Our Improvement Plan – responding to the Care Quality Commission Report

March 2015

Richard Samuda, Trust Chairman
Toby Lewis, Chief Executive

Version as at March 26 2015 – Not yet approved with CQC

The plan is a live document, and will be adapted based on feedback

Room for improvement

Tackling must and should dos | By October 2015

- **No denial**: We are committed to addressing each CQC requirement and recommendation. Where we believe that the issue goes beyond the domain or service identified by inspectors, we will tackle the issue on a Trust-wide basis. Many of the issues were highlighted to the CQC by Trust leaders.
- **No delay**: There are a small number (13) of requirements which are already completed. The balance will be addressed either by the end of June 2015 (30) or by the end of October 2015 (26) (i) . Routine monitoring of the Improvement Plan will occur at the Board and throughout our structure. Our website will provide public information on delivery. If we fall behind, we will be open about that and explain why.
- **Maximising participation:** We want to involve patients, partners and colleagues employed by the Trust in identifying the solutions to the issues raised, and in continuing to work with us to identify and address concerns about care – especially in the responsiveness, leadership and safety domains.
- **Sustaining improvements:** We have invested in a major three year leadership development programme supported by the Hay Group, which is just less than one year old. During 2015-16 we are prioritising reforming our corporate functions to better support local clinical leaders with the data and time-efficient processes needed to develop stronger middle management cultures on a multi-professional basis.
- **Listening into Action:** We have a longstanding commitment to hearing the views of all involved in providing care and acting on that feedback. We intend to build on that tradition, and become better at spreading the learning from improvement across our organisation's many sites and teams.

(i) Where our improvement plan specifies several actions, the data used is the last one that is cited. So more actions are imminent than this proportion suggests.

The big themes identified in the report

5 priorities to address | Work has already started

i. We need to be **better at learning across our organisation**, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust

ii. We need to ensure that we **consistently deliver the basics of great care**, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time

iii. **We need to tackle our sickness and vacancy rates** if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.

iv. We need to **build on our best practice around local management and leadership**, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way

v. We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – **we know where our issues are, and need to address them more quickly when they are identified**

Accident and Emergency [1/3]

What the CQC has told us we need to improve
How we are responding

Learning from incidents and errors is not taking place which means they could recur. There was a risk of less 'serious incidents' not being reported by doctors and as a result trends missed

Reporting rates among nursing, medical and admin staff in A&E are high. These incidents are examined at executive, group, directorate and team level.

Incident reporting data will be incorporated into medical appraisal during 2015-2016 to help identify any employees who are unaware of, or not engaging with, the reporting system **(October 2015**).

[Director of Governance]

The absence of some safety audit data, such as hand hygiene spot checks and the negative findings from some audits such as storage of medication, were not followed through to improve patient safety

In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)**

Safety audit data will be reviewed during our Quality Improvement Half Days. **(June 2015)**

We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)**

[Chief Nurse]

Isolation procedures not being effectively followed by staff

Visual prompts, including notices on rooms and cubicles, are being put in place to prompt the behaviours our policies and best practice require **(March 2015**).

The Infection Control team are carrying out unannounced visits to check that procedures are being followed. **(October 2015)**

[Chief Nurse]

There was a lack of a system for safe medicine storage

We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency departments **(June 2015)**

In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)**

[Chief Nurse]

Accident and Emergency [2/3]

What the CQC has told us we need to improve	How we are responding
There were systems in place to assess and respond to patient risk including using nationally accredited systems to identify early any deterioration in a patient's condition. Systematic gaps in some patient records were noted.	The Trust uses a standard system, and gaps should not arise. Our retrospective data on care in ED is among the best in the W/Midlands. Record keeping standards have been reissued to teams and will be audited on a sample basis each month starting from March 2015 **(June 2015)** *Note link to other should do recommendation* [Chief Nurse]
A review of governance arrangements in relation to supporting the A&E department to more consistently achieve the national 4-hour target.	All employees working in A&E will be issued with written explanations of the governance processes, and local induction will include that briefing **(March 2015**) A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the executive team with a specific brief to ensure multi-professional learning **(March 2015)** [Chief Operating Officer]
The management of governance arrangements in the A&E department.	We will use the new monthly Quality Improvement Half Days to share learning and improve patient care. Participation and attendance is centrally tracked and we will report ED participation through our weekly Emergency Care scorecard, which is widely disseminated among senior clinical leaders. **(June 2015)** [Director of Governance]
Inter-professional relationships within the A&E department must continue to improve.	A bespoke development programme that began in December 2014, supported by Hay Group and our Learning Work Team, is in place. It will take several months to evaluate the impact of this major initiative. **(October 2015)** [Chief Operating Officer]

Accident and Emergency [3/3]

What the CQC has told us we need to improve
How we are responding

What the CQC has told us we need to improve	How we are responding
There is a need to consider what the systemic gaps in the use of patients' early warning score records are indicating about usage of this tool.	The Trust has committed to tackled sepsis, and will meet the new national CQuin which commences assessment monitoring in ED. **(October 2015)** We are exploring implementing in Q1 15-16 the same VitalPacs system we have in place in our acute wards to track remotely and centrally vital signs monitoring status. **(June 2015)** [Medical Director]
Some analysis of staff practice of relying on patients' relatives for language interpretation, and what impact this has on the accuracy of assessment of a patient's condition should be considered.	We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients. **(June 2015)** [Chief Nurse]
Better promotion of the Trust's complaints policy and procedure in the A&E department.	We now have posters and leaflets available in different languages within our A&E departments that explain how people can make a complaint or raise a concern. **(March 2015)** [Director of Governance]
Multi-disciplinary communications within the A&E Department at City Hospital.	A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the executive team with a specific brief to ensure multi-professional learning **(March 2015)** [Chief Operating Officer]

Medical Care [1/2]

What the CQC has told us we need to improve
How we are responding

The Trust should take action to improve the compliance with staff's mandatory training targets.

In 2013-2014 the Trust attained mandatory training coverage that the CQC have advised is more than sufficient.

In 2014-15 we have revised our training models to reduce time away from clinical practice. We expect by October 2015 to be consistently achieving 90%+ in all domains. **(October 2015)**

New arrangements to tackle trainee doctor recording compliance issues are in place within the Trust, which will improve delivery among medical staff. **(June 2015)**

[Director of Organisational Development]

The Trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion.

Fluid balance assessment (sic) is one of our Ten Out Of Ten. We are overtly committed to ensuring that this occurs, and data on nutrition and hydration within the Trust does not suggest a systemic difficulty. Ten Out Of Ten encourages patients and relatives to highlight concerns immediately or escalate them to the Chief Nurse.

Sample auditing of Ten Out Of Ten commences from May 2015, and we will ensure data on this issue is routinely reviewed during the first six months of 2015-2016 by the Nurse Executive, as part of our ward support programme. **(October 2015)**

[Chief Nurse]

The Trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.

We have worked with our Matrons over recent weeks to make sure care documentation is complete, person-centred and up to date. We will hold a staff engagement event in May to explore ways of further individualising and personalising care planning. **(June 2015)**

We will undertake structured reviews of individual case notes to assess both documentation completion and the accuracy of those care plans against delivery – as we did in January 2015 on D26. **(October 2015)**

[Chief Nurse]

The Trust should ensure all patients are aware of and in agreement with their treatment plan.

This is one of our Ten Out Of Ten, and so will audited routinely. Care planning documentation is being changed to provide additional prompts to patient signature and confirmation of planning consent. **(June 2015)**

[Chief Nurse]

Medical Care [2/2]

The Trust should ensure all medicines are stored in accordance with Trust procedures

This is already our policy, and ward pharmacists will be asked to report any discrepancies or innovations that have not been risk assessed **(March 2015)**

We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency departments **(June 2015)**

[Chief Nurse]

Surgery [1/2]

What the CQC has told us we need to improve
How we are responding

The Trust must take action to ensure that general surgeons have up-to-date job plans.

Retrospective analysis does not suggest material deviation against in place plans.

Job plan final offers to in post general surgeons have been issued by the Medical Director and Group Director of Operations. Even if these go to regional appeal they should be in place by the end of Q1. **(June 2015)**

A revised configuration for acute surgery has been subject to a CCG-led public listening exercise with a view to reconfiguration of emergency provision from August 2015. The job plan offer above already makes a second-stage proposal on how this would be reflected in future job plans. **(October 2015)**

[Medical Director]

The Trust must take action to ensure that hand hygiene is carried out appropriately by all members of staff across the Trust at all times.

In March we launched our 'OK to ask' campaign to support staff in challenging behaviours. **(March 2015)**

The numbers of hand hygiene audits has increased and are now undertaken by ward managers and matrons. Results will be displayed at ward and theatre level. **(June 2015)**

A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue. **(October 2015)**

[Chief Nurse]

The Trust must take action to ensure that a suitable system is in place to ensure that patient records are kept secure at all times.

Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)**

Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)**

New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015)**

[Director of Governance - SIRO]

The Trust must take action to ensure that a suitable system is in place to regularly assess and monitor the quality of postoperative surgical care.

A review of existing data does not suggest that that there is extant risk, bearing in mind that complication data is locally assessed and mortality reviews take place consistently.

A post-operative standard care bundle is being developed, for consideration by the Clinical Effectiveness Committee. This will be widely discussed within our Quality Improvement Half Days. **(June 2015)**

Implementation of the bundle during Q2 will be part of our autumn audit programme. **(October 2015)**

[Medical Director]

Surgery [2/2]

What the CQC has told us we need to improve
How we are responding

The Trust should ensure that a safe system is in place, which all surgical staff have received appropriate training in, to safely book patients into the theatre suite and record same.

- The booking systems for our emergency theatres are via a standardised whiteboard. The Standard Operating Policy for that process will be reissued to all three surgical groups' staff during April. Wait times for emergency surgery are already tracked at senior level within the Trust and published **(June 2015)**
- Booking systems for elective booking, following our October 2013 Never Event, were re-designed and guidance was reissued to staff late in 2014. Error rates and near misses are tracked and a month's data for April will be presented to the Clinical Leadership Executive in May**. (June 2015)**
- Our new operating standard is to 'lock down' elective theatre lists one week prior to session. Compliance with this approach will be tracked and systems re-designed to meet this routinely through Q2**. (October 2015)**

[Medical Director]

The Trust should ensure that the World Health Organisation (WHO) surgical safety checklist and preoperative briefing follow the WHO guidelines. The Trust should ensure that staff know what is expected of them and that the checklists are assessed and monitored for quality.

- There is no ambiguity that the Trust complies with this standard, which is already monitored through three different audit methods.
- We have removed the need for staff to sign the WHO surgery checklist, which goes beyond WHO requirements. The new form goes into place at the start of April. **(June 2015)**
- Observational audit of team behaviours around the checklist will become routine for 2015-2016, with all theatre sessions visited at least once over that period **(October 2015)**
- ur highly successful video reflexivity project to allow teams to discuss their approach to working together will be rolled out from eye theatres, across general adult theatres. **(October 2015)**

[Medical Director]

The Trust should consider improving the environment in the pre-assessment unit at **City Hospital** because it is not patient friendly, has inadequate staff facilities and does not promote patients' dignity.

A risk assessment of this environment has been completed. The results of that assessment and any remedial work will be considered in April against competing priorities within our capital plans. **(June 2015)**

[Director of New Hospital Project]

The Trust should consider reviewing its process for booking bank and agency staff. The current system does not flow as the Trust expects it to, and it obstructs staff in ensuring that shifts are staffed safely.

- Fill rates are tracked using the Safe Staffing tool. This does not substantiate the supposition from the CQC. No central system for approval of bank staff was in place when the CQC visited the Trust, nor before or since.
- We moved approval of agency staffing back from Executive (started July 14) to Clinical Group level in December 2014. The Trust Board is monitoring whether this devolution is consistent with good practice Trustwide and continued control of agency use. **(March 2015)**
- Late requests arise through sickness and rostering practices. Both are subject to extensive change work within the Trust, and central monitoring of e-rostering now provides comprehensive data on ward management of workforce issues. **(June 2015)**

[Chief Executive]

Children and Young People [1/3]

What the CQC has told us we need to improve
How we are responding

The Trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed. Staffing skill mix and support on some shifts within the clinical areas were not always meeting national best practice guidance.

Our staffing in paediatrics was reviewed in September 2014. It has been re-examined since. It meets all mandatory national guidance.

We will consider whether there is a case to go beyond current staffing as part of examining our future workforce plans for the Trust. **(October 2015)**

[Chief Nurse]

The Trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.

We already have at least one member of the on-call medical team with APLS qualifications at all times. We make sure that there is always a doctor or nurse on duty with APLS qualifications.

We will fund additional training time for paediatric nursing staff in this area **(June 2015)**

[Chief Nurse]

The Trust must ensure that staff receive appropriate training including mandatory training updates and supervision.

Our training plans and budget are openly displayed Trust-wide. The Board's Workforce and OD committee will review the 2015-2016 plan for paediatrics to ensure that it is satisfied with the sufficiency of proposals coming forward from local leaders**. (June 2015)**

[Director of Organisational Development]

The Trust must ensure that all records are kept securely for the purpose of carrying on the regulated activity.

Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)**

Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)**

New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015)**

[Director of Governance]

Children and Young People [2/3]

What the CQC has told us we need to improve
How we are responding

The Trust must ensure that there is an accurate record in respect of each child that includes appropriate information and documents in relation to the care and treatment provided to each child	The Trust should consider retraining staff in infection prevention practices
Paediatric Matrons and the specialty Clinical Director will ensure that this issue is discussed during May's Quality Improvement Half Day to understand any constraints that staff feel exist in achieving this basic standard. **(June 2015**) A specific audit of the accuracy of paediatric record keeping will be included in our Clinical Audit Plan for 2015-2016. **(October 2015).** [Chief Nurse]	Our focus on infection control is Trust-wide and data does not suggest a specific elevated risk in children's services. We will not be undertaking re-training en masse, other than where individual performance is identified as an issue. In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)** [Chief Nurse]

Maternity and Gynaecology [1/3]

What the CQC has told us we need to improve
How we are responding

The Trust should display the results of safety checks prominently so that the information is accessible to staff, patients and visitors.	The Trust should take active steps to ensure that all staff consistently follow best practice guidance in relation to hand cleansing and infection control dress code.
We will ensure that our measures boards in both maternity and gynaecology reflect our Trustwide standards **(March 2015)** We will undertake listening and survey activity with families to understand if there is additional data on our performance that they would value being displayed. **(June 2015)** [Chief Nurse]	In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)** A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue. **(October 2015)** [Chief Nurse]
The Trust should ensure that resuscitation equipment is checked daily in keeping with best practice guidance provided by Resuscitation Up 2010 in all areas.	**The Trust should ensure that all medication on the maternity unit is securely stored at all times.**
We provided daily check data to the CQC in responding to their report in draft. We will monitor during the first three months of the new year data and report the results to our Patient Safety Committee of the Clinical Leadership **Executive (June 2015)** [Chief Nurse]	We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency Departments **(June 2015)** [Chief Nurse]

Maternity and Gynaecology [2/3]

What the CQC has told us we need to improve
How we are responding

The Trust should consider placing the record keeping on the Trust risk register to ensure that monitoring occurs at the highest level of the organisation.	The Trust should consider separating out the number of hospital-acquired pressure ulcers into specific wards so that action can be targeted accordingly.
We will consider a risk assessment on this issue at April's Risk Management Committee. Review since the visit does not suggest that this would merit a risk entry above 12 which is the trigger for Board escalation. **(June 2015**) [Director of Governance]	We have been doing this for the past three years (it is required nationally too). The data can be viewed on request as reported to the CQC in our Factual Accuracy response to their draft report. No such data was requested during the inspection visits. The Trust Board will continue to monitor pressure ulcer information at specialty level, adding a further data item to our Board reports for any ward reporting more than one pressure ulcer in a given month. **(June 2015)** [Chief Nurse]
The Trust should investigate further ways of improving communication for women who do not understand English.	**The Trust should ensure that staff who are expected to translate are provided with the skills required to carry out this function well.**
We have a full translation service in place presently. In addition we are going to review maternity information for patients to see what gaps can be identified. We will also develop a range of audio-visual support guides. We will identify best practice from other areas and work with different community groups to make sure our information is comprehensive and available in the right formats and languages. **(October 2015)** [Director of Communications]	None of our staff are 'expected' to translate. We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients. **(June 2015)** [Chief Nurse]

Maternity and Gynaecology [3/3]

What the CQC has told us we need to improve
How we are responding

The Trust should consider improving how the outcome of an investigation and resulting action are communicated to complainants.

Improving complaint response times, complainant's reported satisfaction with the process and reducing subsequent complaints are priorities at Board level in the Trust – complaints are falling. We are aiming to resolve more complaints through face to face resolution meetings. All complainants receive a detailed written response scrutinised at executive level.

We are introducing new approaches to try and involve complainants in examining whether our actions to tackle the issues they highlighted have been effective. **(October 2015)**

[Director of Governance]

The Trust should consider updating all midwifery staff about the rationale and outcomes for 'high-risk' women who choose to give birth at the midwifery-led units, so that all staff can be confident that the maternity service promotes the best emotional and physical outcomes for women and babies.

The dataset implied by the CQC will be routinely shared within maternity services over the coming year **(October 2015)**

[Chief Operating Officer]

The Trust should consider ensuring that all risks and issues of high concern are included on the corporate risk register to ensure that senior directors are aware of the progress in reducing and managing the risk.

- All group risk registers are reviewed at the Executive-led Risk Management Committee. Risks are escalated as appropriate to our Clinical Leadership Executive and to the Trust Board. Three Executives are members of the Risk Management Committee and have sight of these registers (all our registers are now published on our Trust Intranet).
- A list of all pre-mitigated 'red' rated risks is shared with our Clinical Leadership Executive and the Trust Board.
- We will make this our standard every three months. **(June 2015)**

[Director of Governance]

The Trust should find a way of increasing feedback about working for the Trust from obstetric and midwifery staff.

- We run the largest staff survey programme in the NHS, asking teams their views every three months. We openly encourage staff to share their feedback about working for the Trust. In March we ran a second series of "Time2Talk" open staff sessions with our Chief Executive and Executive Team for employees to raise any issues of concern or hear about the work of the Trust. We share the CQC's concern about low engagement among our midwives.
- We will hold a specific open event for the Women and Child Health group in May 2015. **(June 2015)**
- We will use the Kirkup Review, within our Quality Improvement Half Days, to develop a specific response plan for maternity services at the Trust. **(June 2015)**

[Director of Organisational Development]

End of Life Care

What the CQC has told us we need to improve
How we are responding

The Trust should schedule repairs to the previously reported cracked concrete floor in the mortuary. This presented an infection control risk and did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

This was resolved in December 2014 (i.e. before the report was received by the Trust) **(March 2015)**

[Director of New Hospitals]

The Trust should review the hospital discharge processes. These have an impact on patients' ability to achieve their preferred place for end of life care and fast-track discharges. This is contrary to national best practice guidance including *One chance to get it right*, Department of Health, 2014

We have made significant progress on this issue over the last three years. A Trust-wide piece of work, led directly by the Trust Board, will analyse the last year of life of palliative patients for additional improvements. When we have the outcome of that audit the Board will oversee a focused improvement plan in this area. This is identified as a priority in our Annual Plan for 2015-16**. (October 2015)**

[Chief Operating Officer]

Review how the reduced chaplaincy services can continue to provide a caring and responsive service to patients when required. The reduction in these services is contrary to national guidance including the NICE *Quality standards for end of life care*, 2011, updated 2013.

The chaplaincy service was included in the staffing consultation undertaken in October 2014. In November 2014 we took the decision not to proceed with changes outlined in that consultation. There will be denominational changes, but we remain consistent with the guidance cited, and guidance issued last month to the NHS as a whole. **(March 2015)**

[Chief Nurse]

The Trust should ensure processes are in place to ensure that doctors consistently complete 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms correctly in line with national guidance published by the General Medical Council.

- Using our extant IT system which centrally records those inpatients with a DNACPR order, we will comprehensively test, ward-by-ward, week-by-week, whether we have accurate information held locally. This analysis will be made available on an ongoing basis to the Chief Executive, and through him to the Board. **(October 2015)**
- In March we launched a 'OK to ask' campaign to support staff in challenging behaviours. This asked teams to examine whether at local level they know the DNA CPR status of all their patients. **(March 2015)**

[Chief Nurse]

Outpatients and Diagnostic Imaging [1/3]

What the CQC has told us we need to improve
How we are responding

The Trust should ensure that communications to staff about workforce changes are timely, clear and consistent.

The CQC visited the Trust during a consultation period, accordingly proposals were developing and being developed based on feedback.

Having examined the specific outpatient and diagnostic imaging concern it is clear that open team meetings were sparse in some areas. The introduction of Quality Improvement Half Days from April 2015 should resolve this issue in key clinical support departments. We will use Your Voice to test the outcome. **(June 2015)**

[Chief Executive]

The Trust should ensure that the outpatient risk register captures all known risk issues.

The publication of the risk register online from December 2014 will allow all staff in all departments to check the accuracy of entries.

The new Quality Improvement Half Days commencing in April 2015 will provide an opportunity for multi-disciplinary review and learning regarding potential and actual risks. **(June 2015)**

[Chief Operating Officer]

The Trust should ensure that support for people with dementia and learning disabilities is available in the outpatients department.

November 2014 was learning disabilities month Trust-wide. This was an opportunity to promote Reasonable Adjustments in all clinical areas. We have asked Changing Our Lives to examine our practice for LD and advise us on any further changes and improvements required. **(June 2015**)

We are actively exploring how to put memory loss scoring methods into key relevant outpatients departments. Part of that work will be providing additional training and support to outpatient staff. **(October 2015)**

[Chief Nurse]

The Trust should ensure that the planned review to assess the current and future capacity in outpatients is undertaken urgently so that the findings can inform the current change programme

It is not factually accurate to state that the staffing consultation in October 2014 took place without an understanding of future capacity.

Our annual capacity planning exercise, using the Intensive Support Team template, is being finalised. This will be the basis for distinguishing backlog supply from routine capacity. We will monitor volumes against this capacity quarterly **(June 2015).**

[Chief Operating Officer]

Outpatients and Diagnostic Imaging [2/3]

What the CQC has told us we need to improve
How we are responding

The Trust must maintain adequate records regarding the qualifications and training of imaging department staff.	The Trust must ensure guidance be available for imaging staff regarding exposure parameter guidance or information surrounding expected dose values.
We hold full records already on qualifications of imaging staff and have extensive training in place. Full competency assessment records were found to be missing and we have an action plan in place that we submitted to the submitted to the CQC in November 2014 that will ensure we are fully compliant by **March 2015** (three months ahead of the compliance notice sent to us in January 2015 for resolution by July) – March 2015. [Chief Operating Officer]	This was largely in place at the time of the CQC visit and is now fully implemented. **(March 2015)** [Chief Operating Officer]
The Trust should ensure that, when complaints about outpatients are resolved at the time they arise, records are kept so that lessons can be learned from the incidents.	**The Trust should ensure that urgent action is taken to improve the privacy of patients in the eye clinic.**
We will introduce a simple proforma to capture these resolutions and share the results across all Outpatient Departments through our Quality Improvement Half Days **(October 2015).** [Director of Governance]	This features explicitly on the corporate risk register, which was provided to the CQC, along with evidence that this has been resolved at Board level. The delay in implementation is because we need to move a third party occupier, which we are working to resolve. **(October 2015)** [Chief Executive]

Outpatients and Diagnostic Imaging [3/3]

What the CQC has told us we need to improve
How we are responding

The Trust should ensure that urgent action is taken to improve the confidentiality of patient records in outpatients, and that patients' privacy and dignity are maintained at all times.

Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)**

Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)**

New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015**)

[Director of Governance]

The Trust should provide Safeguarding adults level 2 training to all staff who run clinics and are likely to have contact with vulnerable people.

Training is provided on the basis described. However, our mandatory training policy distinguished face to face from cascade training. This has now been revised. **(March 2015)**

[Chief Nurse]

The Trust should improve staff understanding and knowledge of responsibilities regarding the Mental Capacity Act 2005.

Mental Capacity Act training and Deprivation of Liberty training is included within Safeguarding Level 2 training. We will update training packages for staff and monitor who has been trained, making sure that people keep up to date with their training and knowledge of this important area. **(June 2015)**

[Chief Nurse]

Community Services: Children and Young People

What the CQC has told us we need to improve
How we are responding

The Trust should have an alerting system for missing children, with links to the MAPPA Multi Agency Public Protection Agency (MAPPA) and multi-agency meeting processes in place to discuss missing children.

We already have this in place through the MASH (multi-agency safeguarding hub) The Safeguarding children's policy review and dashboard will be updated with this detail**. (March 2015)**

[Chief Nurse]

Community Services: Inpatients

What the CQC has told us we need to improve
How we are responding

The Trust should ensure sufficient numbers of staff in the early evening and at night.	The Trust should ensure sufficient supply of hoists resulting in people not having to wait to be transferred at busy times (for example, after meal times and at bed times.)
Staffing levels were examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover**. (March 2015)** [Chief Nurse]	This recommendation was reviewed on receipt. The local 'frontline' staff teams have examined it. They then met with the Chief Executive and recommended no action was taken. That recommendation has been accepted. **(March 2015)** [Chief Operating Officer]

Community Services: Adults

What the CQC has told us we need to improve
How we are responding

What the CQC has told us we need to improve	How we are responding
All out-of-date stock should be removed from clinical areas. The Trust should put processes in place to identify and remove out-of-date stock.	We already have processes in place to do this and will check the compliance in community locations, reporting this to the Board. **(June 2015).** [Chief Nurse]
The Trust should ensure that medication is stored appropriately.	We have begun procurement of sufficient automated dispensaries to cover all our wards **(June 2015)** [Chief Nurse]
The Trust should ensure that community staff are supplied with appropriate equipment when providing care at low levels.	The intermediate care wards have hoists to transfer patients. We also have other equipment available to support patient's rehabilitation. We will complete an equipment inventory for community teams to make sure the right equipment is available at the right time. **(June 2015)** [Chief Operating Officer]
The Trust should complete recruitment processes to fill vacancies across the organisation in a timely fashion.	We monitor the time it takes to recruit staff and fill vacant positions. Currently this takes on average 18 weeks. Meanwhile our completed staffing review means that we can, from April 2015, reduce the time it takes for pre-authorisation on recruitment. It is worth noting that some vacancies are held in a planned way to provide opportunities to 'at risk' colleagues to ensure equality of opportunity. We are revising band 4-6 notice periods to reduce the risk of gaps, in line with practice elsewhere in West Midlands **(March 2015**). [Director of Organisational Development]

Community Services: End of Life Care

What the CQC has told us we need to improve
How we are responding

The Trust should ensure safe staffing levels, particularly at pick-up and drop-off times and times of absenteeism, such as training, annual leave and sickness	The Trust should ensure adequate registered nurse staffing levels on night shifts at the Leasowes Intermediate Care Centre.
A full review of staffing and rostering models at Bradbury Day Hospice will be complete by May 2015 **(June 2015)** [Chief Nurse]	Staffing levels were examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover. **(March 2015)** [Chief Nurse]
The Trust should ensure a variety of activities provided on a daily basis.	**The Trust should ensure reliability of ambulance transport.**
An audit of activities, and survey work on client's views of them, will be completed by the end of May 2015**. (June 2015**) [Chief Nurse]	Ambulance reliability will be monitored and reported to the End of Life Care group (chaired by the Chief Nurse) for six months, so that we can make sure improvements have been made, if that is necessary. **(October 2015)** [Chief Nurse]