Agenda Item 144/11

CQC WHHT Assurance Report Q1 (April – June 2011)

Presented by: Colin Johnston

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1. Introduction

This is the Q1 CQC assurance report, which provides an overview of the Trust's assurance against the CQC Essential Standards of Quality and Safety, April – June 2011.

2. Q1 Update

The CQC requested a progress report on the UCC action plan following the December 2010 inspection and ***this is attached***.

On the 28th June 2011 the Trust achieved NHSLA Level 2. The CQC Quality and Risk Profile dated 31st Aug 2011 indicates its records have not been updated, recording we are still at 1 rating (Amber). We anticipate the QRP will show further improvement once CQC reflects the Level 2 score.

The Trust reviewed its CQC assurance documentation and updated all standards using the CQC Provider Compliance Assessments (PCAs) – this is a self assessment tool which Trusts have been encouraged to adopt.

The Trust is subject to unannounced inspection at any time and has received feedback following inspections experienced by other Trusts. The feedback indicates Trusts may be subject to an unannounced visit on site, without notice, and involving up to 6 CQC inspectors. They will visit areas of their choosing and will undertake any number of inspection activities which could include: direct questions of any member of staff; talking to patients, observing care, requesting documentation. Visits will take place over 2 days but no notice is given for Day 2, in which there will be verbal feedback about each outcome assessed. If there are serious causes for concern the CQC will escalate to the Chief Executive immediately, otherwise the Trust can expect a written report.

Areas of focus for the inspectors include interviewing staff in HR about processes such as employment checks and training; asking about arrangements when staff sickness occurs; a HCA was asked about infection control practice; staff may be asked about reporting incidents, how they learn from complaints, whether they have received all their mandatory training.

The Trust is continuing to raise awareness of CQC registration requirements. It has shared with a number of staff a small information booklet developed by East Kent Community Services and feedback indicates this could be, if adapted to WHHT, a useful guide to CQC required outcomes and the CQC registration process. The Trust is adapting the process used to raise

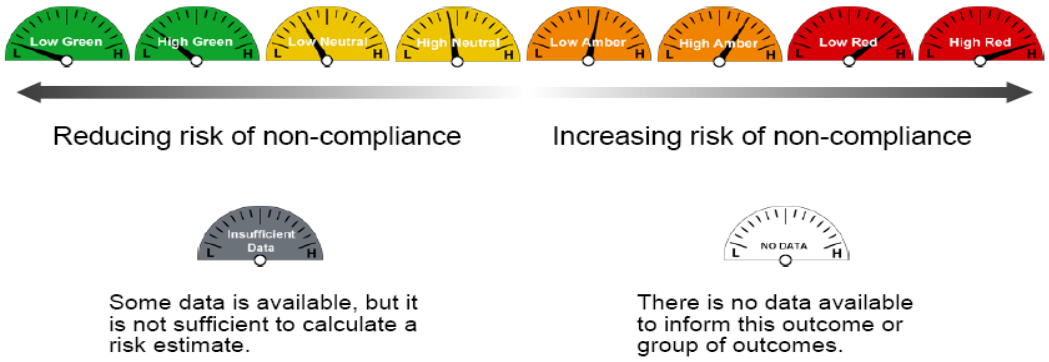
awareness and understanding of the NHSLA assessment process to better prepare staff should we be subject to an unannounced inspection.

3. Quality & Risk Profile (QRP) April - June 2011

As previously indicated, the vehicle for reflecting the Trust's compliance profile is the QRP which records information held by CQC about the Trust and it is used to determine where risks lie and prompts CQC engagement with organisations either through meetings or formal inspections.

The Q1 CQC QRP risk classification for West Hertfordshire Hospitals NHS Trust is shown on the following diagrams and classified on a continuum from low green to high red.

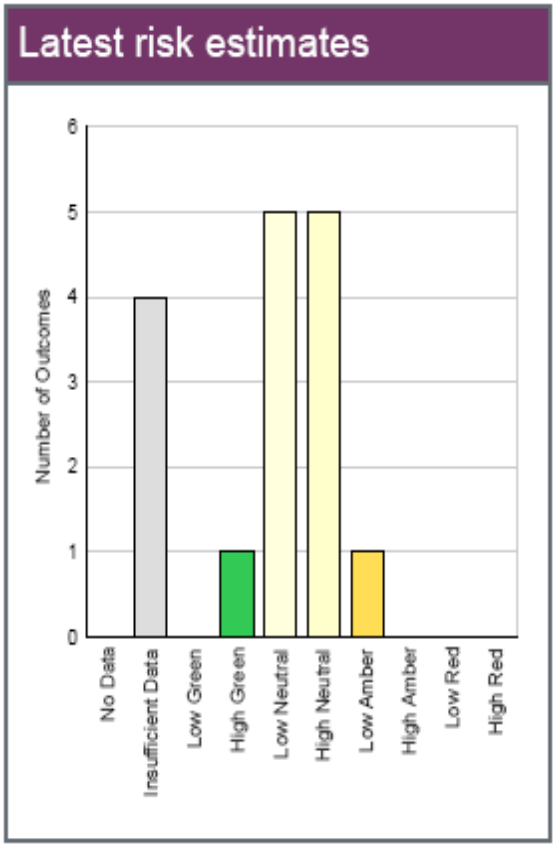
3.1 CQC Risk Classification Scale

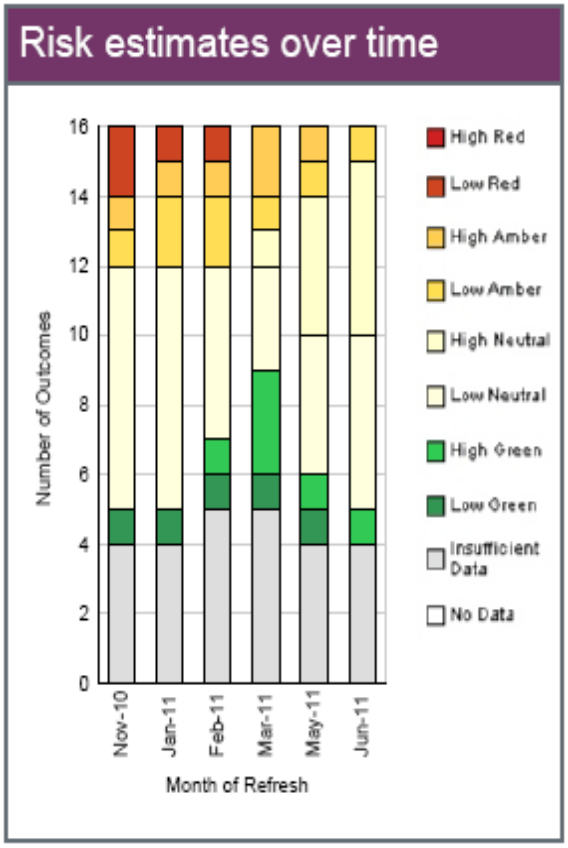


3.2 CQC QRP Risk Estimates

The latest risk estimates shows the number of outcomes according to their risk classification. The Trust has no red risk estimates and only 1 low amber risk estimate which is ***Outcome 14 Supporting Staff***. We believe this risk score is based on poor feedback from the last national staff survey where staff were asked about their training, appraisals, support from managers and work life balance.

The risk estimates over time shows the number of outcomes and the risk estimates and how these have changes since Nov 2010. Based on the QRP risk estimates the Trust has made improvements in reducing the number of red risk estimates.





3.3 CQC QRP Risk Estimates by Quarter and Outcome

Outcomes	April 2011	May 2011 (No Report)	June 2011	30th June 2011 (July Report)
Outcome 1 Respecting and Involving people who use the service (NF)	Low Amber		Low Amber	High Neutral
Outcome 2 Consent to Care and Treatment (CJ)	Insufficient Data		Insufficient Data	Insufficient Data
Outcome 4 Care and Welfare of people who use the service (NF)	High Green		High Green	Low Neutral
Outcome 5 Nutrition **(**NF)	Insufficient Data		High Neutral	High Neutral
Outcome 6 Cooperating with other providers (CP)	High Neutral		High Neutral	High Neutral
Outcome 7 Safeguarding people who use the service from abuse (NF)	Insufficient Data		Insufficient Data	Insufficient Data
Outcome 8 Cleanliness and Infection Control (CJ)	High Green		High Neutral	High Neutral
Outcome 9 Management of Medicines (CJ)	High Amber		High Neutral	High Neutral

Outcomes	April 2011	May 2011 (No Report)	June 2011	30th June 2011 (July Report)
Outcome 10 Safety and Suitability of Premises (SW)	Low Green		Low Neutral	Low Neutral
Outcome 11 Safety, availability and suitability of equipment (SW)	Insufficient Data		Low Neutral	Low Neutral
Outcome 12 Requirements relating to workers (MV)	Insufficient Data		Insufficient Data	Insufficient Data
Outcome 13 Staffing (CP)	Low Neutral		Insufficient Data	Insufficient Data
Outcome 14 Supporting Staff (MV)	High Amber		High Amber	Low Amber
Outcome 16 Assessing and monitoring the quality of service provision (CJ)	Low Neutral		Low Neutral	Low Neutral
Outcome 17 Complaints (NF)	Low Neutral		Low Neutral	Low Neutral
Outcome 21 Records (CP)	High Green		Low Green	High Green

Q1 WHHT Provider Compliance Assurance

The table below provides a summary of WHHT's assurance against the CQC outcomes. The PCAs split each outcome into prompts (which are linked to specific quality or safety issues) against which the Trust is required to risk score accordingly. For the purposes of the summary report an overall risk score has been attributed to each Outcome.

Assessment Boxes

- GREEN – Evidence available demonstrates the outcome is met
- YELLOW – Evidence available shows outcome is mostly met, the impact on people who use the service is low and action required is minimal.
- AMBER – Evidence available shows outcome is mostly met, the impact on people who use the service is medium and the action required is moderate.
- RED – Evidence available shows the outcome is at risk of not being met, the impact on people who use the service is high and action is require quickly.

Outcome 1 Respecting and Involving people who use the service (NF)	Green ☒	Yellow ☐	Amber ☐	Red ☐

- The Single sex policy and interpreting and translation policy need to be updated
- The Trust is recruiting to the Equality and Diversity Manager position
- The Trust had a number of single sex accommodation breaches (privacy and dignity), in April there were 24 (0.7%) May 12 (0.3%) and June 0.
- The Trust needs to fully embed its new discharge booklet/checklist for patients during discharge ('your discharge from hospital').
- The Trust needs to collect and review the results of the new Trust questionnaire. This questionnaire will identify whether the Trust has made improvements on some of the key areas from the last inpatient survey such as ensuring there someone available to talk to the patient about their worries/fears, explaining test results, providing assistance getting to the bathroom and hospital noise.
- Question Cards are being given to patients so they can write down any questions they have so the Dr can answer them the next time they see the patient.

Outcome 2 Consent to Care and Treatment (CJ)	Green ☐	Yellow ☒	Amber ☐	Red ☐

- Consent audits need to be repeated with a focus on identifying whether clinical staff are taking consent whilst not trained to carry out the procedure.
- The Trust failed the NHSLA criterion 2.4.1 for providing information to patients during consent.
- The Consent policy needs to be reviewed by a specialist in consent.
- Complaint received about the Trusts handling of the consent process for a patient whose mental capacity was impaired, the compliant identified that the location was using an old consent form.

Outcome 4 Care and Welfare of people who use the service (NF)	Green ☐	Yellow ☒	Amber ☐	Red ☐

- The Trust failed NHSLA criterion 2.4.7 Resuscitation. The Trust needs to ensure its MEWS documentation is completed appropriately and that adjustments to care plans as a result of changes in observations are consistently documented and that this is audited. The Trust also failed 2.4.6 Blood Transfusion on the appropriate recording of the patient observations during transfusion for similar reasons. Actions are being taken forwarded by the Hospital Transfusion Committee in conjunction with the RTTC project.
- The Trust has not participated in the 3rd round of the National Care of the Dying Audit (NCADH)

- In June 2011 the Trust had 2 NPSA alerts past expiry
  - Essential care after an inpatient fall - A falls protocol has been drafted and is being piloted on Cleves Ward, final review of protocol to take place at the Bone and Health Group 6th Sept 2011. Once approved will need to be rolled out throughout all wards.
  - The Transfusion of blood and blood components in an emergency – a Safety Alert closure form was presented to the September Business Integrated Executive Meeting and the alert has been closed.

Outcome 5 Meeting Nutritional Needs (NF)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- A menu audit carried out in June 2011 identified only 33% of patients were being offered glossy menus to order food. The majority were using photocopied order sheets which are difficult to read, not coded for special diets and availability of ethnic meal choices are not mentioned.
- Nutritional Screening Audit in Dec 2010 identified that the majority of patients were screened but because the date was often not recorded it was difficult to identify whether the assessments were completed with 24hrs.t.
- The first Nursing and Midwifery diagnostic (part of the nursing and midwifery strategy implementation) identified a number or improvements for patient nutrition, an action plan is being developed.

Outcome 6 Co – Operating with other providers (CP)	Green	Yellow	Amber	Red
	☒	☐	☐	☐

- The Trust passed NHSLA Level 2 for the Discharge of Patients
- Emergency Planning - Regional table live exercise held 30/3/11

Outcome 7 Safeguarding people who use the service from abuse (NF)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- The Safeguarding Children Training strategy has been revised for 2011 -12 in line with the Intercollegiate Document 2010. This will allow training rates to be measured more robustly and will ensure clarity regarding which level of training is required.
- Child Protection Training Stage 1 Compliance – 49% (31st May 2011)
- Child Protection Stage 2 Training Compliance – 43% (31 May 2011)
- All staff receive Safeguarding Children and Vulnerable Adults training (level 1) at induction. Level 2 safeguarding children is currently offered to clinical staff as part of mandatory training on an annual basis. Staff that work with children, including midwifery staff, or in unscheduled care such as, A.E and Sexual Health now receive Safeguarding Children Training at Level 3 (this comprises of a 3hr session every 3 years and a 60 min annual update).Compliance for Level 3 Child Protection Training is 91% over 3

years (figures and TNA provided and monitored by Safeguarding Children Lead). The training department are in the process of revising the way safeguarding children training is recorded to ensure all 3 levels training are captured accurately.

- Named Midwife for Safeguarding Children needs to be a substantive post. It is anticipated that this post will be filled in autumn 2011. In the interim this post is covered by a midwife "acting up" into the role. Post filled this week (12.09.11).
- The Trust needs appropriate guidance which can be followed when patient restraint is required.

Outcome 8 Cleanliness and infection control (CJ)	Green	Yellow	Amber	Red
	☒	☐	☐	☐

- The Trust Board receives Infection Control Board reports on a regular basis (28 July 2011)
- No MRSA bacteraemia were reported in May or June - the annual total remains at nil against the Trust annual trajectory of four.
- The total number of *C.difficile* toxin positive isolates reported being classified as WHHT acquired was 1 in May and 3 in June. The total number of hospital acquired cases to the end of June is 4 against the annual trajectory of 33.
- The Trust is required to MESS report and undertake RCA's on all post-48 hour MSSA bacteraemia and all pre-48 hour bacteraemia on patients with risk factors. In May, six bacteraemia were reported (all community acquired) and in June, one was reported which was hospital acquired.

Outcome 9 Safety and Suitability of medicines (CJ)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- Additional pharmacist staffing will enable a greater ward pharmacist presence providing medicines information
- Annual anti-coagulant audits in response to NPSA alert 18 issues 2007
- Heads of Nursing and Chief Pharmacist to take forwards actions further to previous clinical area storage audit and self-medication development

Outcome 10 Suitability and Safety of Premises (SW)	Green	Yellow	Amber	Red
	☐	☐	☒	☐

- Independent report by HYDROP June 2011 (Environmental Consultancy Service) identified poor management of legionella and water systems management and control, an action plan is now in place to address the concerns identified in the report.
- Asbestos management is reactive rather than proactive. This may impact

on the maternity building work. A survey is being carried out to update the Trust's asbestos risk register.

- The Trust's electric resilience systems require improvements to enable further coverage of essential electrical systems.
- The Direct Enquiries Building Disability Discrimination Act Report identified non compliance with the act – a schedule of works is in place.
- There are a number of premises associated risks on the divisional risk registers which have an impact on patient safety and quality of services (e.g. heating systems in SCBU and Pathology, lift breakdowns)
- DH 2005 013 Liquid Nitrogen safety alert is still awaiting the completion of the policy.

Outcome 11 Safety, availability and suitability of equipment (SW)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- The SHA has raised concerns over the number of outstanding safety alerts. It was reported that 11 were passed expiry at the end of June 2011. Most of these alerts related to medical devices or supplies and the majority of these have been confirmed as closed. The delay in closing was attributable to delays in receiving feedback on alerts and the CAS policy has been reviewed to ensure the process of closure is more efficient.

- The Trust failed NHSLA criterion 2.2.7 Medical Devices Training, specifically on the evidence presented for clinicians. A solution going forward on the management process for medical device training is being actioned and will be based on the outcome of a review of the process for managing medical devices.

- There are a number of device associated risks on the divisional risk registers which relate to equipment that is past its life expectancy and needs to be replaced (e.g. Radiology Equipment /CTG machines)

Outcome 12 Requirements relating to workers (MV)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- The NHSLA assessment identified concerns with staff having an appropriate CRB check for the location in which they work and the patients they come into contact with. The HR team are currently reviewing the policy/process in relation to levels of checks, checking long standing staff without CRB checks, and having a rolling programme (3 yearly) of checks for staff.

Outcome 13 Staffing (CP)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

Midwifery staffing

- **Midwifery Vacancy Rate**

In 2009 the service employed a Recruitment Retention Lead Midwife, who has successfully implemented a recruitment strategy to reduce the vacancy factor down from 28% to 18.5%. The Nurse Preceptor-ship programme was revised so that newly qualified midwives rotate to six clinical areas in one year and consolidate their midwifery experience in their first year. This has been well evaluated and the Trust has significantly improved its reputation as an employer of choice.

The pressures in recruitment now lie with the skill mix of staff. The service can reliably recruit newly qualified midwives; however over the next three years over 30 senior midwives will be eligible to retire. This may result in a dilution to the skill mix when set against an increasingly complex pregnancy and childbirth Case mix. The service is reviewing its succession plan to address this.

- **Midwifery ratios 1:34 down to 1:30**
  In January 2009 the SHA for East of England recommended all units should demonstrate working towards a ratio of one midwife to 30 women delivered. At that time the service was working at a ratio of 1:36.9, and at budget setting in 2009-10 the Trust mitigated this risk by setting the midwifery staffing ratio to 1:34. This rolled over to 2010-11 and 2011-12 budgets.

  In July 2011 the SHA wrote to Trust Chief Executive Officers (CEOs) requesting further assurance that Trusts in the region were working towards the recommended 1:30. The service has drawn together an options appraisal outlining the risks associated with recruitment and skill mix and progress towards meeting the SHA recommendation as compared with the other maternity units within the region.

- **Specialist posts**
  The service is supported by only a few specialist posts, three of which have been extremely difficult to recruit to and experience suggests this is attributable to rates of pay and London competitiveness, compounded recently by London Trusts advertising similar former Band 7 posts as Band 8a posts. In an attempt to attract suitable candidates the service is currently applying for Recruitment & Retention premia for three Band 7 posts:
    - Safeguarding children lead midwife
    - Clinical facilitator post
    - Infant feeding lead midwife

- **Senior midwifery managers/matron posts**
  As with the specialist posts outlined above, the three senior Midwifery Matron posts have gradually become vacant over the last 18 months and despite a number of recruitment rounds have not been filled. Matrons now command Band 8b rates of pay instead of 8a. There has also been a lack of suitable candidates applying. The Senior Midwifery Structure has been revised to create two Senior Midwifery Manager Posts at 8b and one Matron post at 8a. To address the concerns around lack of suitable senior leadership, the 8b posts will have a programme of deputyship applied, to

give successful recruits exposure to internal and external arenas and assist in the development of senior midwifery leaders. These posts are currently out to advert due to close 21 August 2011.

Outcome 14 Supporting Staff (MV)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- Local induction completion is only 32% compliant
- Overall mandatory training is only 56% compliant (specific courses and divisions have differing compliance records)
- Appraisals rate completion is at 70%
- Bullying and Harassment training attendance is only 14%
- Requirement to audit local induction of temporary staff
- Improve level of compliance with supervision of medical staff in training

Outcome 16 Assessing and monitoring the quality of service provision (CJ)	Green	Yellow	Amber	Red
	☒	☐	☐	☐

- Improvements need to be made to the safety alert process
- Improvements needs to be made in the National Audit participation and monitoring processes
- The number of DatixWeb incidents awaiting review in a timely fashion needs to be improved

Outcome 17 Complaints (NF)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- Complaint response times (80% of complaints need to be responded to within 40 days) need to be improved in March 2011 only 41% of all complaints were responded to in the agreed timeframe, April 49% and May 22% (provisional).
  - Of the 12 complaints that remain outstanding 7 of these have not yet reached their due date. Providing these are responded to on time compliance can improve to 65%.
  - Providing the one complaint is responded to on time compliance can be expected to be 100%.
  - Of the 11 complaints that remain outstanding 8 of these have not yet reached their final due date. Providing these are responded to on time compliance can improve to 56%.
  - Of the 8 complaints that remain outstanding 6 of these have not yet reached their final due date. Providing these are responded to on time compliance can improve to 77%.
- Complaint action plans needs to reviewed more robustly by divisions to ensure that actions arising from complaints are implemented and signed off as completed.

Outcome 21 Records (CP)	Green	Yellow	Amber	Red
	☐	☒	☐	☐

- The Trust continues to maintain good note retrieval rates for inpatients and outpatients, however in order to maintain these rates this is having a negative impact on the back of house patient record management.
- Medical Records at WGH has undergone refurbishment however some racking does not fit the locations, this is being corrected but in the meantime records are being filed in boxes on tables/floor.
- There is currently not enough space at the WGH site to store all ' active' patient records so 'fat notes' those which are too large for shelves are being stored at HHGH site. This means 'double handling' of notes (tracking and transporting to HHGH)
- In order to create extra space at WGH notes 3 years or older which are not 'active' need to be sent to off site storage, there are currently no resources to action this.
- Unable to archive notes of those deceased patients from the community due to lack of resources.
- Double handling of notes
- Limited ability to recover / merge notes

Conclusion
The committee is asked to review the update above, which provide the details of assurances and gaps in assurance or control. The committee is asked to consider the conclusions drawn about compliance and endorse or challenge.

Dr Colin Johnston
Director of Patient Safety, Medical Director
September 2011