West Hertfordshire Hospitals NHS
NHS Trust

Trust Board Meeting

06 April 2017

Title of the paper:	**Care Quality Commission Quality Report**
Agenda item:	**10/47a**
Lead Executive:	**Tracey Carter, Chief Nurse & Director of Infection Prevention & Control**
Author:	**Jacqueline Birch, Head of Risk, Assurance & Compliance** **Rachael Corser, Deputy Director of Governance & Associate Chief Nurse**
Trust aims :	☒ To deliver the best quality care for our patients ☐ To be a great place to work and learn ☐ To improve our finances ☐ To develop a strategy for the future
Purpose:	The purpose of this paper is to summarise for the Trust Board the judgements made and the ratings given by the Care Quality Commission (CQC) on the quality of care at The Trust following their inspection in September 2016 as published in the Quality Report in March 2017. This paper will highlight the areas of outstanding practice identified and areas where fundamental standards of care were not met. This paper will provide an update to the Trust Board on the immediate actions that have been taken following the inspection and to summarise the programme of work underway to refresh the existing Quality Improvement Plan (QIP) in response to the recommendations made in the report.
Link to Board Assurance Framework (BAF)	**PR1** Failure to provide safe, effective, high quality care

Previously discussed:

Group	**Date**
Integrated Risk and Governance Committee	28 March 2017

Benefits to patients and patient safety implications:

The Trust has a regulatory and statutory obligation to meet the fundamental standards of care below which care should never fall. The Trust has made significant progress against the Quality Improvement Plan (QIP) that was established following the previous inspection in 2015 addressing the gaps in compliance against these standards. Following the CQC inspection in September 2016 work continued to address any regulations that are not fully met in order to ensure that we provide the very best care for every patient, every day.

Recommendations

Trust Board is asked to note the actions that have been taken in response to the recommendations made by the CQC during and following their inspection of our services, and the revised governance process that is in place to monitor the refreshed Quality Improvement Plan (QIP).

Agenda Item: 10/47a

Trust Board - 06 April 2017

Care Quality Commission Quality Report and progress on Quality Improvement Plan

Presented by: Tracey Carter, Chief Nurse and Director of Infection Prevention and Control

1. Purpose

1.1 The purpose of this paper is to summarise for the Trust Board the judgement made by the Care Quality Commission (CQC) on the quality of care at The Trust following their inspection in September 2016 as published in the Quality Report in March 2017. This paper will highlight the areas of outstanding practice identified and areas where fundamental standards of care were not met.

1.2 This paper will provide an update to the Trust Board on the immediate actions that have been taken following the inspection and to summarise the programme of work underway to refresh the existing Quality Improvement Plan (QIP) in response to the recommendations made in the report.

2. Discussion

2.1 Following the inspection of our services in September 2016 the Trust has been given an overall rating of 'requires improvement'. This reflects a Trust wide rating of good in the caring domain and requires improvement in the well led, responsive, effective and safe domains. The number of services rated as good has increased from 25 in 2015 to 40 in 2016 and the number of services rated as inadequate has more than halved from 31 in 2015 to 15 in 2016.

2.2 The current QIP was developed in response to the previous CQC inspection of our services in April 2015 and to date has consisted of five key themes and 23 projects that have comprised the high-level QIP. As reported previously, at the end of January 2017 ten projects were closed and completed. During, and immediately following, the CQC inspection in September 2016 the Trust received initial feedback of findings. In response to this feedback 53 new actions were added to the Quality Improvement Plan (QIP) under each of the existing five key themes and mapped against each of the existing Projects. Following the publication of the Quality Report the Quality Improvement Plan (QIP) has been refreshed further and updated with the new actions that are being taken across the Divisions, and in corporate services, to address the recommendations made within the report.

Where possible new actions have been mapped against existing QIP projects and there are a small number of projects that will be reopened and new projects created in response to the final recommendations. Any new and updated projects will follow the change control process as previously agreed within the QIP project governance infrastructure.

2.3 Progress against the refreshed QIP will be reported monthly through to the Trust Board from May 2017. These reports will be available on our public website and will be shared with our Regulators as part of the agreed Oversight process. The agreed Quality Priorities for 2017/18, which are set out in the Quality Account reflect the Trust aims and objectives for this year and include areas of ongoing focus following the inspection.

2.4 In the final report, the CQC have acknowledged a number of areas of outstanding practice, which include:

- The environment of the children's emergency department
- The trusts sustained reduction in the mortality rate for hip fractures from 12% to 4% following a review of the hip fracture care pathway.
- The Trust's Hospital Standardised Mortality Ratio (H~SMR) rates which are lower than expected and sustained for 18 months.

2.5 The CQC outlined a number of actions that we must and should take in order to address where the essential standards of quality and safety, and regulatory obligations, are not being met. There are 12 fundamental standards and the CQC reported that seven standards were not met at the time of the inspection. These include:

2.5.1 Regulation 11 – Need for Consent

- The CQC found that this regulation is not being met as seven of the completed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms that they reviewed (36) did not comply with the requirements set out within the Mental Capacity Act (MCA).

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***End of Life Care (EoLC) QIP:***

- DNACPR form to include date and time stamp for mental capacity assessment
- Ward DNACPR champions to do a daily audit confirming that any patient, who has a new DNACPR status decided, has had the form stamped for the mental capacity assessment
- Collate and present DNACPR with MCA stamp audit results at resus meeting and QSG

2.5.2 Regulation 12 - Safe Care and treatment

- The CQC found that this regulation was not being met at Hemel Hempstead Hospital and St Albans City Hospital because there were not always robust processes in place to stream and monitor patients in the Minor Injuries Unit (MIU) and Urgent Care Centre (UCC) and not all staff had the appropriate training for the recognition of the deteriorating patient.

- At St Albans City Hospital processes to protect patients from harm in relation to infection prevention and control, water safety and fire safety were not always followed.
- On Simpson Ward staff did not always maintain security of medicines during medicines rounds.
- The pain relief was not routinely checked or provided to patients.
- Patients who were clinically deteriorating were not consistently observed.
- Records were not always completed consistently.
- Hand hygiene policies were not always adhered to in outpatients.
- The theatre teams were not consistently using the five steps to safer surgery checklist.
- The national indicator of the 18 week referral from a GP was not always met.
- The percentage of patients waiting to see a consultant with a suspected cancer did not meet the national target of 93%.
- There had not been reasonably practicable actions taken to mitigate the risks associated with the proper and safe storage of medicines in some areas, including where medications were stored in treatment rooms where temperatures exceeded levels.
- Patients own controlled drugs were not always reconciled adequately and controlled drugs were not always disposed of in line with current guidance.
- There were some prescriptions for syringe pumps that did not comply with the trusts prescribing standards.

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***Patient Flow, Harm Free Care and Caring for our most acutely unwell patients QIP.*** In light of the overall ratings for ***Urgent and Emergency Care, Surgery*** at St Albans and the ***Medical Care*** Pathway at Hemel Hempstead Hospital, new Projects have been developed and will monitor the actions being taken to address gaps in compliance:

- Strengthened triage process in place at the UCC and with frequent clinical oversight and observation of the patients in the MIU/ UCC waiting room
- A review of minor and major pathways in the ED at Watford General Hospital
- A review of the demand in the ED at Watford General Hospital and a review of the workforce profile required to reflect demand
- Review and ongoing monitoring of the application of the ED escalation policy
- Regular reviews and audits of the Royal College of Emergency Medicine (RCEM) standards – to include use of chaperones, pain relief in adults
- ED intranet policies/ guidelines to be reviewed/ refreshed
- Hourly rounding introduced in the ED majors and queue (corridor) to ensure monitoring and response to changes in clinical observations. Pain assessment and fluid and nutritional intake is observed and there has been a pilot and review of a safety checklist to monitor this
- Consultant rounds and physical review of patients at 0800, 1200, 1600, 2000, 0000 and additionally hourly 'progress checks' between consultant shift lead and nurse controller, which will be recorded
- A review and immediate changes to the patient only controlled drugs policy and procedure. These changes took place immediately during the inspection and were communicated widely to the clinical teams

- Ensure room temperature checks are completed in all medicine storage areas and prompt review and escalation of temperatures outside of range
- Junior doctor cover provided between 14:00 and 21:00
- Actions have been taken to address concerns raised in relation to the staffing and skill mix, the clinical leadership, fire training, staff morale and patient flow for Simpson Ward. The admissions policy is under review by the Division
- WHO checklist consistency at WGH and SACH
- VTE reassessment in place

2.5.3 Regulation 13 Safeguarding service users from abuse and improper treatment

- The CQC found that this regulation was not being met as some patients' Deprivation of Liberty Safeguards (DOLS) applications were not tracked or reapplied when the initial assessment period expired.
- All staff caring for 16 – 18 year olds should receive level 3 safeguarding children training and the CQC found that not all medical and nursing staff who were required to do so had undertaken the training.

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***Safeguarding QIP:***

- A written self-harm risk assessment for patients prior to using the mental health room is in use
- Restraint training for the ED department and awareness of the Trust Policy on restraint is in place; Breakaway training for all staff including training for senior staff is underway
- Training Needs Analysis for all adult areas where 16-17 years are cared for in regard to children level 3 has been completed and recommendations discussed at the Trust Safeguarding Panel
- A tracking system is in place for MCA/DoLs applications with weekly updates on continuity of assessment and usage of Datix
- Strengthened adult safeguarding training for Simpson and Theatres at SACH and on De La Mare and Beckett wards at SACH
- A plan has been developed for Medical staff in ED on how to articulate the application of L3 safeguarding children

2.5.4 Regulation 14 Nutrition and Hydration

CQC: This regulation was not always met as regular fluids were not always provided or offered to patients in the emergency department during the course of their inspection.

Actions to address this are identified in the actions highlighted in point 2.5.2.

2.5.5 Regulation 17 Good Governance

- The CQC felt that this regulation was not always met as there were not always effective governance systems and policies in place across the whole trust.
- They felt that not all incidents were always reported.
- They also felt that not all services had a robust audit plan in place

- Specifically on Simpson Ward the CQC reported that there were not robust action plans in place to address non-compliance with infection control standards. They also felt that there was not always good evidence of a full record of nursing interventions. They felt that the admission criteria for Simpson ward had not been recently updated to reflect the changes in patient case load and they could see no evidence of the local risk register.

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***Quality Governance QIP:***

- Options to develop a Patient Safety Team, strengthening clinical leadership within the Quality Governance and Corporate Nursing Teams
- The development of, and implementation of, an improvement plan relating to incident reporting and learning from patient safety incidents, including learning from serious incidents, divisional root cause analysis investigations and ensuring timely application of Candour
- Successfully commenced a Quality Improvement Fellowship with the aspiration to further expand quality improvement (QI) resource across the Trust to build on existing QI programmes of work and infrastructures
- Development of the Datix system creating local dashboards and improved reporting
- Focused risk management training in place
- The actions taken to address the concerns raised about Simpson ward have been discussed in 2.5.2

2.5.6 Regulation 18 Suitably qualified, competent, skilled and experienced persons

- The CQC felt that this regulation was not being met as appraisal rates varied across the trust and the compliance in mandatory training across the service was not in line with trust targets.
- They felt that medical staff cover was not always provided when required at the UCC.
- They also reported that the staffing levels on Simpson did not always allow for one to one care.
- The CQC reported that not all resident medical officers in surgery received a trust induction.

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***Recruitment and Induction QIP***:

- Resident Medical Officer (RMO) induction

The staffing concerns that have been raised regarding the UCC and Simpson ward are addressed in the actions described in 2.5.2.

2.5.7 Regulation 20 Duty of Candour

- The CQC felt that we did not meet this regulation because staff knowledge was variable and processes were not robust. Not all incidents that met the threshold were identified or managed appropriately.

The following actions have been taken to address the gaps in compliance against this standard and reflected in the ***Quality Governance QIP***:

- Communication campaign in place regarding duty of candour for all staff
- Duty of Candour compliance discussed at Divisional Performance Reviews and monitored bi-monthly at Safety and Compliance Committee going forward.

2.6 ***In conclusion***, the Trust Board are asked to note the immediate actions that have been taken, some of which have been completed, to address where the CQC felt the essential standards of quality and safety, and regulatory obligations, are not being met.

3. Next steps

3.1 The completed refreshed QIP will be presented for approval by the Trust Executive Team at the Strategic Delivery Board (SDB) on 12 April and will be presented for ratification at the Safety and Compliance Committee on 13 April. The refreshed QIP will then be monitored bi-monthly by the Safety and Compliance Committee and as described at the beginning of this paper, the QIP will continue to be reported to the Trust Board monthly.

3.2 The ***Quality Transformation Group (QTG)***, a subgroup of the Strategic Delivery Board, is overseeing the programme of work that will monitor and report progress against the QIP.

3.3 The Quality Improvement Plan (QIP) will evolve and conclude in the next six months as the outstanding actions that are needed to be taken are completed. One key quality priority for the next six months will be to develop a Quality Strategy for the next three years, which will drive a culture of continuous quality improvement across the Trust. We will develop the strategy in consultation with staff, patients and partners. The strategy will provide a coherent view to our approach to quality, by bringing together organisational quality priorities, compliance against the fundamental standards of care, CQUINs, contractual requirements set out in our Quality Schedule and any outstanding QIP activity.

4. Recommendation

The Board are asked to note the actions that have been taken in response to the recommendations made by the CQC during and following their inspection of our services, and the revised governance process that is in place to monitor the refreshed Quality Improvement Plan (QIP).

Tracey Carter, Chief Nurse and Director of Infection Prevention and Control

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