The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	27 January 2014
Title:	CQC Inspection
Executive Summary:	The CQC made an announced inspection in September 2013; the final report was published by the CQC on their public website on 21 November 2013. An action plan has been developed with involvement and agreement from all divisions. The plan is being monitored monthly through the Quality Standards Action Group (QSAG). The first report was received earlier this month and is attached. The evidence supporting actions is an iterative process with compliance is updated weekly. Evidence to support actions and demonstrate change is stored on 'Health Assure' a centrally held repository enabling us to automatically update performance regulatory regimes.
Action Requested:	For the Board to approve the action plan and consider the recommendation for sustaining improvement in the future.
Report of:	Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Charlotte Hall, Deputy Chief Nursing Officer
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	QSAG Jan 2014
Appendices/ **References/** **Background Reading**	CQC Registration Monitor Governance Framework
NHS Constitution: **(How it impacts on any decision-making)**	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

1. Background Details
In September 2013 the CQC launched their new inspection process with the aim of enabling the inspection to 'get to the heart of patients' experiences based on the things that matter to people'. The inspection specifically looks at five domains judging whether the service inspected in:

- safe.
- effective.
- caring.
- responsive to people's needs.
- well-led.

Through this approach, the CQC aim to obtain a richer and broader understanding of the quality provided in each service and Trust.
After the inspection, the final report was published on the CQC website in November 2013, two months after the announced inspection and following a quality summit attended by a range of different stakeholders for the Trust. The link to the CQC report is provided below.

http://www.cqc.org.uk/search/all/new%20cross?location=wolverhampton

The Trust was required to develop a comprehensive action plan covering all disciplines and addressing the key areas highlighted in the CQC final report. This forms Attachment 1 and has been shared widely across the organisation as well as the TDA. Following advice from the TDA we have started to publicise monthly updates of progress on the Trust's external facing website.

2. CQC Action plan and demonstrating improvement
Each action in the plan has a director as the responsible executive and a named lead who provides evidence of compliance with the agreed actions. The evidence is provided through a number of routes obtained through the deputy CNO and leads for each action. It is collated and presented monthly to Quality Standards Action Group. The Patient Experience team will, in the immediate future, conduct targeted patient surveys to specifically test out actions undertaken. This will be fed back to QSAG along with the monthly update on the action plan.

3. Sustaining improvement and moving forward
A key factor from the new inspection process is to get to the heart of the patient's experience and understanding what matters to them. The Trust already uses a range of methodologies to do this. However, it is widely acknowledged that peer review, or the evaluation of work by one or more people of similar competence to the producers of the work (peers), constitutes a form of self-regulation by qualified members of a profession. Peer review methods are employed to maintain standards of quality, improve performance, and provide credibility and in academia, peer review is often used to determine an academic paper's suitability for publication.

In order to sustain improvement in quality and performance a system of service peer review could be used similar to that of the CQC, using similar methodologies and information already collected by the Trust. This would need the organisation of triumvirate directorate management teams (clinical director, general managers and matron) reviewing each other's services. This might involve the ward, the service and corresponding workforce (CNS, staff grades, research staff) and activity attached to the service utilising the range of information already collected about the service and centring it on the five CQC domains; safe, effective, caring, responsive to patients' needs and well led.

The Trust already has a group of 'critical friends'; A critical friend can be defined as a trusted person who asks provocative questions. We already have volunteers, HealthWatch, the Patient Experience Forum and retired employees who could potentially be mobilised to look at our services from the public's perspective, pose the challenge to our services and enable staff to reflect in a safe

environment.

3. Recommendations
The Trust Board is asked to approve the action plan and consider recommendations for future planning for peer review.

The Royal Wolverhampton NHS
NHS Trust

CQC Action Plan in response to the announced visit 26/27 September 2013.

V4 January 2014

Introduction

The CQC undertook an announced inspection on 26/27 September and subsequently held a Quality Summit on 19 November 2013. At the summit, five areas of concern were raised that the Trust are required to address as a matter of priority. These priority areas form the action plan as detailed. The CQC will re inspect in one month from 19 November and will be looking for evidence of improvement. They will also undertake a full inspection in six months time.

Actions to be taken

There are five priority workstreams each with an executive director and leads to ensure actions are completed appropriately and on time. Assurance for each of the actions will be provided to the relevant group as stated in the governance column using Health Assure, a platform for evidencing actions. This will document plans in place and actions already achieved. The overarching action plan will be monitored via the Quality Standards Action Group that meets monthly and this will commence in January 2014. The action plan will be published on the Trust intranet for staff, however the public can access a monthly update on our progress with actions.

Key:

Green = all actions are complete and evidence available to demonstrate compliance with this action.	**Yellow = achievement of actions but sustainability not yet achieved** **Amber = Partial completion of actions with evidence still required**	**Red = No progress has been made in actioning this point or the action is unable to move forward**

December update

Staffing

Key communication: To enable staff to provide safe and high quality care to patients we need staff to be able to report and escalate concerns about staffing. We will be responsive to patients needs particularly at mealtimes and we will respond promptly to call bells.

Problem	Actions in place already	Actions required	What does success look like?	Executive Director	Lead	Governance	Update on actions	Timeframe	Evidence to support actions. RAG Rating
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.	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.	Recruitment plan to be agreed between HoM and HR. Recruitment resource to actively seek out experienced midwives	Midwifery vacancies will reduce monthly. The Midwifery Led Unit will remain open and provide maximum choice to women.	Director of Human Resources	**Deputy Director of HR & Head of Midwifery**	**Maternity Directorate Meeting**		**Dec-13**	MLU remains open. Improved staff sickness evidenced in December performance meeting reviewing November data. Reduced sickness (down from 4.9% in Sept to 1.77% in Nov.
		Monthly report on RM/MSW vacancies and numbers recruited/ new starters will be reported to QSAG from January 2014. Maternity Unit will display numbers of staff on every shift in an easily understood way for the public to see.	There will be a 10 % reduction in staffing midwifery vacancies month on month . Sickness absence will be 2% or less and the use of planned leave will be within the 20% uplift.	COO	**Head of Midwifery/Deputy HR Director**	**Maternity Directorate Meeting**	**Recent recruitment now beginning to take effect and reflected in vacancy updates**	**Dec-13**	**RM Vacancies reduced from 5.43% in Sept to 1.77% in November. E Roster demonstrates excellent compliance with un used hours (4%)**
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.	Phase 1 of workforce review complete: To achieve funding in place to support supervisory status of ward sisters/charge nurses. 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.	Continue to monitor staff in place to facilitate supervisory status.	Improved KPIs, Active management for sickness absence, 100% compliance with E Rostering, budgetary control. All wards will display the number of staff on duty versus rostered on each shift.Turnover per ward will stabilise and start to reduce. Each ward will minimise the time spent to get staff in to post by active recruitment.	CNO	**Heads of Nursing / Midwifery**	Senior Nurse Strategic Group (SNSG)	KPIs mapped to CQC outcomes. Available for all Band 7 staff at ward level to input monthly. Metrics to be discussed at Divisional Accountability Groups (DAG). HoN ch\rged with agreeing process for displaying staff numbers of duty outside every ward. To be completed and in place by Feb 2014. Proactive recruitment plans in development and to be presented at Trust Board Jan 14.	**Jan-14**	**100% ward sister/charge nurse supervisory. KPIs agreed and in place. To formalise a methodology for accountability forum in discussion with Governance and pending agreement with CNO.**
		CCG to confirm decision to fund by 13.12.13. This must be reported to the TDA. Agree to fund bank staff to increase numbers of nursing staff on designated wards at night	Funding will be agreed to recruit into priority areas with a targeted recruitment plan. Agreement to provide additional staff on night shifts will be agreed and staff sought from Bank as a priority by Dec 13.	CNO/COO /Director of Finance	**Heads of Nursing / Midwifery**	SNSG	Medical Wards already have additional staff in place on night duty (2 + 2)	**13/12/2013**	**Business Case presented to CCG 17 Dec 2013. Conversations in place**
		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.	Director for Human Resources and CNO	**Heads of Nursing with Human Resources Lead for recruitment**	Senior Nurse Strategic	Bespoke Recruitment Team in place managed through HR. CNO to agree wards to be addressed first	**Dec-13**	**Recruitment plan to go to Board Jan 14 (HR Director) Plans in place to recruit all new graduates in Jan (28 RNs)**
	Vacancy report available from Workforce team. Separate sickness report also available.	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	Director of Human Resources	**Deputy Director of HR**	QSAG	Confirmation from Deputy HR Director this data already available and will be incorporated into workforce metrics using e roster and HR data	**Jan-14**	**Formal reporting mandated by NQB to start May 2014**
	Draft escalation plan in place from Matrons for a Quality Management System	Agree and circulate formal escalation process for staff to use when less than minimal staffing in place. Process to be confirmed at SNOG Dec 2013	All staff at Band 5 upwards can demonstrate how to escalate process to report and manage with less than minimal staffing. Staffing levels are corrected on E Roster on a shift basis and be up to date.	CNO	**Matrons to Band 7 ward sisters**	Senior Nurse Strategic	Matrons Away Day discussed QMS, Matron charged with development and demonstrated at December band 7/8 Forum	**Jan-14**	**Matrons have agreed an escalation process using a quality management system**
	Elderly care wards have access to vitalpac and SBARD	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.	CNO	**Matron Elderly Care**	Patient Safety Improvement Group		**31/12/2013 23/2/14**	**Evidence in KPIs of improvement in late observations. Matron to povide report on SBARD Feb 14.**
	Protected mealtimes policy in place. Access to volunteers to support assistance at mealtimes	Reinforce the standard that all staff must help at mealtimes. Actively seek positive experiences of help at mealtimes from other wards. Peer review will evidence change in practice to ensure all wards achieve consistency.	Peer review demonstrates compliance with help at mealtimes on every ward and patients will receive consistency across the organisation. Patient experiences reflect support at mealtimes. Use of SafeHands reports will demonstrate more time by patient at mealtimes.	CNO	**Heads of Nursing and Matrons . Matron responsible for CBP Nutrition workstream.**	QSAG	KPIs in ward metrics have Nutrition and Hydration Bundle which is recorded on ward performance dashboard.	**Jan-14**	**Peer review demonstrates improvements in support at mealtimes and strengthened protection where possible. Matrons have developed a meal time quality round audit to identify problems with assistance at mealtimes, to copnfirm where will be recorded**
	The Nursing Workforce Strategic Group will reform with redefined Terms of Reference to coordinate the workforce reviews of nursing and midiwfery. Phase 3 of workforce review will take place and identify efficiencies .	A workforce tool 'PANDORA' will be scoped to review the Clinical Nurse Specialists activity across the Trust.	The review will be completed encompassing all CNS activity	CNO	**Head of Nursing Division 1**	Senior Nurse Strategic	Pandora tool now available	**Completed by May 2014**	
		A review of outpatients and operating theatres will take place	A workforce analysis of need based on activity with review of shift system in Theatres	CNO	**Head of Nursing Division 1/Matron Theatres/Matrons T&O and Surgery to review OPD**	Senior Nurse Strategic		**May-14**	
		A workforce review of community nursing staff will take place in February 2014 using the Queens Institute tool planned for release January 2014.	A completed workforce review detailing WTE required based on activity will be completed	CNO	**Head of Nursing Division 2 / Matron Community Services / Head of**	Senior Nurse Strategic	Scoping use of the tool through QNI	**May-14**	
	Ward Clerks in place in most wards	A review of ward clerk workforce and availability across all areas matching demand to activity as closely as possible. Consistency in ward clerk job description	Availability of ward clerks based on demand in most active areas requiring support out of hours	COO	**Head of Patient Access**	QSAG	Scoping work has been done by Head of Patient Access. To receive evidence of this piece of work from Head of Patient Access	**Jan-14**	**Evidence to support scoping not yet provided**

December update

Environment

Key communication: All staff are responsible for ensuring care is delivered in a clean and safe environment which is free from clutter.

Problem	Actions in place already	Actions required	What does success look like?	Executive Director	Lead	Governance	Update on actions	Timeframe	Evidence to support actions. RAG Rating
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'***	A robust method of audit using IP/5 Moments/PLACE and environmental audits is in place which are reported to the Environment Group and the Infection Prevention Control Group. Regular deep cleaning schedule using HPV is in place.	A review of environmental standards across each clinical area including outpatients. Urgent action will take place in outpatients and paediatrics to address non compliance with hand hygiene and cleaning schedules. The IP will re launch a Hand Hygiene campaign in Jan 14 in tandem with the Local Authority and the CCG using social media to target all groups of public who enter Trust premises.	The Environment Group will report by exception those areas failing technical environmental audits. Hand Hygiene reports will be reported to Infection Prevention & Control Group (IPCG) by the Inefection Prevention Lead Nurse. Matrons will monitor and understand the technical and nursing audits for the environment and escalate as necessary.	CNO	Infection Prevention Lead Nurse/Matrons/ Head of Estates	Infection Prevention & Control Group (IPCG)	IP and Estates have launched a declutter programme in conjunction with wards. Re launch of five momnents and robust monitoring through IPG. Five moments and audit results of the environment will become available in Jan 14	Dec-13	Awaiting reports from de clutter programme IP/Hotel services
	Robust IP programme and work plan is in place	A review of practice by the TDA	TDA will support and ensure current practice	CNO	IP Lead Nurse	IPCG		Dec-13	TDA have provided support to IP in a walk round
	OPD 1 already identified for refrubishment and funding identfied. Work to commence Jan 14. Viewing room identified to Estates Development as requiring review for refurbishment. A Capital programme group is already in place and this group will provide information to TMC for priority areas for refurbishment.	Commence refurbishment in OPD and plans for viewing area of mortuary. Identify areas for redecoration and minor works to upgrade as priority.	An approved, prioritised plan for refurbishment will be approved at TMC	COO/CNO	Head of Estates Development/IP Lead Nurse	Trust Management Committee (TMC)	Funding approved to refurbish OPD1	Apr-14	
	Wards have a list of bed space equipment available and the opportunity to declutter regularly. Mini PLACE audits take place twice a week using a rolling loist of wards to ensure the environment is fit for purpose and will pass the annual PLACE inspection	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.	CNO	Ward Sisters with support from Housekeeping	Environment Group	Decluttering in process however audit of environments not available untill Jan 14	Jan-14	Mini PLACE audits in place already between senior ward sister/charge nurse and housekeeping. Reports need to be formalised and reported on
	WRVS Café opening times (sporadic) in OPD	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	COO	Head of Hotel Services.	Environment Group	Discussion with WRVS have taken place and café opening times are now posted for the public. Vending facilities are available	Feb-14	
	Resource of information available for patients and public through the Patient Information Centre	A review of patient information available in outpatients	Patients will report easy access to information and peer review will confirm evidence	COO	Patient Experience Lead and Matrons for OPD (KA and LB)	Patient Experience Forum (PEF)	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	Feb-14	
	Safeguarding lead for the Trust	More evidence of how to identify safeguarding issues in outpatients	Evident in peer review of safeguarding posters and information in OPD.	COO	Matrons for OPD	SVA/JHSCG	Safeguarding information is available in OPD and training is complete	Dec-13	
	Dedicated cleaning schedules for OPD	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	CNO	Head of Hotel Services/IP Lead nurse	Environment Group	In place	Dec-13	
	One lift is in place between surgical wards and theatre	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	CFO	Head of Estates Development/ Head of Estates	Environment Group	Dir of Estates Development has confirmed designation of lift Awaiting confirmation of notices in place	Dec-13	
	A policy for transporting patients in chairs and beds is in place	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.	CNO	Ward Sisters and Matrons	Senior Nursing Operational Group	Policy reviewed and reinforced by ward staff and head of portering	Jan-14	
	A Viewing area separate from the main hospital with parking spaces outside.	A review of the viewing area is required to consider how best to reflect relatives needs and update into a more appropriate setting. Dedicated parking available to those who come to view the deceased. Provide an appointment service and have designated staff available from Bereavement Service for relative to view the deceased.	A viewing room that has been refurbished and is updated to reflect modern standards of care post bereavement.	CFO/COO	Head of Estates Development / Head Biomedical Scientist - Cellular Pathology Department	TMC	Case put forward for costing of refurbishment of viewing area proposed by manager for mortuary.	Jan-14	Confirmation pending from Estates Development on refurbishment of viewing area
			A formalised practice where all relatives who are seeing their loved one in the viewing room are supported by an appropriate member of Trust staff	COO	Division 1 Group Manager Surgery/ Heads of Nursing	QSAG	Outline procees changed proposed, to be formalised with line manager	Jan-14	Pending policy changes due to be ratified Feb 14

December update

Patient Feedback

Key communication: We will encourage and actively seek out patient and public feedback in order to evaluate and continuously improve standards of care.

Problem	Actions in place already	Actions required	What does success look like	Executive Director	Lead	Governance	Update on actions	Timeframe	Evidence to support actions. RAG Rating
Limited information to patients regarding how to complain.	Task and Finish group (Clwyd/Hart report)	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 areas 5. 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.	CNO	Patient Complains Manager/Head of Education and Training	QSAG		Feb-14	Group formalised with terms of reference
Low compliance to complaint response times	The divisions receive weekly reports detailing complaints and delays in process. This is provided by the Complaints Service Manager	Directorates to clarify how complaints are processed within each directorae and clarify who is managing the final response.	100% of complaints responded to in a timely way and open complaints not already closed by day 25 will have the complainants consent as per policy. DDivisions will be able to report on compliant themes and trends at their directorate governance meetings.	COO	HoN/M	Directorate and Divisional Governance Meetings.	Monthly trackers sent out to Divisions. Agreement being reached on when a complaint is closed down following multiple correspondence	Feb-14	
Not all Staff understand chatback.	Chatback in place and HR resource to manage this	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	HR Director	Deputy HR Director	Workforce Assurance Group		Feb-14	
Information about quality and performance in complaint responses not readily available in each ward	PALS in conjunction with CBP workstream trialling system for providing patient information and performance and quality on every ward	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	CNO	PALs	Patient Experience Forum (PEF)	Each ward is receiving core information about quality and performance all wards will have this by Jan 14	Feb-14	
Signage considered poor	Clear directions now in place in every entrance	Develop 'tear off maps' of the hospital site to enable public to work out where to go and to encourage staff to help direct. Provide wayfinders on every entrance at peak times 5 days a week and at visiting time.	Patients will comment on ease of finding wards and departments. All appointments and communication to patients will include up to date information on the location of the appointment in the new format.	CNO	Head of Patient Experience and Volunteers Manager	PEF/PSIG		Feb-14	
Incidents where call bell unanswered.	Patients Voice captures patients views on call bells and prompt response enabling us to monitor it monthly by ward and publish results.	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	CNO	Heads of Nursing and Matrons	Patient Safety Improvement Group (PSIG)	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	Jan-14	
Delays in the provision of pain relief at night time on surgical wards	Dedicated resource of an acute pain nurse to provide education for staff particularly at night. Data available from patients using vitalpac pain score and response and also data from Patients Voice	Closer monitoring of acute pain rmanagement on surgical wards. Data will be provided through Patients Voice, dedicated audit of patient experience on surgical wards and through analysis of data from VitalPac.	Patients in surgical wards will respond positively to Patients Voice **'Do you think the hospital staff did everything they could to help control your pain?'**	CNO	Head of Nursing Division 1, Matrons for Surgery and T&O/Patient Experience Lead/Acute Pain Nurse	QSAG	Monitoring of pain through the Patients Voice is in place and is to be presented as a report for Feb QSAG	Jan-14	

December update

Mental Health

Key Communication: All staff will understand the key criteria to use for dementia outreach referal and use of the dementia care pathway.

Problem	Actions in place already	Actions required	What does success look like?	Executive Director	Lead	Governance	Update on actions	Timeframe	Evidence to support actions. RAG Rating
Staff safety concerns re existing designated room for Mental Health patients.	Conflict resolution training is provided to all staff. Mental Health awareness training provided for A&E staff	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.	COO	HoN/DMD Division 2	Emergency Department Directorate Meeting	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.	Feb-14	
Inconsistent Dementia care provision and access to Dementia outreach team.	Dementia care bundle developed and consultant nurse and outreach team in post. Dementia care training developed.	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.	CNO	Nurse Consultant for Dementia with HoN Division 2	Rehab and Ambulatory Medical Group Governance Reports monitor activity of Dementia Outreach and audit of use of dementia care bundle. Report quarterly to PSIG.	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.	Feb-14	
Specialist staff to support children with learning disabilities not available.	Learning disabilities nurse in post and available for teaching/advice and support across all services. Inpatients services have access to Autism Nursing services provided by LA	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.	CNO	RWT Head of Nursing (Safeguarding) / Learning Disability Nurse	SVA/JHSCC	LD Nurse in post across all specialities and haas highlighted provision of LD advice in every speciality as minuted in governance meetings	Feb-14	

December update

End of Life

Key Communication: Our staff will make sure patients and their relatives are aware of their 'Do Not Resuscitate' status and ensure bereavement is handled sensitively and with compassion. Bad news will be broken by the most appropriate health care professional and again with sensitivity and compassion in a suitable environment.

Problem	Actions in place already	Actions required	What does success look like?	Executive Director	Lead	Update on actions	Governance	Timeframe	Date Achieved per action
Relatives of the bereaved find the bereavement service business like and lacking in compassion.	A dedicated bereavement office in the centre of the hospital. Information from Bereavement Services is available for families. Bereavement services staff as part of General office resource who manage bereavement.	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 be asked to comment on the service provided and report a positive experience.	COO (Management of bereavement services/General Office part of Division 1)	Group Manager Surgery/Head of Patient Services		QSAG	Feb-14	
Documentation of DNAR demonstrates lack of involvement of the patient, their family and medical signature.	Monthly live record check, Annual DNAR policy audit.	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.	Medical Director and Divisional Medical Directors.	Divisional Medical Directors		Divisional meetings will report directorate compliance with local live records check. Report through to PSIG	Mar-14	
	Monthly live record check	Ensure all members of the multidisciplinary team consider the patient's DNAR status with the patient and their family and that this is documented fully in the clinical records.	All of the MDT understand the need to obtain compliance with DNAR and to confirm discussions with family/patient are documented	Medical Director and Divisional Medical Directors.	Divisional Medical Directors		QSAG	Mar-14	
Improvement needed in how staff in particular junior doctors, break bad news to patients.	Breaking Bad news policy within approval process	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.	CNO/MD	DMD/HoN/Head of Education & Training	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.	QGAG	Feb-14	