Reporting to:	**Trust Board – 26 September 2013**
Title	Update following CQC inspection (April 2013)
Sponsoring Director	Sarah Bloomfield - Acting Director of Nursing and Quality
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Previously considered by	The Quality & Safety Committee
Executive Summary	The CQC made an unannounced inspection to Princess Royal Hospital on 25th April 2013 and reported that there were compliance actions that the Trust had to take to respond to the concerns raised of standards not being met. This report is an update of actions undertaken to provide assurance against the standards for outcomes 1 and 4 below, following notification from the CQC. 1. Respecting and involving people who use services 4. Care and Welfare of people who use services.
Strategic Priorities ☐ Quality and Safety ☒ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** HS3 Deliver all key performance targets.
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☐ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☐ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT
Care Quality Commission (CQC) Domains ☒ Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well led	**Outcomes** Care and welfare of people who use services. People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered. People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

Recommendation	The Board is asked to: ☐ **Receive** ☒ **Note** ☒ **Review** ☐ **Approve**

1.0 Introduction

The CQC made an unannounced inspection visit to Princess Royal Hospital on 25th April 2013 and carried out observations on wards 9, 12, accident & emergency (A&E) and the medical assessment unit (MAU). During the visit the CQC spoke with patients and staff in all the wards and departments visited. Where patients were not able to talk for a variety of reasons, time was spent by the CQC observing how care and support was delivered.

Most of the interactions observed between staff and patients were positive and staff took time to explain what they were doing and why. The CQC also saw some positive examples of staff promoting patient privacy and dignity. However, the CQC also observed situations where patients' privacy and dignity was not respected. Likewise, some of the care records and assessments did not reflect people's needs, or were incomplete or inaccurate. This meant there was a risk that not all patients experienced care, treatment and support that met their needs.

Following the inspection the CQC advised that the following standards weren't being fully met in some areas and that action was needed in relation to:

1. Respecting and involving people who use services

2. Care and welfare of people who use services.

2.0 Actions undertaken

This report aims to update the Board of the actions and measures put in place to provide assurance against the standards for the above following notification from the CQC. The report also provides assurance to the Board that the Trust has implemented changes using a planned approach (Appendix One). For information the CQC have been made aware of the actions undertaken and have been responded to within the required timeframe.

3.0 Conclusions

The review and audit of nursing documentation and quality dashboards will be an ongoing priority in order to embed actions and ensure that improvements are sustained. Likewise, the training and education of staff regarding the importance of respecting and involving people who use our services and their care and welfare will continue to form part of the actions to prevent poor patient experiences and outcomes. The review and oversight of patient experience and the achievement of key performance indicators is reported to the Clinical Governance Executive, Quality & Safety Committee and Operational Risk Group.

Associate Director of Patient Safety

September 2013

Appendix One

Trust Improvement Action Plan relating to CQC Outcomes 1 & 4

Progress - Rag Rating: **Red = Not complete** **Amber = In Progress** **Green = Complete**

How the regulation was not being met.	**Measures put in place** (Improvements being made, sustained, measured and assured via systems and processes).	**Actions undertaken**	**Responsible Lead/Rag Rating**
People's privacy and dignity was not always respected. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care and treatment. Regulation 17	Ward metrics relevant to privacy & dignity, including the care given and patient experiences are measured on a monthly basis via the "Ward to Board" test your care system and via a new quality dashboard. Trends in performance presented on a monthly basis at Matron's meeting in order to use peers to challenge and promote improvements. Ward to Board metrics reported to the Board via Quality & Safety Committee for review and performance oversight, achieve governance arrangements and ensure that the expected improvements are made through the Board Assurance Framework. Where individual staff have been identified as providing sub-optimal care, once advised of their responsibility regarding this standard, any further observation of poor care will result in formal human resource process using supportive or disciplinary measures. This is achieved using direct line management oversight and expected improvements through managerial accountability.	The Trust is committed to ensuring that people's privacy and dignity is respected and all staff has a responsibility to ensure that people's views and experiences are taken into account when services are provided and delivered in relation to their care. Where sub optimum standards have been identified the Trust has taken the following actions in order to achieve the regulation: The wards identified within the report where there is evidence of sub-optimal care have been advised of the findings. The findings have also been shared with senior nurses across the Trust. This will act as a reminder to staff of their responsibility and achieve senior nurse oversight of expected improvements through managerial accountability. Individual staff where identified have been formally advised of their responsibility regarding this standard. This will act as reminder to staff of their responsibility and	Director of Quality & Safety (Chief Nurse) & Medical Director

	Ward 12 to continue on a formal improvement framework until there is evidence of measurable and **sustained** improvement being made. A report is provided to the Chief Nurse on a weekly basis in order to ensure progress is being made. The key areas where improvements have been made are: Leadership – Recruitment to a new ward manager (Complete). Change to ward function from escalation to short stay. Quality audits - Senior Nursing Staff have been carrying out Quality Checks and these have shown sustained improvement in the thoroughness of nursing documentation, risk assessments and patient feedback. Care delivery metrics- Ward to board audits have shown overall improvement in the care being delivered. Visits from the Patient Engagement and Involvement Panel during observations of care have also reported improved patient feedback whereby the patient experience has been reported as positive. Complaints – All complaints have been reviewed and continue to be reviewed on a monthly basis to ensure that staff behaviours are not continuing to be sub-optimal. The "fundamentals of care" training will be evaluated at each training event. Impact of training will be measured through "ward to board" metrics, whereby improvements in quality metrics performance will be expected to be evident as a result.	achieve senior nurse oversight of expected improvements through managerial accountability. Ward 12, identified within the CQC report has been on a formal quality improvement framework since April 2013. This is led by a senior nurse within the Corporate Nursing team, supported by a matron and regular updates with implemented actions are reported to the Board and Quality & Safety Committee. This will achieve governance arrangements and ensure that the expected improvements are made through the Board Assurance Framework. Training relating to privacy, dignity, respect and the patient experience ("Fundamentals of Care") commenced in June 2013. This programme looks particularly at the requirements of this regulation using a peer review approach to practice. Evaluation of the training will be part of the programme in order that we achieve our target of all nurses attending the training. Where issues of demand and capacity have been a contributory factor to the provision of sub-optimal care, following the "risk summit" a 36 point plan has been fully implemented in order to achieve improvements. This plan implements the changes necessary to improve patient experience, patient "flow", achieve KPIs, increase permanent nursing and medical staffing, improve appraisal rates and maintain financial sustainability.	

	The original "risk summit" 36 point plan has been reviewed and implemented via the Executive Team and external organisations, including the CQC in order to measure improvements and ensure sustainability. The Medical Director and Associate Medical Director within the Trust have oversight of the performance management of medical staff through job planning and appraisal. Where individual staff have been identified as providing sub-optimal care, once advised of their responsibility regarding this standard, any further observation of poor care will result in formal human resource processes using capability or disciplinary approaches. This will be achieved using direct line management oversight and expected improvements through managerial accountability.	Where sub-optimal care relating to medical staff has been evidenced, the findings have been shared with the Medical Director and Associate Medical Director within the Trust. This will be disseminated to medical staff and remind doctors of their responsibility. Oversight of expected improvements will be through managerial accountability.	
People did not always experience care, treatment and support that met their needs because care was not always planned or delivered to meet the individual needs or to ensure the health and welfare of people who used the service. Regulation 9 (1) (a) and (b)	Metrics relevant to this action are reported to the adult safeguarding board, chaired by the local authorities. Any variables or trends in performance are presented on a monthly basis and critically challenged to promote and sustain improvements. Safeguarding reports are received at the Trust internal safeguarding committee and subsequently to the Board and Quality & Safety Committee for review and performance oversight. This will achieve governance arrangements and ensure that the expected improvements are made through the Board Assurance Framework. Reports in April and May 2013 showed a significant decrease in referrals following the implementation of actions from the risk summit action plan.	The concerns identified within the report; where there was evidence of increasing referrals of adults requiring safeguards have been investigated using a sub-group approach involving the local authorities and CCGS. The result of this investigation has been shared with the respective safeguarding boards in order to achieve sustained performance in reducing safeguarding referrals against the Trust. The findings have also been shared with senior nurses across the Trust. This will act as a reminder to staff of their responsibility and achieve senior nurse oversight of expected improvements through managerial accountability.	Director of Quality & Safety (Chief Nurse) & Medical Director

	Improvements in leadership and patient experience will be evidenced and measured via the ward to board metrics and quality indicators. The inpatient survey for 13/14 will also provide information to demonstrate increasing or decreasing performance relating to patient experience. All wards now have the revised audit tool for "friends and family" testing with an evidenced market testing approach enabling anonymity when patients provide feedback. A leadership development programme developed specifically for Ward managers and their deputies (Ward sisters) will be commencing October 2013. Evaluation of the programme will be part of the programme in order that we achieve our target of all relevant nurses attending. The "fundamentals of care" training will be evaluated at each training event. Impact of training will be measured through "ward to board" metrics, whereby improvements in quality metrics performance will be expected to be evident as a result. The "risk summit" 36 point plan has been reviewed and implemented by the Executive Team and external organisations, including the CQC in order to measure improvements and ensure sustainability. The "deep dive" trolley wait review identified whether the extended trolley wait led to sub-optimal care or poor outcomes for the patients. 32 patients were identified as having waited longer than 12 hours on a trolley in the A & E Department within the time frame and the case notes were reviewed using an adapted and evidenced audit pro-forma. The Associate Director of Patient Safety, Patient Safety Advisor and Clinical Governance Manager	The findings have also been reported to the Trust Board and Quality & Safety Committee to achieve governance arrangements and ensure that the expected improvements are made through the Board Assurance Framework. Where it has been identified within the report that there is evidence of sub-optimal care being provided, the findings of the report has been shared with senior nurses across the Trust. This will act as a reminder to staff of their responsibility and achieve senior nurse oversight of expected improvements through managerial accountability. A specific issue currently being addressed through the senior nurse forums is the issue of ward leadership. Training ("Fundamentals of Care") referencing the importance of leadership on the patient experience and the 6Cs as cited by the CNO has commenced in June 2013. This programme looks particularly at the requirements of this regulation using a peer review approach to practice. Evaluation of the training will be part of the programme in order that we achieve our target of all nurses attending the training. Where issues of demand and capacity have been a contributory factor to the provision of sub-optimal care, following the "risk summit" a 36 point plan has been implemented in order to achieve improvements. This plan implemented the changes necessary to improve patient experience, patient "flow", achieve KPIs, increase permanent nursing and medical staffing, improve appraisal rates and maintain financial sustainability.	

	completed an audit pro-forma based on the Trust's Medical Mortality Review Form and Global Trigger Tool. Additions and adaptation was provided by the Clinical Lead for Medicine. The overall outcome of the patients was graded using the Confidential Outcome into Stillbirths and Deaths in Infancy (CESDI) outcome grading score. It was identified that the care of 3/32 patients was sub-optimal. The learning and actions from the report has been shared with commissioners and improvements measured at the monthly clinical quality review meeting led by commissioners. The Medical Director and Associate Medical Director within the Trust have oversight of the performance management of medical staff through job planning and appraisal. Where individual staff have been identified as providing sub-optimal care, once advised of their responsibility regarding this standard, any further observation of poor care will result in formal human resource processes using capability or disciplinary frameworks. This will be achieved using direct line management oversight and expected improvements through managerial accountability.	A number of extended Trolley Waits occurred within the Accident and Emergency Department (A & E) during the period February to April 2013. These were reported as Serious Incidents (SIs) and had associated Root Cause Analysis (RCA) completed within the required time-frame. This was in order to ensure that the outcomes for patients were unaffected by their extended wait in A & E. It was felt by SATH and commissioners that further Clinical Risk Assessment would be explored and that there was a need to review the Clinical Care of these patients in more depth. Where sub-optimal care relating to medical staff has been evidenced, the findings have been shared with the Medical Director and Associate Medical Director within the Trust. This has been disseminated to medical staff and remind doctors of their responsibility. Oversight of expected improvements will be through managerial accountability.	