Trust Quality Improvement Plan

The Care Quality Commission (CQC) has released its report into Lewisham and Greenwich NHS Trust, following the inspection carried out earlier in the year.

As a new organisation, we welcomed the CQC inspection. It complemented quality assessments we had been carrying out ourselves to ensure we have a good understanding of how our services are performing and to identify areas where we need to improve.

We were pleased to find that there were many positives recognised in the CQC's report. In particular, the inspectors said that we have hard working, loyal and caring staff who are committed to the highest quality of patient care. The report refers to a number of areas of best practice, and it is important we share this positive feedback and build on what we do well.

In other areas, the CQC report is less positive, and we need to work with you and with our partners to address these issues. We will be building on recent progress, including:

- Working with local Clinical Commissioning Groups to improve the emergency care pathway
- Continuing our recruitment and retention campaign to increase our establishment of staff
- Working with staff to improve our rating for hand hygiene compliance
- Continuing partnership work with Initial and ISS around the implementation improved processes for clinical waste.

Over the next month, we will be working with you to develop an action plan in response to all the issues highlighted by the CQC. We look forward to delivering significant improvements for local people.

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INTRODUCTION:

Lewisham and Greenwich NHS Trust is a new organisation, established on 1 October 2013. Lewisham and Greenwich NHS Trust was formed from the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, formerly part of the South London Healthcare NHS Trust, which was dissolved following a decision of the Secretary of State for Health in January 2013.

The Trust has a recurrent turnover of around £460 million and employs around 6,000 staff. We provide a comprehensive portfolio of acute healthcare services to a critical mass of 660,000 people living across the London Boroughs of Lewisham and Greenwich, and the north Bexley area, together with a broad portfolio of community services, primarily, but not exclusively, for those living in Lewisham. Community services are provided across Lewisham and acute services are provided from two main hospital sites, University Hospital Lewisham and Queen Elizabeth Hospital. Some outpatient, maternity, elective surgery, and endoscopy services are also provided at Queen Mary's Hospital, Sidcup, and community services across Lewisham.

Our Trust is based in the South East London health economy, which encompasses parts of the London Boroughs of Lambeth, Southwark, Lewisham, Bexley, Bromley, and the Royal Borough of Greenwich, and is home to a diverse and growing population of c.1.7 million people. While there are areas of relative affluence, it also includes some of the most deprived communities in England. The areas of highest deprivation are those closest to our main hospital sites. Over the next five years, we expect demographic change to drive a 2.3% growth per year in our activity, with the largest absolute growth in younger age bands and the largest relative growth in adults over 85 years of age.

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Many of the improvements that need to be made are the responsibility of the Trust. However, one of the major areas for improvement is the emergency care pathway. For this area, successful improvement needs our actions to fit into the health economy strategy and also needs the support of partners. The relationship between the improvement plan and the health economy strategy is described in the patient flow section, and the support required from partners will be detailed in the work stream plans.

EXECUTIVE SUMMARY

The inspectors arrived on 26 February 2014 and stayed for three days. During their visit, they used 115 pages of detailed data analysis; sought information from some national and professional bodies; asked patients and their families what they thought of the service in well-attended listening events and spoke to staff in focus groups throughout the hospitals during their visit.

Three separate reports were published for the organisation the 13 May 2014. All reports can be found by clicking here. The CQC have five themes against which they assess services – safe, effective, caring, responsive and well led.

This section provides a summary of the findings:

1. Are Services Safe?

The CQC said that our adherence to hand hygiene was poor, putting patients at risk of catching infections. They found that one group of staff were particularly poor at hand hygiene.

They also said that our policies and procedures about dealing with clinical waste were inadequate. The CQC found that members of the public had access to used sharps, that clinical waste bins had been left unlocked and that we had allowed public access to hazardous material.

Where we had equipment in use, some of it had either not been checked or had not been checked for a long time. Other clinical areas told the CQC that they either had no access to equipment, or that equipment was obsolete. The CQC told us that we needed to make sure that staff had access to the proper equipment, and that we were sure that equipment was safe.

The CQC identified areas where the volume of work had increased so significantly that there was little space to care.

2. Are Services Effective?

The CQC told us that the pathways we have designed for patients, from admission to discharge, were not as effective as they could be, leading to patients being in hospital for longer than they would wish and making it difficult to find beds to admit new patients into. The CQC also commented that we did not have enough empty admission beds and that this created blockages elsewhere in our systems.

While we did have sufficient staff numbers to provide safe services in the majority of areas, our staffing levels were a little lower that those needed to provide effective care, that is care that happens when the patient needs it to happen.

3. Are Services Caring?

We take a regular survey of patients which is published nationally called the Friends and Family test. The question is simple – would you, as a patient, recommend this service to people you love? The CQC told us that while some of our areas scored well, other areas needed help to achieve better scores.

The CQC also found that while we had high standards of care and that most of our staff provided care to our standards, there were some members of staff who let us all down. The CQC told us that we needed to help these members of staff understand and implement our standards.

4. Are Services Responsive?

The CQC told us that our pathways and shortage of admission beds were creating blockages elsewhere in our systems, and one of those areas was the Emergency Department, where waiting times were outside the national and local averages. Our facilities at the Queen Elizabeth Hospital meant that long waits were uncomfortable for patients and did not protect their dignity and privacy.

The CQC identified high bed occupancy as leading to insufficient capacity for patients' needs.

The CQC inspection team also found that there were delays and excessive waiting times in our outpatient and radiology clinics which we needed to resolve.

5. Are services well-led?

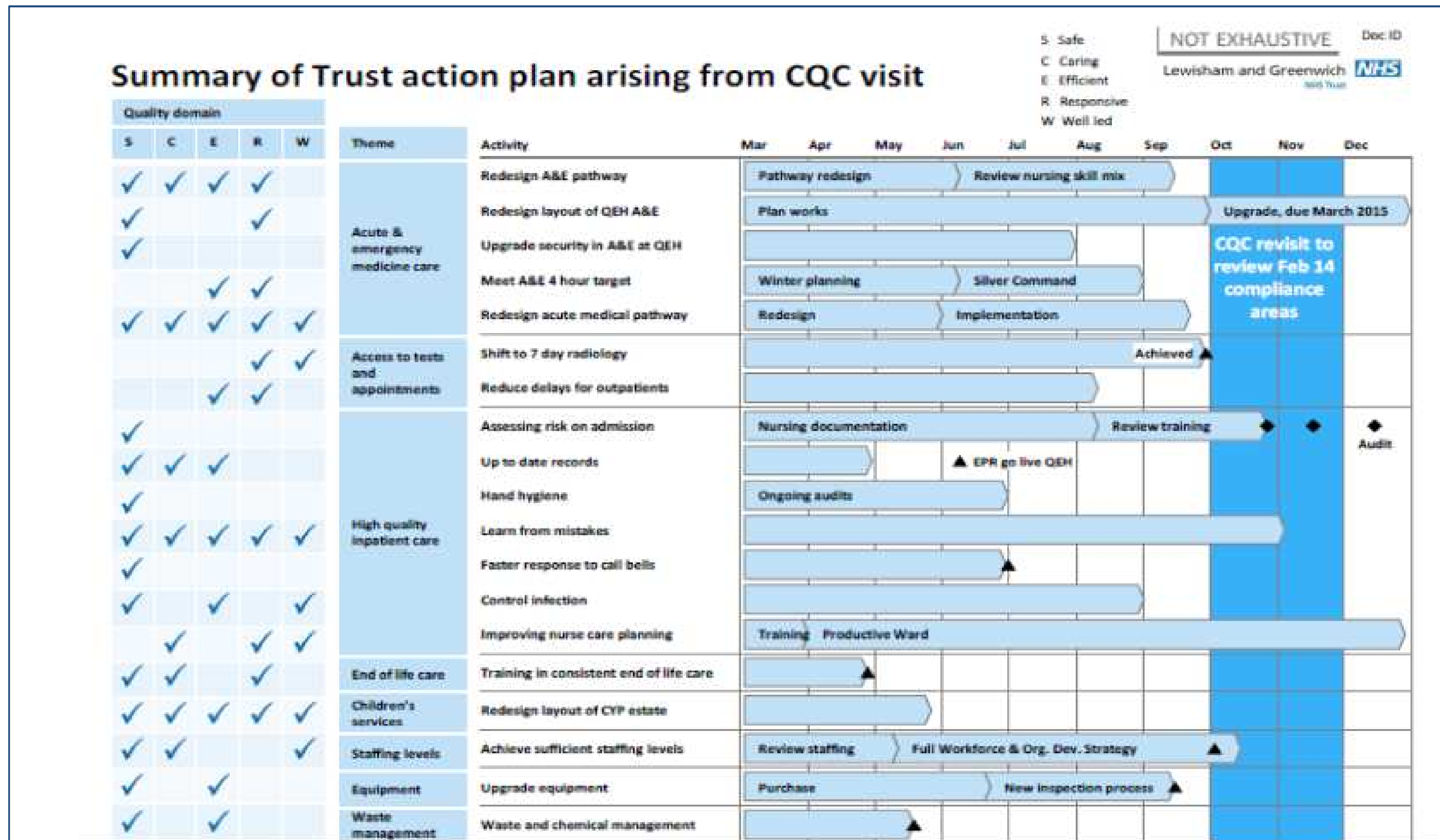
While the CQC identified the need for greater staffing numbers, they acknowledged that shortages of appropriately qualified and experienced staff is a national problem, however they also found that there were barriers to recruitment and retention of staff that hadn't been resolved.

The CQC told us that the non-clinical workforce felt undervalued.

We informed the CQC that our governance teams were integrated during the October merger, however the CQC still found that staff perceived that we were running a dual service and that the arrangements were separate. The CQC told us that this could lead to confusion and ultimately poor reporting.

We have taken four themes from the information the CQC gave us and are using this to make our services as safe as possible, so that we can care effectively, placing the patient at the centre of everything that we do, be responsive to the needs of our patients and their families, all the while improving how we lead and develop our new organisation.

The diagram below illustrates the summary of the Trust action plan arising from the CQC visit



These themes are:

1. PATIENT FLOW

i) Improving the Emergency Department at the Queen Elizabeth Hospital:

The Emergency Department (ED) no longer has adequate capacity for the population of Woolwich and Greenwich, to provide 24-hour care which treats the urgent and emergency needs of adults and children. This has created delays for ambulance patients and ambulatory patients alike.

Our objective is to improve all of the facilities at the A & E department, making sure that ambulances can deliver patients in a safe and timely fashion to obtain rapid assessment and treatment, that our facilities protect the privacy, dignity and independence of our patients and that they are all seen and their problems resolved or the patient journey begun within mandated waiting times.

ii) Improve our patient journey, from admission and ED, through to the transfer to another service, discharge or to the end of life:

Our pathways mean that we are not always effective at moving patients along their pathway to health and wellness. This means that sometimes, patients requiring specialist care experience delays in being assessed, intensive care beds are used for patients who don't need them; operations have to be cancelled as we are not able to move patients from the recovery room back to the ward; some patients who are due to go home have their discharges delayed; patients attending outpatients miss work and have severe delays because of our appointment systems; and that not all of the staff who need to implement end of life care are confident in how this can be achieved well.

Our objective is to review and streamline our pathways for all of our patients*. We will improve the way that we *assess people when they come to hospital, and to work with our community services to significantly improve the pathway for frail older people. We will reduce admissions, and ensure people do not spend avoidable time in hospital by changing processes, behaving as one team across organisations and making better use of community services to provide care and assessment that currently takes place in an acute bed. We will support this with a new model of clinical are for patients who do need to be in acute beds, being seen daily by a consultant 5 days a week and moving to 7 days a week across more wards. We will overhaul the way we plan and manage outpatient appointments to make them more effective. For day care surgery, we will improve the environment, reduce the number of cancelled operations and improve care for patients after surgery. For patients facing the end of their lives, we will strive to make this a better, more peaceful experience.

2. WORKFORCE

i) Improve the numbers and core skills of all of our staff:

In order to make the pathway improvements possible and to provide effective care, we need more appropriately qualified, experienced and enthusiastic staff.

Our objectives are to increase the number of staff, attract more permanent staff to work here; instil our behaviours and values, and keep staff for longer.

3. SAFETY

i) Improve our management of clinical waste:

Unintentionally, we exposed our service users, their families and our staff to hazardous materials, used sharps and clinical waste. We did not have procedures in place which would protect the hospital community and we were not able to assure ourselves that our policies were known to the staff who are tasked to implement them, that staff knew how to handle clinical waste and hazardous materials and that we had live data to show that our policies were being adhered to.

Our objectives are to establish a safe environment, and to assure ourselves that all of our staff have the knowledge, training and experience to maintain that safety for the entire hospital environment.

ii) Improve our hand hygiene compliance:

Although we have hand hygiene policies in place and compliance audits which assess our compliance with the policies, our staff were seen failing to adhere to these.

Our objective is to ensure that all of our staff know and understand what our policies are on hand hygiene and that they need to comply with these policies.

iii) Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability

Not all of our staff had access to equipment and devices necessary to make their work either possible or to simplify tasks for them. Some of the equipment that was available had not been regularly maintained. The CQC were not able to assure themselves that this equipment was safe or accurate. The CQC also had no assurance that the staff using our equipment had the necessary training to use equipment in a manner that was safe for both staff and patients.

Our objectives are to ensure that we continually audit all of our equipment and interrogate the maintenance logs to ensure that we are not using poorly

maintained and potentially dangerous devices. We will then ensure that all of our staff using our devices has been training in their appropriate use so that privacy, dignity and independence are maintained. Finally, we will make the process of ordering and bidding for equipment easier and more transparent so that all of our clinical areas have the equipment levels that they need.

4. ORGANISATIONAL LEARNING

i) Improve the knowledge we share with our staff about our incidents, complaints and the learning gained from them.

We do have governance arrangements across the sites which work well in helping staff to report incidents, accidents, near misses, alerts, patient safety recommendations and complaints. We also have good arrangements to share learning from this with divisions and directorates. The CQC found that although good governance arrangements were in place, they found that we did not have a robust pathway which ensures all learning is shared across the organisation with all members of the staff body.

Our objective is to ensure that staff working most closely with our service users and their families, have access, are able to discuss and utilise the knowledge and learning that comes from these valuable sources.

1. Patient Flow

Action proposal one and two have been merged as it is not possible to discuss changes to the physical layout of the hospital without discussing the plans to alter and streamline the patient flow within the department and discharged either into the local community or to be admitted as an inpatient. Similarly, some of the capacity issues of the Emergency Department, identified by the CQC were as a direct result of inadequate discharge arrangements.

Why this is important.

The CQC found that our Emergency Department (ED) at Queen Elizabeth Hospital was unfit for the number of people that attended on a daily basis. It found that of the constraints volume of patients attending, the physical layout of the department and the lack of capacity, we were unable to attend to ambulance patients in a timely manner and that we could not protect the dignity and privacy of our ambulatory patients. The CQC suggested that some of our practices may put patients and their families at risk from contracting infections carried by other patients.

The CQC found that:

- In A & E, patients were waiting significant amount of time on ambulance trolleys, causing delays in the assessment and treatment of patients.
- People who use services and others were not protected against the risks associated with lack of capacity in A & E
- Capacity and timely response from the A & E service must meet the of the service user. There must be an escalation strategy and cross site working policy.
- Following an incident in QEH ED, where a patient had left the department unnoticed, the Trust had agreed to fit keypad access to prevent a recurrence. This had not happened and there was free access to all areas.
- In A & E, the area known as the grey chairs was being used to treat people, which compromised their privacy and dignity. People being cared for seated in chairs who may have benefitted from being able to lie on a trolley or bed and patients who may have been infectious were being cared for there
- Capacity and timely response from the radiological service must meet the needs of the service user
- Our end of life care seemed to be inconsistent and not all of the staff who had to implement EOLC were confident in doing so
- In the children's department, the layout of the ward made it difficult for staff to achieve constant observation of patients.

Our assessment of the key issues:

- The QEH ED was built to service a projected population but planning did not predict the closure of the ED in Queen Mary's Hospital in Sidcup, which has significantly added to the numbers being seen. There was no additional capacity considered at the time of closure.

- The PFI nature of the QEH site will increase the difficulties in making changes to the physical layout of the ED

Our objectives are:

1. Redesign the ED so as to create an environment which enables the most efficient and effective flow of patients through the department, so that they are assessed rapidly, investigated where appropriate and discharged or placed where appropriate.
2. Join with health economy partners to reduce the numbers using the QEH ED.
3. Ensure that ambulance and urgent patients are seen, assessed and treated in a timely manner.
4. Ensure that our processes and pathways are streamlined for patients who are assessed within the ED, including use of the grey chairs and a defined pathway for gastroenterology patients requiring urgent care.
5. To ensure that we meet and exceeding our mandated targets to achieve excellence in emergency care.
6. Increase the number of senior ED medical staff through improved recruitment, training and job design.
7. Ensure that all of our sites protect the security of our service users.
8. We will ensure that our radiological services have the capacity for timely response to patients' needs.
9. Ensure that our patients facing the end of their lives are cared for in the place they want and in a manner that improves the experience for them and their loved ones.
10. Ensure that we are able to maintain line of site observation of our children and young person service users.

<u>Objective 1: Redesign layout of ED</u>

1.1 The redesign work has commenced with the recruitment of a design team, a redesign plan has been drawn up and planning has commenced for the relocation of main services which currently occupy locations which need to be redesigned. The planning phase is due to be completed by October 2014 and upgrade work to commence in March 2015.

<u>Objective 2: Join with health economy partners to reduce the numbers using the QEH ED</u>

1.2 The Trust has set up a Whole Systems Improvement Group [WSIG], led by the Acute Medicine Division, which involves stakeholders from Trust, Community, Primary and Social Care, to commence the work for admission avoidance and timely, efficient discharge of patients.

This group will focus on extending current initiatives to avoid admissions and will develop new joint initiatives to ensure that proactive discharge from day of admission is the priority and timely discharges occur at all times.

Objective 3: Ensure that ambulance and urgent patients are seen, assessed and treated in a timely manner

1.3.1 The redesign of the ED will incorporate the development of a Rapid Assessment and Treatment Unit [RATU] and Clinical Decision Unit [CDU], this will enable patients to be handed over safely from the ambulance staff to the department. This work has already commenced.

Objective 4: To ensure that we meet and exceed our mandated targets to achieve excellence in emergency care

1.4 To achieve London quality standards for emergency care.

To date the Trust has met nine of the fourteen Emergency Care Quality Standards, continued work with our local commissioning, Primary Care, Social Care colleagues, local Deaneries and Higher Education Institutes will assist in implementing our plans to achieve all the London Quality Standards.

Objective 5: Increase the number of senior ED medical staff through improved recruitment, training and job design

1.5 To deliver the workforce plan on improving recruitment and retention

Please see section on staffing

Objective 6: Ensure that all of our ED sites protect the security of our service users.

1.6.1 We will introduce swipe card access to QE ED

1.6.2 We will introduce swipe card access to QE ED ambulance bay doors

1.6.3 We will review entire department for vulnerability and security and take all of the necessary actions

Objective 7: We will ensure that our radiological services have the capacity for timely response to patients' needs

1.7.1 As part of the Trust's Five Year Strategy, we have committed to rolling our seven day working across a number of specialties.

We have looked at areas which have most impact on the ED department and patient flows and work to shift to seven day working will commence within radiology. This work is already underway and it is aimed to have seven day working within the core radiology services by April 2015.

1.7.2 We will make capital investments in imaging equipment and the supporting technologies.

Objective 8: Ensure that our processes and pathways are streamlined for all of our patients

1.8 Pathways

Acute and Emergency medicine:

1.8.1 A project already underway with the A & EM and McKinsey's is modelling capacity within A & EM, including the Emergency Department. The review has resulted in two business cases – one short term and due for implementation ready for the winter of 2014/2015, the second a long term plan which will be ready for implementation in June 2015.

The scoping of the medical models has commenced and is due for completion at the end of the July with a view to preparing for implementation from July onwards.

1.8.2 The development of specific standards and model pathways has already commenced. These plans include:

- Ensure the use of Urgent Care Triage system
- 100% of patients to have an estimated date of discharge (EDD) within 24 hours of admission
- Daily MDT patient flow board rounds
- Rapid extension of Ambulatory model
- Development of a standard pathway for specialist medicine patients
- Development of pathway for emergency care for gastroenterology patients
- Development of new model for Frail and Elderly
- Development of a Single stroke service post-acute care

1.8.3 Women's and Sexual Health

- Enhanced recovery pathway for elective lower segment caesarean section (LSCS) on the postnatal ward
- Streamlined discharge processes on the postnatal wards
- Outpatient management of hyperemesis and induction of labour in low risk women
- Review of prophylactic intravenous antibiotics given to new-borns on the postnatal wards
- Review of the pathway for women with complex social care needs and whose babies are at risk
- Review of postpartum women who are awaiting court dates as these women can remain on the ward for three weeks
- Safeguarding midwife to collate and share data at senior team meetings on all pregnant women with at risk babies which will include length of stay

1.8.3.1 Capacity will be reviewed three times daily, monitored through the manager on call, with an escalation policy to be applied in times of raised activity and acuity

1.8.3.2 The appropriate pathway will be identified for all women at the booking appointment

1.8.3.4 Discharge planning will begin antenatally

1.8.3.5 We will implement early reviews of women and their babies by the obstetric and neonatal teams

1.8.3.6 We will ensure that there is collaborative working with allied health professionals

1.8.3.7 Monthly meetings between midwives and health visitors to enhance community services

1.8.3.8 General Practitioner open evenings to encourage community access

1.8.3.9 The Multi Agency Risk Assessment Conference (MARAC) will meet quarterly as part of a co-ordinated community response to domestic violence. MARAC attendees include the police, social services, midwives, doctors (both community and hospital based) and other professionals

1.8.4 Surgery, Elective Surgery and Critical Care:

1.8.4.1 On-going 5 year plan with bed reconfiguration

1.8.5 Long Term Conditions and Cancer:

- We will review all of our space for required by our outpatients
- We will use advanced technology to review capacity in outpatients and endure the effective use of space
- We will complete a thorough review of capacity and demand within outpatients
- We will review our Did Not Attend (DNA) rates and establish if there are any Trust made barriers to patients attending
- We will ensure the safety of our most vulnerable patients

1.8.6 Medical Records:

- We will ensure that our staff have the most up-to-date information on patients as possible
- We will reduce the number of temporary patient notes in outpatients
- We will ensure that patients operations and outpatient appointments are not cancelled due to lack of notes

Objective 9: Ensure that our patients facing the end of their lives are cared for in the place they want and in a manner that improves the experience for them and their loved ones

1.9.1 The Trust has developed its approach to phasing out of the Liverpool Care Pathway and has approved the rolling out of the ‘Principles of Care for the Dying Patient’.

100% Palliative care patients to have a plan of care following admission, 100% palliative care patients to have four-hourly reviews documented in their care plans. All staff dealing with End Of Life Care [EoLC] patients to have in-house informal training from the palliative care team.

Across the Trust we will:

- Roll-out of the principles of care for the dying patient
- Sage and Thyme communication training rolled out to all staff
- Our Nursing education team will work with Greenwich Hospice to implement EoLC training
- Ensure EOLC included is in the new Band 5 Preceptorship training
- Complete the DNAR policy review – led by the resus committee
- Develop new pathways for the Fast Tracking EOLC discharges – A & EM and LTC & C to discuss standardising and streamlining discharge process
- Ensure that there is robust Review of after death care – checklist to be created to prepare bodies for transfer to the mortuary, last offices box review
- Review the information available for patients and their families – including a review of the advertisements within the literature

Objective 10: Ensure that we are able to maintain line of site observation of our children and young person service users

1.10.1 This is a difficult issue as the PFI nature of the QE hospital contract will make it extremely difficult to make changes to the physical building specifications. We will ensure that all reconfiguration plans are discussed with are PFI partners.

1.10.2 An increase in staffing numbers will be agreed.

1.10.3 We will review the available technologies to enhance the nurse response to patient’s needs

2 WORKFORCE

Improve the numbers and core skills of all of our staff

Why this is important?

While the CQC agreed that our care was safe, we were criticised for not having sufficient numbers of staff to provide effective care that was responsive to patient's needs. The trust was also reminded that for good quality care to be given, staff had to know was expected of them and we were also tasked to deal with the very few members of staff who let everybody else down. The Trust's values and behaviours will not be achievable without greater numbers of staff, all of whom have who have knowledge, training and confidence to care with compassion.

The CQC found that:

- On some wards, call bells were not answered as there were insufficient staff, particularly on medical wards
- Staff shortages were noted in many areas, and while recruitment plans were in place, these had not yet filled the vacancies
- QEH ED was singled out as there was a staffing review underway but heavy reliance on agency staff
- E-Rostering may be problematic in places and the CQC recommended a review of how E-rostering was being utilised
- Service users were at risk if there were insufficient numbers of suitably qualified skilled and experienced staff
- The trust needed to assure itself that staff with the required competencies were available within all clinical areas
- Insufficient numbers of staff on surgical wards meant that there were sometimes delays in patients receiving their meals
- A significant shortage of appropriately qualified staff was noted in children's services

Our assessment of the key issues:

- There is a national shortage of staff with specific experience and skills, especially in ED and C&YP
- Under the South London Health Trust, many posts, and accompanying expertise, were lost. It has taken some time to recruit back into these roles.
- The E-rostering system was implemented during 2013 and will be reviewed

Our objectives are:

1. Review the staffing needs of each clinical area and each division
2. All divisions have appropriately trained, skilled, experienced and competent staff in place
3. Ensure that clinical directorates and the Human Resource department have a shared objective to improve recruitment and retention
4. Strengthen and diversify the workforce
5. Improve the oversight and deployment of the workforce on a strategic and operational level
6. Increase the number of senior medical ED staff by improved recruitment, training and job design
7. Improve our recruitment and retention processes to reduce reliance on bank and agency staff
8. Ensure that all of our staff members are aware of the high standards that the Trust expects, that they work to exceed the 6C's and the Trust Values and Behaviours

Objective 1: Take time to review the staffing needs of each clinical area and each division

2.1.1 The clinical strategy is now being developed to include workforce requirements to reflect changes to service delivery

2.1.2 Development of the "Safer Staffing" review for nursing and midwifery in line with national guidance

2.1.3 Further specific reviews into job planning for consultants, nursing skill mix, A & EM workforce and EM staffing review. ED staffing review to follow change programme for pathway development by A & EM

2.1.4 Implementation of the safer nursing tool – facilitates the assessment of safe staffing by identifying acuity and dependence allowing real time planning of staffing levels.

2.1.5 Development and Implementation of the Nursing and Midwifery staffing escalation policy

2.1.6 Development and implementation of a Trust wide recruitment and retention plan

2.1.7 We will equip staff with the knowledge and expertise to support the recruitment process

Children's and Young People

2.1.8 The review and improvement plan has increased establishment to 1:4 (completed April 2014)

2.1.9 Escalation policy in place to ensure adequate staffing when staff members are ill – both within hours and out-of-hours

2.1.10 Safer staffing review to include specialist nursing review to care for children with oncological needs

Women's and Sexual Health

2.1.11 Use of the Birth Rate plus calculations and rota model to inform midwifery staffing levels

2.1.12 Minimum levels set at 1:29

2.1.13 Use of the Birth Rate plus calculations and rota model to inform skill mix, monitored daily and escalated appropriately

2.1.14 Shortfalls to be covered by re-deployment before use of Bank or Agency staff

<u>Objective 2: All divisions have appropriately trained, skilled, experienced and competent staff in place</u>

2.2.1 Newly qualified staff will mentored – new preceptorship programme in place – completed May 2014

2.2.2 Band 5 competencies reviewed and implemented with the preceptorship programme – completed May 2014

2.2.3 All other competencies per band are currently under review

2.2.4 Part of the OD strategy is a review of Leadership Development – group and individual development in clinical and non-clinical areas – includes Service Improvement, Transformation and management of change

2.2.5 Practice Development Nurses (PDN's) to be recruited to assist and support clinically based mentorship and learning following a review to ensure alignment with trust and local clinical priorities

2.2.6 The Trust to ensure that clinical staff have access to a wide range of clinical development opportunities via the HESL finding scheme.

2.2.7 Clinical link lecturer to support registered staff on the wards, supporting pre-registration students

2.2.8 All members of staff required to attend yearly mandatory training

2.2.9 Newly qualified midwives undertake a preceptorship programme and cannot progress to the next pay band until all competencies have been signed off.

2.2.10 All temporary staff are required to complete a local induction and self-declare competencies

Objective 3: Ensure that clinical directorates and the Human Resource department have a shared objective to improve recruitment and retention

2.3.1 Nursing documentation pack has been reviewed to ensure that all risks to patient welfare are assessed, reviewed and documented

2.3.2 The Trust Nursing and Midwifery strategy has been launched – highlighting trust values and 6C's.

2.3.3 Pilot schemes on selected wards to use Productive Ward principles with an aim to share learning across other areas

2.3.4 E-Rostering reviews across all areas

Objective 4: Strengthen and diversify the workforce

Objective 5: Improve the oversight and deployment of the workforce on a strategic and operational level

Objective 6: Increase the number of senior medical ED staff by improved recruitment, training and job design

Objective 7: Improve our recruitment and retention processes to reduce reliance on bank and agency staff

2.7.1 There are already active recruitment campaigns to secure skilled and experienced qualified staff from Europe

2.7.2 There are dedicated recruitment days for newly qualified nursing and midwifery staff

2.7.3 Return to Practice supported by the Higher Education Institute

2.7.4 Improvement of the Exit Interview so that we can actively reduce the number of people who want to leave the Trust

Objective 8: Ensure that all of our staff members are aware of the high standards that the Trust expects, that they work to exceed the 6C's and the Trust Values and Behaviours

2. 8.1 The Trust has developed a set of values and behaviours – staff are made aware on induction and the Welcome booklet, wallet cards for staff, open staff meetings and bespoke events

2.8.2 Staff members to review how they are already living the values at team meetings

2.8.3 Values are to be linked to appraisal, recruitment and workforce policies

2.8.4 Training is being commissioned to enable managers both to identify good practice and to give staff the confidence to challenge colleagues when Trust values are not being met

2.8.5 A Trust recognition scheme is being launched – the first ceremony is planned for November 2014

We will know we have been successful if:

- Our staffing establishments meet the capacity and demand of our activity on our wards
- Staff will be inducted and trained to deliver care according to their expertise
- Implementation of Safer Staffing Tool
- Implementation of Recruitment and Retention Plan
- Staff and patient satisfaction levels are improved due to enhanced levels of care and compassion
- Vacant posts are recruited to and staff remain in post until natural career progression
- Production of competencies for all banded staff
- All staff are up to date with their Mandatory Training
- All staff have appraisals once a year
- All staff leaving the Trust participate in exit interviews
- Less reliance on agency staff

3 SAFETY

3.1 Improve our management of clinical waste

Why is this important?

The danger to patients through poor adherence to Infection Control and Prevention policies cannot be overstated

The CQC found that:

- Our systems for managing clinical waste were poor.
- Many areas with clinical waste were accessible to members of the public

Our assessment of the key issues

During the CQC visit we were taken around the sites and shown the areas of non-compliance, these were immediately rectified and were subject to on-going audits

Our objectives are:

1 We will have robust policies in place for the management of clinical waste
2 We will ensure that all our staff and partners are complaint with our policies

Objective 1: We have robust policies in place for the management of clinical waste

3.1.1 We will review all of our waste management plans, and align across the sites

3.1.2 We will review our clinical waste storage site locations

3.1.3 We will fit digilocks as additional security as required

3.1.4 We will work with colleagues to enhance our Sharps policy

Objective 2: Our staff and partners are complaint with our policies

3. 1.5 We will communicate our plans to all staff groups

3.1.6 We will put in place enhanced training for all of our waste handlers

3.1.7 Training will enable staff to understand when they must use personal protective equipment

3.1.8 Personal protective equipment will be monitored on a monthly basis for compliance with its use

We will know we have been successful if:

- Our waste management plans have been successfully communicated to all staff groups and implemented
- Compliance with clinical waste storage sites is >85%
- Compliance with PPE usage is 100%

3.2 Improve our hand hygiene compliance

Why is this important?

The CQC found that although the Trust had comprehensive infection control and prevention policies in place, they had not been robust enough to ensure that all of our staff adhere to them. This leaves our patients vulnerable to the chance of acquiring a hospital related infection.

The CQC found that:

- In some areas compliance with being 'Bare below the Elbows' and hand hygiene was poor. This causes a risk of cross-infection for patients.

Our assessment of the key issues

- Compliance measured against some members of staff is better than others

Our objectives are:

1. To enhance training across all staff groups and ensure that all staff adhere to the guidelines
2. Assure compliance across all staff groups and complete on-going compliance audits across all staff groups
3. Ensure all staff understand importance of compliance to policy using examples of light box technology

Objective 1: Enhance training across all staff groups

3.2.1 Poster and information campaign to a public hand hygiene campaign, to include granting permission for patients to challenge staff to wash their hands

3.2.2 Develop and implement Trust wide Hand Hygiene roadshows

3.2.3 Training and updates during induction and mandatory training

3.2.4 Divisional purchase of training gel and light boxes for use when auditing and training

3.2.5 Aseptic Non Touch Technique and hand hygiene included in band 5 preceptorship training and all induction programmes

Objective 2: Assure compliance across all staff groups

3. 2.6 Review and update of policy to reflect new organisation and include a clear escalation process for non-complaint staff

3.2.7 All hand hygiene and infection control audits to be undertaken using online audit tool and presented at Divisional Performance Reviews

3.2.8 Purchase of lockable hand rub dispensers for outside clinical areas, with agreement with facilities for replenishing

3.2.9 Hand rub monitored at point of care – 95% compliance monitored by divisional performance report

We will know we have been successful if:

- Observational audits show increased compliance
- Formal monthly Hand hygiene audits show >85% compliance
- Patients and staff are able to challenge poor compliance
- Hospital acquired infection rates decrease

3.3 Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability

Why is this important?

Every aspect of patient care revolves around technology, equipment and devices. It is important for patient and staff welfare that there is sufficient equipment to provide effective care; that staff are trained not only to use the devices, but to use them in such a way as to protect patient privacy, dignity and independence; that we know what equipment we have and that all of this is maintained to a high standard on schedules that are adhered to.

The CQC found that:

- Checks to medical equipment should be carried out regularly to ensure that when they are required, they will be working. These checks are recorded. In some areas, the checks were carried out regularly, but in other areas this was more sporadic and often missed.
- The hospital must ensure that there is appropriate clinical equipment available in all areas

Our assessment of the key issues

Our objectives are:

1. We will be able to say exactly what equipment we have within the Trust
2. We will ensure that our staff have appropriate equipment for the tasks they need to perform
3. We will ensure that all of our devices have appropriate maintenance schedules
4. We will make sure that our maintenance schedules are current
5. We will monitor the devices in their place of use, with regard to daily cleaning and availability
6. We will ensure that all of our staff have training to be able to use the available equipment in a manner that keeps them and their colleagues safe.
7. We will ensure that all of our staff training includes the use of equipment in protecting patient's dignity, privacy and independence, while respecting the patient's wishes.

<u>Objective 1: We will be able to say exactly what equipment we have within the Trust</u>

3.3.1 We will create a new single integrated policy for the management of medical devices

3.3.2 We will create a staffing structure to ensure that our policy is implemented effectively

3.3.3 We will create a robust ledger of all devices we currently have in stock

<u>Objective 2: We will ensure that our staff have appropriate equipment for the tasks they need to perform</u>

3.3.4 We will identify gaps in the provision of equipment at a divisional level

<u>Objective 3: We will ensure that all of our devices have appropriate maintenance schedules</u>

3.3.5 We will ensure that the Trust has a planned preventative maintenance schedule

<u>Objective 4: We will monitor the devices in their place of use, with regard to daily cleaning and availability</u>

3.3.6 We will create a robust system to manage medical devices at ward/department level

<u>Objective 5: We will assure ourselves that the Trust has a robust system of effective device management to ensure staff and patient safety</u>

3.3.7 We will monitor staff competencies with equipment and devices

3.3.8 We will establish committees to provide assurance that the medical device policy is adhered to.

4. ORGANISATIONAL LEARNING

4.1 Improve the knowledge we share with our staff about our learning from when and where things did not go well and from complaints made by patients

Why is this important?

Information gleaned from alerts, complaints and incidents allows us to analyse how we administer our policies and programs, deal with patients and their families and manage issues. It also helps us to identify areas that need work, leading to innovative solutions to problems, improvements in service delivery and better decision making. If we fail to share this information Trust-wide, we risk the same issues being repeated unnecessarily.

The CQC found that:

- The new governance structure was in place and worked well from the top to the Divisional level and that it had clear objectives but there was significant work needed to engage all staff from within all divisions and to improve complaints response times
- An underlying challenge is the need to ensure that staff learn from complaints and incidents and that information is shared widely
- Continued training in both complaints handling and investigation will ensure that processes are improved and consistent across the Trust

Our assessment of the key issues:

The new governance structure works well delivering information from many sources from alerts, complaints and incidents etc. from the board to the divisional governance level. Sharing this information with our staff who deal with patients on a day-to-day basis has been more challenging.

Our objectives are:

1 We will ensure that we continue to develop the culture of ‘no blame’ and encourage all staff to continue to report all incidents
2 We will use the After Action Review process to ensure that incidents can be reviewed and discuss without fear of blame culture
3 We will identify key learning from incidents, complaints, never events
4 We will share this information with staff at all grades and levels throughout the organisation
5 We will identify alternative sources, media and initiatives with which to disseminate information
6 We will not focus on negative attributes but share instances of good practice
7 We will embrace the Francis recommendation of the Duty of Candour

Objective 1: We will encourage the reporting of all incidents from all grades and levels of staff

4.1.1 Staff induction and mandatory training will include incident reporting

4.1.2 Trust wide Poster and “Staff Briefing” campaign to encourage the reporting of all incidents

4.1.3 We will develop our Workforce policies to include the requirement to report all incidents, accidents and near-misses as a professional duty

4.1.4 Serious incident training will be included in the band 5 preceptorship programme

Objective 2: We will identify key learning

4.2.1 Identification of lessons learned through the Outcomes with Learning (OWL) group which will then be shared across the organisation

4. 2.2 Identification of lessons learned through the Aspiring to Excellence (A2E) group which will then be shared across the organisation

4.2.3 Identification of lessons learned through the divisional governance meetings

4. 2.4 We will introduce a programme of After Action Reviews for staff

4. 2.5 Divisions will develop Patient Safety Improvement Plans (PSIPs) for their top three incidents (excluding pressure ulcers and falls)

4. 2.6 Patient safety and risk teams to develop PSIPs for the Trust top three incidents (excluding pressure ulcers and falls)

4. 2.7 The Patient Safety Team will organise PSIP staff events and road shows throughout the year

4. 2.8 Trends and themes arising from serious and red incidents will be analysed quarterly and provided to Divisional and Corporate Teams for dissemination at departmental meetings

4.2.9 All Divisions will be required to produce quarterly reports on patient safety and complaints

Objective 3: We will share this information with staff at all grades and levels

4. 3.1 The Trust will publish a newsletter with highlights and learning from the previous months’ incidents

4. 3.2 Each division will publish a monthly newsletter with highlights and learning from the previous months' incidents

4. 3.3 Quarterly payslip messages delivered to all staff highlighting lessons learned

4. 3.4 Inter-divisional learning will be a standing agenda item on all Divisional Governance Agendas

4. 3.5 Each Divisional Governance meeting to start with a patient story

4. 3.6 Governance and Patient Experience Managers will meet with staff at ward/department meetings to discuss the lessons learned cross trust. This will include the Trust's partner organisations.

4.3.7 Trends and themes arising from quarterly analysis will be disseminated to all staff in leaflets, posters and on the intranet

Objective 4: We will identify alternative media with which to disseminate information

4. 4.1 All published newsletters will be available in paper copies and on-line of the staff accessible intranet

4.4.2 All areas of good practice and patient compliments will be shared on the intranet

4. 4.3 Key Messages and Key Facts will be printed for staff on payslips

Objective 5: We will not focus on negative attributes but share instances of good practice

4.5.1 Areas of good practice will be shared with the staff body as examples of good care

4. 5.2 Patient compliments will be widely shared and published

Objective 6: We will embrace the Francis recommendation of a Duty of Candour

4. 6.1 Our analysis of red and moderate incidents will include the duty of candour discussion and compliance to our Being Open Policy will be audited on a six monthly basis

4. 6.2 Nursing staff and clinicians will receive additional training on speaking to patients following an adverse incident

4. 6.3 We will monitor and report on how many of our red and serious incidents included a patient discussion of the incident

We will know we have been successful if:

- all staff are aware of how to recognise and report an incident and feel confident to do so
- staff feel comfortable participating in AAR sessions
- staff will be able to identify errors and complaints within their own area of practice, and the learning that came from this
- staff use initiation, creativity and innovative techniques to share best practice amongst other team members
- staff will be able to identify learning from other areas and how to incorporate that into their own practice
- staff will be aware of examples of good practice and how to replicate this
- staff will be aware of the impact that errors, accidents, mistakes and near misses can have on patients and their families.