Agenda Item No: **5**

Health Scrutiny Panel

19 December 2013

Report title	**Royal Wolverhampton Hospital NHS Trust - Update on Care Quality Commission Chief Inspector of Hospitals Inspection Report**	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating Service	Royal Wolverhampton Hospital NHS Trust	
Accountable organisation	David Loughton Tel Email	Chief Executive 01902 695950 david.loughton@nhs.net
Report to be/has been considered by	List any meetings at which the report has been or will be considered, e.g.	Royal Wolverhampton Hospital NHS Trust Board - November 2013

Recommendation(s) for action or decision:

The Panel is asked to:

1. to scrutinise the findings of the CQC inspection report and comment on the action plan.

2. agree to receive a further report on the outcomes of the planned CQC visits to review progress against recommendations when drafted.

1.0 Purpose

1.1 The Trust received two inspections from the Care Quality Commission (CQC) during September 2013 - an unannounced inspection involving community services and an announced inspection as part of the new CQC inspection programme.

1.2 This report is to update the panel on the Royal Wolverhampton NHS Trust's (RWT) response to the findings of the inspections

2.0 Background

2.1 The first inspection during September 2013 was an unannounced to RWT Community Services, which took place on 17 and 18 September 2013. The inspection took place in District Nursing Clinics and Health Visiting Clinics. The final report demonstrates that the Trust meets the five CQC standards and there were no further actions to be taken. The report is available to the public on the CQC website:

http://www.cqc.org.uk/sites/default/files/media/reports/RL4X2_The_Royal_Wolverhampton_NH S_Trust_Community_Services_INS1-784834232_Scheduled_23-10-2013.pdf

2.2 The second inspection was an announced inspection that took place on 26 and 27 September 2013 with a further unannounced inspection during the afternoon/evening of 7 October 2013.

This inspection was one of the first of the new wave of inspections involving 42 assessors over two days. Further details about the inspection criteria is available on the CQC website

http://www.cqc.org.uk/sites/default/files/media/documents/methodology_and_information_sources_for_new_surveillance_model.pdf

The Trust received a copy of the draft report for factual accuracy and subsequently the final report was published on the CQC website.

3.0 Progress.

3.1 A 'Quality Summit' took place on 19 November 2013. The Trust acknowledged the recommendations and developed a draft action plan (Appendix 1), which was presented to CQC and Trust Development Authority (TDA) at the Quality Summit. Agreement was reached on the areas for priority actions:

- Staffing
- Environment/ Infection prevention
- Mental Health including dementia
- End of Life
- Complaints handling

A full and detailed action plan has been developed and awaiting approval.

3.2 There is a governance process agreed around the approval and monitoring of actions within RWT.

3.3 The CQC will visit the Trust within the next month to review progress against the 2 key recommendations – staffing and complaints, and in 6 months to ensure other actions have been implemented across the priority areas cited in 3.1.

4.0 Financial implications

4.1 A case has been approved by the Trust Board for increased staffing as part of the workforce review, phase 2.

The Royal Wolverhampton NHS
NHS Trust
Care Quality Commission
September 2013
Announced inspection
Draft action plan
'An NHS organisation that continually strives to improve patients' experiences and outcomes'

Introduction

The CQC selected 18 NHS Trusts for a new regime of inspection which looks at a wide range of data including patient and staff surveys, partner organisations and public view. The Royal Wolverhampton NHS Trust was selected because it was considered a medium risk service and was inspected on 26/27 September 2013.

The core services that were inspected were:

- A&E
- Paediatric Services
- Medical Services/Older people's Services
- Outpatients Department
- Surgical services
- ICCU
- Maternity Services
- End of Life Services

The CQC asked five questions of each service: Is it safe, effective, caring, responsive to need and well led?

Actions following the inspection

Two essential standard CQC regulations (as per the Health Social Care Act, 2008) for quality and safety were found to require attention:

Regulation 9: Care and Welfare of Patients *HSCA 2008*
CQC Outcome 4
'People who use the services were not protected against risks of receiving care or treatment that is inappropriate or unsafe by ensuring the welfare and safety of the service user'

Regulation 19: Complaints
CQC Outcome 17
'The provider has not brought the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format'

The Trust is required to develop an action plan to achieve greater alignment with these two regulations.

Action Plan

The plan sets out the required actions, the measure of success, identifies those responsible and the timescale for implementation. The actions are divided into those required on a Trust-wide and Department level.

The action plan will be monitored through the Trust's governance framework and will be a standing item on every directorate and divisional agenda, to ensure the whole organisation learns from the inspection and implements the actions as necessary. Each Core Service will take action to ensure the Trust achieves compliance through this action plan. Each Core Service will provide assurance to the Quality Standards Action Group that the actions are being implemented. We will publish the action plan on our website for easier public access.

DRAFT

TRUST WIDE ACTIONS

Safe	We will keep wards and public areas clean and clutter free	Review of environmental audits at the Environment Group	Head of Hotel Services and clinical divisions	
	We will review the midwifery recruitment plan and reduce the timeframe to recruit into post wherever possible	Monthly monitoring of numbers of Midwives in post will increase	HR Director with HoM	
	We will provide the correct staffing skill mix according to acuity and dependency is managed with a planned recruitment and retention plan for nurses and midwives	We will receive [illegible]roval to recru[illegible]ew staff and twice a [illegible] eviews of staffing [illegible]sed on acuity by [illegible] will be discussed at Bo[illegible]rd level	CNO	
	We will monitor how we care for patients in need of mental health care in the A&E	We will ensure th[illegible]he escalation process [illegible]patients requiring mental health care is e[illegible]	COO	
	We will move towards a faster system for determining harm from hospital acquired VTE and ensure that data reported on Safety Thermometer is robust	Timely revi[illegible]f all hospital acquired VTE will continue an[illegible]view of how VTE is recorded on Safety [illegible]ermometer will be reviewed and st[illegible] educated	Medical Director and Deputy Chief Nurse	
Effective	We will provide access to the Dementia Outrea[illegible]team and information on using the care bundle to every [illegible]rd to provide the best care for patie[illegible]ntia	The Dementia Outreach team will review the [illegible] of the dementia Champions and audit spread of use of dementia bundles in use	Dementia Nurse Consultant and Dementia Care Champions	
	We need to obtain and docume[illegible]our patient's understanding of DNAR in the cli[illegible]l notes for every patient with a DNAR order	[illegible]review of DNAR audits will be done at e[illegible]h directorate's governance meeting with actions on poor compliance escalated through the clinical director structure.	Divisional Medical Directors/Clinical Directors	
	We will improve how we manage breaking [illegible]d news in particular the skills of the medical staff and a[illegible]cess to a suitable environment in which to do this	A review of how medical staff are taught to break bad news will be undertaken. Each ward will know how to facilitate a conducive environment for breaking bad news	Medical Director and Associate Divisional Medical Directors	

DRAFT

TRUST WIDE ACTIONS

	We will improve the post bereavement pathway for relatives in hospital from the ward to mortuary making it easier to use and more caring and welcoming	A review of the bereaved relative pathway needs to be taken and actions around any gaps managed	COO as part of End of Life Objective through Division 1	
	We need to show the public how they can provide us with feedback including raising concerns	A task and finish group will review the Clwyd/Hart Report and ensure we follow the recommendations	CNO and Patient Experience Lead	
Caring	We need to improve the mealtime experience with help for those who need it	Matrons and [illegible] sisters will revi[illegible] how the meals a[illegible] anaged ensuring tha[illegible] ll patients are [illegible] lped	Heads of Nursing and Midwifery	
	We need to improve the environment in the General Office for privacy and compassion and also the environment in the viewing room for the public	A review of hov[illegible] e bereaved relative or c[illegible] rer needs to tak[illegible] lace and gaps [illegible] aged.	COO/ Division 1 management team and Head of Pathology	
	We need to ensure every patient has a good experience in the discharge lounge and don't feel rushed or unwanted	Focussed ex[illegible] iences of patients in the discharge lounge [illegible] be undertaken to identify what the t[illegible] es and problems are	Division 2 with capacity team and PALs	
Responsive	We need to provide an up to date minimum data [illegible] displayed on every ward and department about wha[illegible] clinical performance is around h[illegible] nd wha[illegible] our patients think about our s[illegible] es	Agree and display multidisciplinary KPIs and [illegible] rics about quality, safety and performance for staff and patients to see within each department	Divisional Management Teams	
	Chatback needs to be widely kno[illegible] about across junior staff	A [illegible] view of how we circulate Chatback and how the results are disseminated will be undertaken	HR Director	
Wel led	All wards and departments need to display th[illegible] management structure to enable staff to understand the governance arrangements	Senior nurses and directorate managers will agree what level of detail is displayed and a process for keeping this updated.	Divisional Management Teams	

DRAFT

THE EMERGENCY DEPARTMENT (ACCIDENT AND EMERGENCY) ACTIONS

	Finding from CQC Audit	Action	How will we know this is achieved	Lead	Agreed timescale
Safe	We were concerned about the safety of mental health patients	We will ensure that the escalation process for patients requiring mental health care is enacted and work with the CCG and BBCP to ensure there is a timely response to delays in A&E for patients.	Monitoring of this action will be provided to QSAG	A&E Directorate Management Team	
Effective	The % of unplanned readmissions within 7 days was higher than national average	The Mortality Review Action Group (MORAG) will review and take action where trends of patients who re-attend occur.	MORAG reports will verify this and be presented at QSAG	Medical Director	
Responsive	We had concerns about consultants responding to requests for support in A&E. We saw numerous incident reports but no action taken	The number of consultants who do not attend A&E when requested will be reviewed the next day by the clinical director and appropriate action taken. This will be monitored at the bi weekly A&E meeting	A&E Directorate Management Team will monitor this through the governance meeting and then to the Quality Standards Actions Group (QSAG)	A&E Directorate Management Team	
Well led	There is a risk that the service may not learn from adverse events	Review all serious incidents on Datix and ensure learning is circulated to the whole department	A&E Directorate Management Team will ensure learning is circulated to whole department	A&E Directorate Management Team	

DRAFT

	Staff in A&E said they felt isolated from the rest of the hospital	We will meet with A&E staff to understand their concerns and agree actions to be taken. Back to the floor sessions will be organised as part of the safety walk round programme for Non-Executive Directors and Executive Directors	A&E Directorate Management Team will provide a report of findings to the governance meeting and sent to the QSAG	A&E Directorate Management Team	
	Trends are not being identified and corrective action is not being taken	We will agree and display multidisciplinary KPIs and metrics about quality, safety and performance for staff and patients to see.	This will be evidenced in the department	A&E Directorate Management Team	

DRAFT

MEDICAL CARE (INCLUDING CARE FOR OLDER PEOPLE) ACTIONS

	n CQC Audit		achieved	ead	e
Safe	Elderly care and dementia wards were not sufficiently resourced especially evening and night	The nursing workforce and skill mix review will be presented to Trust Board 24 Nov 2013 for approval. We will develop the use of SafeHands to track acuity and skill mix on a daily basis. We will provide a display for the public that gives the numbers of staff on duty for that shift compared to the number that should be on duty and this will be done on every ward in the trust. Agree a stepped prioritised approach to recruitment to priority areas.	Twice annual reports to Trust Board on staffing, sickness and vacancies. Implementation of SafeHands making acuit lepend y monitoring real ti will become rt of quality rts	HoNs with CNO. SafeHands project lead	
	We were concerned about a patients observations and staff were unable to show us what intervention there had been	Staff in Elderly care wards will receive training in track and trigger and ARD and Matron will monitor escalati his through live records check. Elder ca wards to receive further training in track and trigger from Outreach team.	Repo ed via performance review and demonstrated through monthly KPIs	Matron and manager of Critical Care Outreach Team to provide training	
Effective	Full implementation of dementia care bundle across trust	We will ensure dementia outreach team provides ed tion and advice across the Trust and ll formally review the role of the Dementi	Monitored via directorate governance meeting and peer reviewed by matrons across medical wards.	Dementia Nurse Consultant and Lead Dementia Clinician	
	We observed many examples where patients did not get the help they needed to eat	We ll review help at mealtime part of the m n's KPIs and sisters /charge nurse's ctives	Monitored via KPIs and peer review audit. Monitored at Performance Review.	Matrons & HoNs	

DRAFT

	An incident where the call bell rang for 20 minutes despite staff sat at the desk	Call bells will be monitored and form part of sisters feedback from patients on discharge. Identify electronic reporting system through estates to monitor length of time call bells taken to answer	Monitored via KPIs at performance review and through patient experience via 'Patient Voice'	Matrons and HoNs	
Well led	Chatback was not known to many junior staff	Chatback will be re launched specifically targeting more junior staff	HR audit will demonstrate understanding and awareness of Chatback with junior staff	Nominated HR lead to manage through directorates	
	Information about the Trusts and wards performance does not always filter down to junior staff	A minimum information data set will be agreed by senior nursing staff to display on every ward as part of 'knowing how we are doing' boards.	Evidence of data on ward boards ratified through Senior nurse Operational group	HoNs and Midwifery with Patient Experience Lead	

DRAFT

SURGERY ACTIONS

	n CQC Audit		achieved	ead	e
Safe	We had some concerns about night time staffing and particularly in relation to pain relief	As part of the staffing review surgery is included, however we will continue to monitor acuity using SafeHands technology daily. We will also monitor patient's experience of pain relief through the discharge cards used to record FFT and use this to monitor improvement. Agree a stepped prioritised approach to recruitment to priority areas.	Continue implementation of SafeHands making acuity dependency monitoring real time in every ward which will form suite of reports from SafeHands. Twice a year reports to board will provide skill mix sickness and vacancies	HoNs with CNO. Matrons for individual wards	
	We saw staff opening pedal bins with their hands	IP and use of pedal bins will be targeted as part of the visual audit of hand hygiene conducted as part of the sisters KPIs.	Observational audits will demonstrate compliance with IP practice	Ward Sisters/Charge Nurses through KPIs	
Effective	We saw no evidence of 2013 performance for falls	A minimum data set will be agreed by senior nursing staff to display on every ward as part of 'knowing how we are doing' boards.	Falls data will be part of the minimum data set in every ward on display and audited as part of matrons rounds demonstrated through observation	Ward Sister/Matron	
	There is a risk for IP, dignity and privacy for patients going or returning from the operating theatre due to lack of a dedicated lift	We will ensure there is a dedicated lift for transferring patients from the [illegible] and bac[illegible]	IP Lead will liaise with Estates and report actions through to QSAG	Estates Manager/Lead IP Nurse	
Caring	Patients well enough to be moved in chairs are unescorted	Implement the transfer policy and reduce the number of bed transfers and make more use of wheelchair transport if this is appropriate.	Monthly reports using Teletracking data spot audits checking transfer policy is being followed through Environmental Group	Head of Hotel Services with Matrons	

DRAFT

SURGERY ACTIONS

Responsive	There were a number of broken TVs	We will ensure all TVs and regularly checked by the service provider and that staff know how to escalate this	Environment Group will report on TV service	Environmental audit reports	

DRAFT

MATERNITY ACTIONS

	Finding from CQC Audit	Action	How will we know this is achieved	Lead	Agreed timescale
Safe	There is a shortage of midwives	Birth Rate Plus has been used and a business case approved. A recruitment and retention plan will be developed to meet this requirement.	W&C Governance Committee will report vacancies to QSAG	Head of Midwifery	
Caring	Patient's notes were left unattended in a public area of the clinic	Ensure there is appropriate storage for medical records in the antenatal clinic out of public view	Observational audit will demonstrate compliance	Matron	
	In the antenatal clinics there is limited information for people who have English as a first language	We shall maintain a range of patient information leaflets in different languages for patient and staff use that is easily accessible	Observational audit will demonstrate compliance	Matron	

DRAFT

CHILDREN'S CARE ACTIONS

	n CQC Audit		achieved	ead	e
Safe	Some toilets were dirty and had not been cleaned for 24 hours. We observed poor practice of hand hygiene amongst staff	We shall maintain and monitor cleaning of toilets in daily environmental checks. All staff will have 5 moments monitored weekly with support from other matrons through peer review	Environmental audits will be 100% and peer review results will be available through KPIs	Ward sister and housekeeping	
	Staff need access to specialists in Learning Disabilities	The staff have access to the LD nurse and also to education from the Gem Centre around the autistic spectrum disorder. This needs to extend to all services in paediatrics	Training database will demonstrate compliance and reported through performance meeting	Paediatric Directorate management Team	

DRAFT

END OF LIFE CARE ACTIONS

	Finding from CQC Audit	Action	How will we know this is achieved	Lead	Agreed timescale
Safe	Documentation did not clearly set out discussions with patients about DNAR	We will ensure DNAR is documented in patients records and that discussion with the patient is evidenced as signed by the patient or family	Each CD will raise with directorates and undertake review of notes to ensure compliance in line with live records check	All Clinical Directors supported by Divisional Medical Directors	
Caring	We were concerned about the care for relatives after a person has died	We will incorporate a review of the Bereavement Service into the End of Life Strategy which is part of Trust's objectives and work with the division responsible to ensure improvements take place including training for staff in the General Office	A plan to improve bereavement care in the Trust will be presented to Board as part of the End of Life Strategy	Division 1: Bereavement Services Manager/Directorate Manager Surgery and COO	
	We were concerned about the care for relatives after a person has died	We will undertake a review of the Viewing Room and consider how best to update/improve the area to make it more peaceful and conducive to bereavement including supporting relatives who have been bereaved and wish to view their loved one.	Observation through re inspection will demonstrate improvement. PALS will demonstrate feedback in bereavement of improvements	Head of Pathology and Head Mortuary Attendant/PALs	

DRAFT

OUTPATIENTS ACTIONS

	n CQC Audit		achieved	ead	e
Safe	We did not see any information about safeguarding	We will ensure all staff are appropriately trained in safeguarding and have information available to the public and other staff about this.	Training database for OPD. Peer review by matrons	OPD Matrons to lead	
	We found the cleaners room inadequate and no written cleaning schedule. We found thick dust in clinical areas on trollies	We will ensure the cleaners room is managed and a cleaning schedule is in place and regular environmental audits take place with matron	H[illegible]ekeeping en[illegible]nmental audits	Matron and Housekeeping	
Effective	Sister told us there were incidents when sometimes the consultants did not arrive for clinic	We will ensure there is an escal[illegible]n process in place for a consultan[illegible]t arriving for clinic which involves th[illegible] divisional medical directors	Monitor incidents through OPD governance meetings	Outpatients sister through directorate team	
Responsive	Signage is poor and there is little information for patients. The WRVS café is rarely open	We will improv[illegible]age and ensure information is a[illegible]ble on a range of health issues. We [illegible] also scope the provision of a vending [illegible]achi[illegible] patie[illegible] to use when th[illegible] closed.	Environment group and OPD Matron. Scope availability of vending machines in OPD and access times to café with WRVS	Estates, Matron and PALs	
	Patients told us they did not know how to make a complaint	W[illegible] ensure [illegible]lti media [illegible]vailable to [illegible]rm patients how to raise a[illegible]cern an[illegible]se PALS	Task and Finish group implementing findings from Clwyd/Hart Report	CNO	
	Nurses were not clear how to contact the Learning Disabilities Nurse	Ensu[illegible]ll information is also available for patients [illegible]h Learning Disabilities and ensure sta[illegible]nderstand how to access the specialist [illegible]se	Observational audit assurances via matron	Matron and PALs	

OUTPATIENTS ACTIONS

Well led	We were not able to see any quality assurance such as how the clinics were performing against targets	We will ensure a core set of quality and performance indicators are well displayed in the outpatients department for the staff and public	Observational audit through Matron audits and patient feedback	Matron and PALs	

DRAFT