The Royal Wolverhampton NHS Trust

CQC Action Plan Report

1. Staffing											
Action Type	**Actions**	**What does Success Look like?**	**RAG Rating**	**Evidence to Support Actions**	**Update on Actions**	**Lead**	**Executive Director**	**Governance**	**Start Date**	**Review Date**	**End Date**
CQC Action Plan - ARCHIVE											

****ARCHIVE** 1.1 The hospital currently has a shortage of midwives due to staff maternity leave and sickness absence. This issue has been included on the trust risk register and actions have been taken to improve, such as establishing a pool of maternity staff to fill gaps on rotas. Further work is needed to improve staffing levels in the maternity ward, as it is impacting on the responsiveness and effectiveness of staff.**											
Actions in place already	Business case approved. New appointments of Midwives in progress, Closure of Midwifery led Unit (Oct 2014 now re opened Nov 2013). Risk added to risk register, daily review and escalation of safe staffing.	Maternity vacancies will reduce month on month and Birthrate Plus level will be achieved. The MLU will remain open for ladies to use.	**Green**	Integrated Quality Performance Report. Coninued monitoring reports of absence/vacancies and sickness. Maternity directorate governance meeting minutes.	Recruitment of midwives is proceeding well with additional interest in working at RWT from across the East and West Midlands. Unplanned absence is being actively managed by matrons and Head of Midwifery with a focus on HR support to bring staff back in to practice. No staff on supervised practice now. Sickness levels stable and MLU remains open. Vacancies planed to be recruited to using overseaqs staff from Ireland, now being scoped. Ongoing monthly monitoring of sickness: vacancies and recruitment to continue monthly. Recruitment plan in progress with HoM and Deputy HR Director	Head of Midwifery	Director for Human Resources and CNO	Directorate and Divisional Governance Meetings	17/11/2013	25/05/2014	29/06/2014

Actions Required	Monthly report on RM/MSW vacancies and numbers recruited/ new starters will be reported to QSAG from Janurary 2014. Maternity Unit will display numbers of staff on every shift in an easily understood way for the public to see.	Monthly vacancies will not deteriorate. Active recritment will take effect. Planned and unplanned absence will be within 20% uplift.	**Green**	RM Vacancies reduced from 5.43% in Sept to 1.77% in November. E Roster demonstrates excellent compliance with un used hours (4%)	Improved sickness in Feb from Jan with 4.24% RMs (down from 16.8% in Jan) and 4.54% in HCAs (down from 15.68% in Jan)	Head of Midwifery/Deput y HR Director	COO/CNO	Maternity Directorate Meeting		09/03/2014	30/04/2014
Actions Required	Recruitment plan agreed between HoM and HR. Recruitment resource to actively seek out experienced midwives using external recruitment company in to look i Ireland.	Midwifery vacancies will reduce monthly. The Midwifery Led Unit will remain open and provide maximum choice to women. Active recruitment from overseas will yield positive results with new midwives coming to work at RWT.	**Green**	MLU remains open. Improved staff sickness here with zero sickness. However remainder of maternity unit sickness being managed, see action below. Active management of unlanned and planned absence through use of Electronic Rostering. Positive maternity survey evidenced through reports sent to RWT in February to be reported at Trust Board in March 2014. Positive Friends and Family response rate and score across all 5 touch points of the survey. Birthrate Plus ratio remains below 1:30, active recruitment contiues	Recruitment plan agreed at Trust Board Jan 27 2014. Currently being enacted. Active recruitment to contiue oversees with Head of Midwifery recruiting from European countries in April 2014. Now deferred to May/June pending change of sourdce of midwives from Greece to Ireland	Deputy Director of HR & Head of Midwifery	Director of Human Resources	Maternity Directorate Meeting	02/02/2014	09/03/2014	31/05/2014

****ARCHIVE** 1.2 The hospital must take action to improve the responsiveness of care for older patients. We were concerned that older people's care, surgical and dementia wards were not sufficiently staffed, particularly at night. Evidence of patients not receiving help at mealtimes; observations not escalated approrpiately, and nurses having to respond to mulitple telephone calls and undertake clerical roles.**											
Actions Required	Bespoke monthly reports will detail % of vacancy and sickness absence and staff waiting to come into post by ward	A report by ward detailing vacancies and all sickness will be provided ward by ward to the directorates and divisions. There is divisional nursing/midwifery representation on bespoke recruitment plans.	**Green**	workforce meetings take place already and plans are in place to recruit.	Confirmation from Deputy HR Director this data already available	Deputy Director of HR	Director of Human Resources	Directorate and Divisional Governance Meetings	19/01/2014	19/02/2014	31/01/2014
Actions Required	CNO and Director of HR to agree priority areas to recruit from and ensure targeted recruitment plan in place	Recruitment will start for areas of concern and staffing breaches will demonstrate a reducing trend.	**Green**	Recruitment plan agreed at Board Jan 14. Plans in place to recruit all new graduates in Jan (28 RNs) up to 60 RNs now commenced in post on preceptorship programme started Feb 14. Plans to recruit overseas led by HR and managed through bespoke recruitment team reporting to Workforce Assurance Group.	Bespoke Recruitment Team in place managed through HR. Corporate HoN/M confirmed for first recruitment drive overseas April 2014.	Heads of Nursing with Human Resources Lead for recruitment	Director for Human Resources and CNO	Senior Nurse Strategic		19/02/2014	31/01/2014

Actions Required	Confirmation to source of funding to increase nurse staffing following submission of business case to CCG.	Funding will be agreed to recruit into priority areas with a targeted recruitment plan. Agreement to provide short term additional staff on night shifts will be agreed and staff sought from Bank as a priority by Dec 13. Maximise use of substantive staff through the effective use of e roster to control additional expenditure.	**Green**	Business Case presented to CCG 17 Dec 2013. Change Programme Group meetings minutes 2013. Funding approved of 1.5M through contracting process. Recruitment plans now need to be added to monitor progress of expecnditure in recruiting additional staff through to WAG.	Medical, Elderly and T&O Wards already have additional staff in place on night duty (2 + 2) as a cost pressure. Discussions continue with external bodies on funding of nurse staffing. Additional work on E Rostering needs to be presented to Change Programme Board as a specific project linked to benefits realisation across Trust in reducing additional staff spend and maximising contribution of substantive staff. Recruitment plan presents risks in achieving which will be presented as a seperate action May 2014	Heads of Nursing / Midwifery/CNO/ DCNO/	CNO/COO/Director of Finance	Trust Management Committee (TMC)	19/11/2013	01/06/2014	27/04/2014

Actions Required	Continue to monitor staff in place to facilitate supervisory status.	Improved nurse sensitive indicators and KPIs, reduced harm to patients. Improved management of staff and reduced bank and overtime usage.	**Green**	Ward sisters are now supervisory evidencing closer accountability for ward performance and patient outcomes.Use of Safe Hands to monitor acuity and dependancy supporting effective management of existing staff on duty.	KPIs mapped to CQC outcomes. Available for all Band 7 staff at ward level to input monthly. All wards display staff on duty outside ward - need to review timeliness of boards thru Matrons rounds. Accountability forum for ward sisters to be defined. Ward to Board key metrics defined and system in place to record and report date through to PSIG using Health Assure rpeorts. Accountability framework in place to define how ward sisters are held to account through to Matrons and HoNs. First report due to PSIG May 2014.	Heads of Nursing / Midwifery	CNO	Senior Nurse Strategic Group (SNSG)	19/11/2013	01/05/2014	25/05/2014
Actions in place already	Elderly care wards have access to vitalpac and SBARD	Observations will be done in a timely manner in line with NICE clinical guidance. Escalation of observations using a track and trigger system will be monitored.	**Green**	Monthly live record audits have demonstrated escalation to medical staff and this audit contiues monthly within elderly care and also across other directorates. Late observations are monitored daily through vital pac and this has demonstrated 6% which is well in line with best practice across the Trust.	Vitalpac is in place on NX site. Paper track and trigger audit is used at WPH. Compliance with this is variable, to be monitored via division. Escalation to medical staff is improved to 98 - 100%.	CNO/MD	CNO/COO/Director of Finance	Patient Safety Improvement Group		19/02/2014	09/02/2014

Actions in place already	Phase 1 of workforce review complete: To achieve funding in place to support supervisory status of ward sisters/charge nurses.	Improved funded staffing on night duty on medical, surgical and elderly wards at night. Agreement to fund business case for additional nursing staff across the acute adult inpatient wards. Improved KPIs evidenced at divisional accountability reviews . Improved use of E Roster by ward staff to manage staff resource in particular use of un used hours instead of bank or overtime and individual sickness and more even spread of annual leave. Robust management of planned and unplanned absence to evidence maximum use of substantive staff in place. Evidence of wards displaying planned numbers of staff on duty versus actual staff therefore identifying gaps in staffing. Evidence of escalation to senior nursing staff of staffing deficiencies on a shift by shift basis. Patient experience improvement is evidenced in the responsiveness of staff to patient's need. Evidence to	**Green**	100% all wards funded now have supervisory ward sisters/charge nurses in place. KPIs reported to CCG quarterly on progress. Pressures of opening additional capacity to support MSFT 24 Feb supported with corporate nursing, R&D and divisional support from Division 1 as well as Division 2 in order to mitigate risks to patients. Responsiveness of staff to patient need evidenced improvement in Feb 14 report of Patient's Voice quantified in monthly Integrated Quality Performance Report and ward KPIs on Nursing & Midwifery site. 60 new RNs recruited on to Preceptorship Programme Feb 2014 with plans to recruit overseas for April 2014. No increase in complaints on wards around responsiveness of staff to patients in medicine, elderly care or T & O. Approval through contracting to fund 1.4m additional staff. Recruitment plan to be added as additional risk	Wards in medicine, Trauma & Orthopaedics and Elderly Care have increased staffing at night to reflect CQC recommendations at a cost pressure. Refocus of supervisory status has been undertaken with all Band 7 staff and also Band 6 staff. New job descriptions encompass supervisory status and expectations. Escalation of staffing issues established through senior nurses and up the line to CNO. HR report to Trust Board 24 Jan 14 (385 RN vacancies including those required following workforce business case) outlined plans to recruit nationally and internationally . Ward boards with staffing levels now in place. E Roster training in place but evidence supports limited use of e roster and confined to data entry for payroll use only. Report on ward clerk cover requested and	Heads of Nursing/Midwifery	CNO	Senior Nurse Strategic Group (SNSG)	19/11/2013	28/05/2014	13/07/2014

		support improved cover of ward clerks at ward level.			pending from Head of Patient Access. KPIs in place and completed by ward sisters/matrons. Need forum to hold to account, to use the Divisional Accountability Review process quarterly. Recruitment planned to Greece in April. HoN planning for first tranche of new recruits to start end of May 2014. New graduates spoken with who register in September.						
Actions Required	Staff on elderly care receive further training on the use of Track and Trigger and SBARD, matron will involve Critical Care outreach as necessary.	Late observations on elderly care wards will be 5% or less. Matron rounds will report use of SBARD.	**Green**	Evidence in KPIs of improvement in late observations. Matron to povide report on SBARD Feb 14. Live record review has reported excellent complaince		Matron Elderly Care	CNO	Patient Safety Improvement Group		10/03/2014	28/02/2014

2. Environment											
Action Type	**Actions**	**What does Success Look like?**	**RAG Rating**	**Evidence to Support Actions**	**Update on Actions**	**Lead**	**Executive Director**	**Governance**	**Start Date**	**Review Date**	**End Date**
CQC Action Plan - ARCHIVE											
****ARCHIVE** 2.1 The environment requires attention which includes managing infection prevention risks and increasing the amount of information available to patients particularly in the Outpatients Department and in the Viewing Area for bereaved relatives. 'The Viewing room in the mortuary requires updating; it is clinical and uni faith and fails to provide a conducive environment for relatives in an emotional state**											
Actions Required	A declutter of all wards, clinics and public areas to improve the environment will take place coordinated by ward sisters with support from housekeeping/ estates and IP	All wards and departments will be clutter free. Notice boards will be professional and tidy. Patients will comment that the areas look clean and tidy through patient feedback. Ward sisters will be fully involved in mini PLACE audits and see their results as well as environmental audit results monthly. These will be displayed for the public to see.	**Green**	Positive envionmental audits at Environment comittee	Decluttering in process however audit of environments not available untill Jan 14	Ward Sisters with support from Housekeeping	CNO	Environment Group			31/01/2014
Actions Required	A review of patient information available in outpatients	Patients will report easy access to information and peer review will confirm evidence	**Green**		Review of OPD demonstrates variety of information available however assurance sought from Matrons on how this is managed on-going. LD nurse has raised awareness to nurses in OPD. New posters provide information to public on how to complain and also who is who	Patient Experience Lead and Matrons for OPD (KA and LB)	COO	Patient Experience Forum (PEF)			28/02/2014

Actions Required	Ensure portering staff and nursing staff move patients in chairs in preference to beds if their condition allows - decision to be made by ward nurse in charge.	Patients will only be moved on their bed if their clinical condition requires, this will be as minimal as possible and the use of wheelchairs will be preferred option if condition permits.	**Green**		Policy reviewed and reinforced by ward staff and head of portering	Ward Sisters and Matrons	CNO	Senior Nursing Operational Group			31/01/2014
Actions Required	Ensure the lift is designated as a dedicated Theatre Patients Only lift and signage is provided. Porters to be communicated change in use.	Visitors or general public will not use the lift	**Green**		Dir of Estates Development has confirmed designation of lift Awaiting confirmation of notices in place	Head of Estates Development/ Head of Estates	CFO	Environment Group			31/12/2013
Actions Required	Improvement to drinks and snack facilities in outpatients department. Clarify times of opening of café	Vending machines or alternatives will be scoped in outpatients and feedback will support significant improvements in OPD	**Green**		Discussion with WRVS have taken place and café opening times are now posted for the public. Vending facilities are available	Head of Hotel Services.	COO	Environment Group			28/02/2014
Actions Required	More evidence of how to identify safeguarding issues in outpatients	Evident in peer review of safeguarding posters and information in OPD.	**Green**		Safeguarding information is available in OPD and training is complete	Matrons for OPD	COO	SVA/JHSCG			31/12/2013
Actions Required	Revised cleaning schedule for Outpatients department will be in operation and on display	OPD will be cleaner and evidence of regular cleaning will be in place	**Green**		In place	Head of Hotel Services/IP Lead nurse	CNO	Environment Group			31/12/2013
Actions in place already	Wards have a list of bed space equipment available and the opportunity to declutter regularly. Trialling new bed stools. All wards have now been deep cleaned using HPV system. Clean and make bed team in place	Improving picture of patient experience, tidy wards, reduced infection rates, no outbreaks of norovirus. Patients have access to new information folders	**Green**	New boards in place in OPD with information including on safeguarding for patients to view. one outbreak of norovirus to date	New information folders being printed and will be distributed by PALs end of March in new folders to all inpatients beds across Trust.	COO/CNO	COO/CNO	Environment Group			19/03/2014

3. Patient Feedback											
Action Type	**Actions**	**What does Success Look like?**	**RAG Rating**	**Evidence to Support Actions**	**Update on Actions**	**Lead**	**Executive Director**	**Governance**	**Start Date**	**Review Date**	**End Date**
CQC Action Plan - ARCHIVE											
****ARCHIVE** 3.2 Incidents where call bell unanswered.**											
Actions Required	To monitor call bell response time for every ward in December 2013 through the Patients Voice cards and show ward by ward changes for next 6 months or until 100% coverage of no delay achieved.	A month on month improvement in response to call bell from 77% (Nov 13) by ward	**Green**	Integrated quality performance report demonstrates improvements in staff response time to buzzers. Further accountability using individual ward KPI though the divisional accountability reviews will drill down to individual wards.	Monitoring of calls bells as per Patient Voice for every ward is available and Trust wide demonstrates a slow improvement. Specific ward reports will be available for Feb QSAG	Heads of Nursing and Matrons	CNO	Patient Safety Improvement Group (PSIG)			31/01/2014
****ARCHIVE** 3.3 Information about quality and performance in complaint responses not readily available in each ward**											
Actions Required	Agree consistent level of information provided to every ward and department (OPD) with a process to update monthly and ensure displayed on every ward by Feb 14	Information is evident in every ward, department and Trust website, and staff and patients comment on it	**Green**	Improvement in response rate on ward to FFT with above average score for Trust (above national average). Wards more engaged with patient feedback and system in place to support monthly posters and distribution from PALs	Each ward is receiving core information about quality and performance all wards will have this by Jan 14	PALs	CNO	Patient Experience Forum (PEF)			28/02/2014

****ARCHIVE** 3.4 Limited information to patients regarding how to complain.**											
Actions Required	1. Develop new literature and modes of communication on the process for complaints.2. Review existing posters and locations published.3. Review existing complaints management process (effectiveness, levels of engagement/barriers) 4. Improve local communication of F&F test results to ward areas5. Improve compliance with F&F questionnaire returns. Develop multiple means of social media to obtain patient feedback. 6. Devise new customer care course. 7. Improve routes of access to feedback/complaints through Trust website	Positive response from patient feedback and survey. New customer care course initiated for areas with high numbers of complaints to attend. Updated website, active social media presence for outward communications and as a route for feedback. Link to all patient stories recorded is available to all staff for groups for training, local meetings/fora or individual learning via local intranet.	**Green**	Improved tracking of complaints by divisions is reducing time to respond. Completing Patients Association survey of our complaint responses to complainants. Revised information on how to complain cascaded.		Patient Complaints Manager	CNO	QSAG			28/02/2014
****ARCHIVE** 3.6 Not all Staff understand chatback.**											
Actions Required	1. Improve use and communication of Chatback. 2. Publish Chatback results and actions locally.	Staff at all levels will understand Chatback when asked. 2014 staff survey demonstrates a favourable result in response to being listened to	**Green**	Information about Chatback cascaded		Deputy HR Director	HR Director	Workforce Assurance Group			28/02/2014

4. Mental Health											
Action Type	**Actions**	**What does Success Look like?**	**RAG Rating**	**Evidence to Support Actions**	**Update on Actions**	**Lead**	**Executive Director**	**Governance**	**Start Date**	**Review Date**	**End Date**
CQC Action Plan - ARCHIVE											
****ARCHIVE** 4.1 Inconsistent Dementia care provision and access to Dementia outreach team.**											
Actions Required	Dementia outreach team to provide more information re service and referral requirements. Dementia champions role will be clarified and monitored by Dementia Lead Nurse. Best practice Dementia care to be rolled out across all areas (including community adult services and involvement of LA). Outreach model to be maximised and monthly activity reported through a range of KPIs to be developed.	All ward nurses and doctors understand how to access the dementia outreach team. All patients with dementia have access to the dementia care pathway and evidence demonstrates it's use through audit. Activity of referrals for dementia outreach increases and demonstrates use across all services.	**Green**		Nurse Consultant in Dementia Care providing more training on use of the care bundle, About me document and the services of outereach as part of a rolling training progreamme across the Trust commenced Dec 13.	Nurse Consultant for Dementia with HoN Division 2	CNO	Rehab and Ambulatory Medical Group			28/02/2014
****ARCHIVE** 4.2 Specialist staff to support children with learning disabilities not available.**											
Actions Required	LD nurse to develop outreach facilities to enable access across all specialities (inc Paeds and community). LD nurse to provide information and literature re access and referral requirements. Develop audit/evaluation of service usage/uptake through KPIs.	Positive results from audit/evaluation of service. Activity monitoring demonstrates increase use of resource across wide span of areas not just adult inpatients.	**Green**		LD Nurse in post across all specialities and haas highlighted provision of LD advice in every speciality as minuted in governance meetings	RWT Head of Nursing (Safeguarding) / Learning Disability Nurse	CNO	SVA/JHSCC			28/02/2014

****ARCHIVE** 4.3 Staff safety concerns re existing designated room for Mental Health patients.**											
Actions Required	Review care pathway and escalation process for Mental Health patients in ED. Develop audit of care pathway/policy for care of mental health patients. Review staff training compliance and capability for managing the care of mental health patients.	The Directorate are able to report the length of time any patients spends in the MH room in the Emergency Department. Faster responses to escalation by BCP in response to mental health needs of Emergency Department patients.	**Green**	Improved training in use of MH room. Fixtures work completed. SOP in place and reported thru Directorate meetings	Standard Operating procedure in place in ED. Further work being done by Lead Nurse Safeguarding Children into access for adolesants with mental health needs particularly in ED.	HoN/DMD Division 2	COO	Emergency Department Directorate Meeting			28/02/2014

5. End of Life											
Action Type	**Actions**	**What does Success Look like?**	**RAG Rating**	**Evidence to Support Actions**	**Update on Actions**	**Lead**	**Executive Director**	**Governance**	**Start Date**	**Review Date**	**End Date**
CQC Action Plan - ARCHIVE											
****ARCHIVE** 5.1 Documentation of DNAR demonstrates lack of involvement of the patient, their family and medical signature.**											
Actions in place already	Monthly live record check	Improved compliance with DNAR in live records checks across all directorates	**Green**	results from live record checks completed monthly	Live records check in place across all directorates led by clinical directors and divisional medical directors	MD and Divisional Medical Directors	Medical Director and Associate Medical Directors	Divisional meetings			19/03/2014
Actions Required	Review monthly audit results for DNAR by directorate. Improve sample size, local escalation and accountability for DNAR live record checks.	Consistent improvement in live records check and annual audit. No complaints on this subject.	**Green**	Live records check demonstrate improvements on questions 10 - 13 (DNAR and associated questions) and improvement across all areas in compliance.		Associate Medical Directors	Medical Director and Associate Medical Directors	Divisional meetings			31/03/2014
****ARCHIVE** 5.2 Improvement needed in how staff in particular junior doctors, break bad news to patients.**											
Actions Required	Adopy breaking bad news training already in place (Cancer Services) across the Trust. Show DVD patient stories at junior doctors forum and medical and staff induction.	Favourable feedback from Patient surveys. Reduction in complaints on this subject.	**Green**	There will be zero complaints about how bad news was given to patients or relatives through review of complaints quarterly at Trust Board - nil for last quarter. System established with DCNO re alert on any complaint involving BBN.	Training on BBN is being scoped by the Head of Ed and Training to provide multi professional and specific medical sessions to be delievered starting in NY. Grand Round has had BBN and communication skills patient feedback DVD also to be used in all under and post graduate medical training in future.	DMD/HoN/Head of Education & Training	CNO/MD	QSAG			28/02/2014

ARCHIVE 5.3 Relatives of the bereaved find the bereavement service business like and lacking in compassion.											
Actions Required	1. Review use of bereavement service and room as part of the General Office in terms of privacy and dignity.2. Review Bereavement service and resources/information including training available to bereavement staff and the provision of follow up of those bereaved. 3. Review process of support with viewing the body in the Viewing Room. 4. Initiate an evaluation/feedback mechanism for relatives to comment on the service which is fed into wider patient experience feedback.	Relatives who have used the bereavement service will provide a positive experience of the service they have received. The viewing area will be more conducive to visiting and relatives will be supported in their journey/visit to the bereaved.	**Green**	Drafts of new information avauilable. Pending results of survey of those recently bereaved to be provided. New furniture in place in bereavement suite. new working practices now in place. Capital spend on rfurb of mortuary approved. Evidence in June of surveys of users feedback	Manager of bereavment has undertaken review of service. To provide additional education, information for patients and change of practice to take patients to viewing area.	Group Manager Surgery/Head of Patient Services	COO (Mgmt of bereavement services)	QSAG			28/02/2014