 Undertake a Trust culture survey.	M Arthur/P Archer M Arthur/ HGMs HR Dept HR Dept M Arthur/D Locke
K. Teamwork and communication p8	1. Failures in communication, teamwork, intolerance and a culture of blame. 2. Significant failures in MDT working. 3. Poor communication leading to inconsistent and flawed handovers within teams, across agencies and across management and leadership at all levels. 4. Staff lacked time for adequate handovers, training and time for good record-keeping and documentation. 5. Staff lacked time reflect, learn and review performance and clarity of own and organisational objectives. 6. Inconsistent time for training, supervision and appraisal. 7. Team members not aware of clear goals in complex care management. 8. Care goals not agreed with or communicated with patients. 9. Breakdown in MDT working – 'us and them' attitude between clinicians and others prevented	1,3,8 The Trust has invested and promoted PCM to support and improve all aspects of communication. Six monthly evaluation report on the impact of PCM. 3. SBAR handover model and tool in use. 4. Recruitment and retention plans seek to address staff time capacity. 4. Documentation audit completed quarterly- results Q4: - Comparison of previous Trust wide results (quarter 3 17/18) has shown an increase in compliance with standards Q1 and Q2 relating to patient name and identification, Q6 relating to using 24 hour time and Q9 relating to health professionals name on every record. Outpatient had 1 standard drop in compliance, Q11 relating to clinicians designation. - All electronic outpatient records	1,3,8 Continue promotion and evaluation of PCM. 5,7,9 Seek ongoing people or financial resource and support to continue prioritised TOM roll out in 18/19.	Ed&T/ SU2S M Arthur/ SU2S

	any constructive approach to learning from safety incidents and risk reduction.	standards have achieved >75% across the Trust. Standards Q10, Q11 and Q12 remained moderate compliance since the last quarter. - All Directorates completed required documentation audit returns. - Items where <50% compliance achieved was for clinician's professional identification number, clinician's designation and any deletions and alterations signed. 5, 7, 9 Team Development model (TOM) is applied in some areas of the trust – supports the effective functioning of goals (ie objectives), roles, processes and relationships (including MDT working) in teams.		
L. Pressure Damage p6,7	1. Failure to act (for more than 2 years) on reported themes and causes leading to preventable pressure damage ie. record-keeping, documentation, assessment, wound care, supervision, equipment, training and communication – added to by staffing problems. 2. Underlying causes of incidents not addressed (staffing levels, competency, training, skill mix). Instead the word 'reinforce' compliance with above themes was regularly used in TB papers. Appraisal and supervision were highlighted as a shortcoming of staff undertaking them but not in relation to the time allotted to do them. 3. District nursing teams not undertaking timely risk assessments or follow up and not using a preventative framework for pressure damage. Delay in receiving pressure relieving equipment.	(see point C. patient harm above)		
M. Falls p7, 8	1. Although focused work undertaken to reduce	Actions to address outcomes from the	Re- audit due October 2018	D

	falls, falls risk assessments were irregular leading to poor care planning in bed based services. 2. Falls audit showing 37% compliance with care planning lack of staff knowledge and retention after training showed the same themes 6 months later following high risk incidents. Also failure to investigate incidents due to incomplete records. An update report to the Assurance committee was never produced. Failure to report falls with serious harm as SUI.	National Falls Audit results 2017 are currently being implemented.		Hickman
N. Medicines Management	1. Lack of Policies and SOPs. 2. Non-compliance with policy including inappropriate storage temperatures, omission in administration, lack of administration checks, lack of medicines reconciliation. 3. Failure to undertake control drugs register audits and weekly balance checks.	1,2,3 RWT demonstrates a good compliance generally with policies on storage and administration of medicines. Controlled Drug audits are done quarterly by ward teams. A new SOP is in development for monitoring of fridge and drug storage area temperatures.	1,2,3 Improvements are needed to ensure that non-compliance is escalated to MMG and Heads of Nursing in a timely manner. This will be undertaken by the Chief Technician –Patient Services. The new SOP for temperature monitoring is in consultation and will be in place by September 2018.	A Tennant
O. Records and Record-keeping	1. Vital records missing leaving patients vulnerable. Failure to reconcile records leaving previous medical intervention unknown – 8 years of prescription charts and ECG found in cupboard (not scanned to complete the patient record). 2. Lack of reliable track and trace system for documentation. 3. Breach of Records Management Retention periods.	1. Records are collected from each ward and taken for scanning and coding. Datix incidence are monitored for trends and reported to the Health Records Project Group 2. Track and trace system monitored through the Health Records Project Group for Acute and community records 3. OP07 policy in place containing retention schedule. Mass destruction departmental flow chart for Health Records in place.	2. consider monitoring tracking for inpatient skinny files 1,2,3 Full review of OP07 will take place by end of 18/19	S Smith
P. Commissioner/N	**Findings for External redress** 1. Inadequate oversight and assessment of risk by CCG.			

HSE/SHA/TDA/ CQC Oversight	2. Inadequate impact assessment and decision to reduce contract income whilst maintaining same level of service. 3. Failure to identify concern over the challenges of a new service type – Prison service. NHSE monitoring failures. 4. TDA raised concerns but reversed its assessment for unknown reasons. 5. CQC did not identify concerns until MP alerted to the problems. 6. Above failures contributed to by reconfigured organisations coming to terms with new roles and not communicating effectively – however above insufficient to account for the missed opportunities to intervene.