Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

**Council of Governors**

**20th February 2012**

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| **TITLE** | **CQC Report** |
| **EXECUTIVE SUMMARY** | This report aims to inform the Council of Governors of the outcome and ensuing actions of Care Quality Commission's (CQC) Review of Compliance, which was carried out on the Trust on Thursday 1st December 2011. The CQC published their report 25 January 2012. |
| **ASSURANCE (Risk) / IMPLICATIONS** | This report provides assurance that the Trust is acting quickly and effectively to address the issues raised by the CQC. |
| **STAKEHOLDER / PATIENT IMPACT AND VIEWS** | The CQC Report will have reputational impact and work to inform stakeholders and give reassurance and information is active. |
| **EQUALITY AND DIVERSITY ISSUES** | All of our services give consideration to equality of access, taking into consideration gender, disability and age, and all matters are dealt with in a fair and equitable way regardless of the ethnicity or religion of patients. Incidents will be investigated and any Equality & Diversity themes categorised and reported so that themes can be monitored. This will be included going forward as part of the questions raised in the Terms of Reference for the investigation. |
| **LEGAL ISSUES** | Poor quality for patients can lead to litigation.<br>Poor quality care can lead to non-compliance with essential standards of quality and safety. Compliance with these standards is a requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor licence. The CQC has issued compliance action with more than one moderate / major concern. |
| **The Council of Governors is asked to** | The Trust Board is asked to note the contents of the report. |
| **Submitted by:** | Heather Caudle, Associate Director of Quality, on behalf of Suzanne Rankin, Chief Nurse |
| **Date:** | 3rd February 2012 |
| **Decision:** | For action |

## Action Plan

On Monday 1st December the CQC conducted an unannounced inspection on the St Peter's site of the Trust focusing on six of the core outcomes within the 16 Essential Standards Judgement framework: outcome 1: respecting and involving people who use services; outcome 2: consent to care and treatment; outcome 4: care and welfare of people who use services; outcome 7: safeguarding people who use services from abuse; outcome 14: supporting workers and outcome 16: assessing and monitoring the quality of service provision.

The areas visited were: the Day Surgery Unit (DSU), Holly Ward, a care of the elderly ward, and Falcon ward, a surgical ward. Meetings were held with the Chief Executive, Chief Nurse, Deputy Chief Nurse, Associate Director of Quality and the Complaints Manager. One of the inspectors, upon invitation from the Chief Nurse, observed the Clinical Governance Committee meeting.

## CQC feedback

The general feedback from the CQC on the day was that St Peter's was a safe hospital with committed staff.

### Capacity Pressures

There were concerns about the Trust's utilisation of the DSU as a place of escalation when the hospital was operating at 100% capacity with sustained pressure on beds. Whilst it was clear this was done safely, there were concerns over the ability to safeguard the privacy and dignity of those patients who arrived at the DSU in the morning for their procedures. This pressure on capacity also had an impact on some of the processes, in particular discharging patients, which appeared to be rushed and carried out to a sub-optimal standard. Staff morale was also thought to be low.

### Documentation

On one of the wards visited, there were concerns expressed about documentation. Identifiable as well as medical information were missing from some of the progress sheets and one consent form was found which had illegible handwriting and, although it was signed, the patient did not print her name.

### Safeguarding

The significant strides made in ensuring that all staff received mandatory training in safeguarding were acknowledged. The CQC was reassured by the evidence submitted, which included Safeguarding training records, regarding this. The plans to have specialist training in Mental Capacity Act and Deprivation of Liberties addressed the issues that arose from staff demonstrating a worse than expected level of clarity and knowledge in these areas.

### Governance

One observation made in the Clinical Governance meeting was the need for standardisation and robustness of data presented in the dashboard. This was already in the action plan and work underway to address this

### Appraisals and Preceptorship

Largely positive, however, whilst appraisals and preceptorship did take place, there was uncertainty about the objective setting within these processes. The relevant trust policies were submitted as evidence as well as examples of appraisals take took place.

Action Plan

The action plan was submitted to the CQC on Friday 27th January 2012.

The Trust action plan is divided into:

1. **Immediate Capacity Action Plan**: addressing the capacity and flow issues in the Trust that led to use of the Day Surgery Unit as an escalation area.

2. **Compliance Action Plan**: addressing outcomes: 1, 4, and 14. Compliance actions are defined as

   > *"actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make them comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure the essential standards are met*"

3. **Improvement Action Plan**: addressing outcomes 2 and 7. Improvement actions are defined as

   > *"actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so*"

4. **Definition: Action Plan Performance Key**

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| Delivering or exceeding Target | |
| Underachieving Target | |
| Failing Target | |

## 1.1 Reporting

The report, action plan and progress will be reported to the Trust Board by the Associate Director of Quality on behalf of the Chief Nurse.

The Integrated Governance and Assurance Committee (IGAC) is the Trust Committee responsible for Essential Standard 16, which is *Assessing and monitoring the quality of service provision* and therefore will have the responsibility for monitoring the progress of actions against this plan for the Trust.

### 1.2 Organisational Learning and Reflection

Following the CQC visit, an organisational learning and reflection event took place on the 13th January 2011. The aim of the event was to communicate the corporate level action plan and facilitate divisional level reflection and planning. The event aimed to ensure that corporate and divisional teams were focused on continuing compliance activity across the 16 Essential Standards as well as on the compliance and improvement actions necessary to respond to the CQC visit. Attendees of that event were the Trust Executive Committee, The Divisional Directors, the Divisional General Managers and the Divisional Heads of Nursing.

A copy of the agenda for that event can be found in Appendix one.

A copy of the North West Surrey Urgent Care Capacity Programme is at Appendix two.

## Immediate Capacity Management Plan

| Corporate Actions | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|
| **1. Engage health economy partners in creating additional capacity in NW Surrey to support closure of escalation beds (Day Surgery and Admissions Lounge) at ASPH.** | Chief Executive and Deputy Chief Executive<br><br>4 December 2011.<br><br>**Complete.** | 1. Day Surgery Unit at St Peters closed to overnight and in-patient stays. | 1. ASPH has access to additional community hospital and adult social care beds. |
| **2. Engage with health economy partners to improve the management of unscheduled care across NW Surrey.**<br><br>**North West Surrey Urgent Care Capacity Programme Brief. At Appendix 2** | Deputy Chief Executive.<br><br>Programme initiated January 2012. | 2. Additional 23 community and partnership beds now available to support capacity and flow management.<br><br>2.1 Weekly cross organisational operational meetings now established to monitor North West Surrey Urgent Care and Capacity Programme progress. | 2. Days Day Surgery used for escalation - n – to be monitored via CoC meetings weekly.<br><br>2.1 Days since Admissions Lounge used for escalation - n – to be monitored via CoC meetings weekly.<br><br>2.2 Reduced number of GP urgent referrals to A&E<br><br>2.3 Increasing capacity in Community Hospitals<br><br>2.4 Reduced non-elective admission conversion rate<br><br>2.5 All to be monitored weekly via Urgent Care Dashboard once in place. |

| Divisional Actions | Lead and Timescale | Divisional Actions Update | Test of Effectiveness |
|---|---|---|---|
| **1. Plan to reduce the patient throughput through the Day Surgery Unit and to optimise use of Ashford DSU facilities.** | Divisional General Manager Anaesthetics, Critical Care & Theatres January 2012. | 1. Increased proportion of day surgery procedures now taking place at Ashford DSU. | 1. Increasing numbers of DSU patients on Ashford site and decreasing numbers on St Peters site – monitored monthly at divisional performance meetings. |
| **2. Implementation of; Calm Ordered Care Programme (CoC) to enhance divisional ownership and resolution of operational and flow issues across the Trust.** | Associate Director of Operations.<br><br>**Complete.** | 2. Weekly meetings with Divisional Directors to monitor Calm Ordered Care<br><br>2.1 Programme well established.<br><br>2.2 ED performance improving.<br><br>2.3 Length of Stay Project underway. | 2. Reducing length of stay.<br><br>2.1 Improved ED performance<br><br>2.2 To be monitored at weekly CoC meetings with Divisional Directors. |

## Compliance Action Plan – Outcome 01

| Regulated Activity | Regulation | Outcome 01 | Corporate Actions | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| **Treatment of Disease, disorders or injury.** | **Regulation 17**<br><br>**HCA 2008 (Regulated Activities) Regulations 2010.**<br><br>**How this Regulation is not being met (moderate concerns):**<br><br>**Suitable arrangements are in place to ensure the dignity, privacy and** | **Outcome 01: Respecting and involving people who use services.** | 1. Review nursing documentation to enable patients/carers to indicate their agreement with the plan and actions.<br><br>1.1. Embed the approach to sharing and planning care with patients. | 1. Assistant Director of Nursing. 13 February 2012<br><br>1.1. Assistant Director of Nursing with Matrons. 29 February 2012. | 1. Documentation review underway. | 1. Audit "patient confirmed patient/carer agreement with plan of care (signature)" monthly as part of the Best Care Nursing Documentation audit and report via Best Care Dashboard. March 2012. |
| | | | 2. Continue with Trust wide Living our Values Programme to continue to build cultural approach to patient care that | 2. Living our Values Project Lead. 31 March 2012 | 2. 1137 Trust staff attended Living our Values workshops | 2. Staff attendance at LoV workshops. Target:<br><br>85% Trust staff by 31 March 2012.<br><br>100% Trust Staff by 31 |

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| | **independence of patients are promoted, but these are not always adequate and the use of the day surgery for in patients does not promote consideration and respect for people.** | supports respect, involvement and effective communication. | | | May 2012<br><br>3. Monthly reporting of ward level Net Promoter Scores. |
| | | **Corporate Actions – outcome 01** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | 3. Continue with Trust wide Improving Discharge Management Project. | Chief Nurse. | 3. Discharge Competency Framework designed and now in implementation. | 3. 30% reduction in discharge related complaints by 31 March 2012 (against 10/11 out turn) as per Quality Account trajectory. |
| | | 4. Discharge Management Road-shows to be repeated. | Chief Nurse. February 2012. | | 4. Discharge Management Roadshows completed. End February 2012. |
| | | 5. Implement a 3-key questions poster in areas where patients are waiting to be seen to assist in effective | Improving Patient Experience Project Lead, Outpatients Matron, and Head of | 5. Shared Decision Business Case approved Strategic Delivery Board 24 January 2012. | 5. Posters implemented 31 March 2012. |

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| | | shared-decision making.<br><br>5.1 Develop Shared Decision Making Project for implementation April 2012 on. | Communications – 28 of February.<br><br>5.1 Chief Nurse/Medical Director. 1 April 2012. | | 5.1 Project Lead identified and Project Initiation Document complete and approved 31 March 2012. |
| | | **Corporate Actions – outcome 01** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | 6. Protect patients from impact of high demand on capacity and flow via update of the On-call Escalation Policy to ensure a rigorous approach to issues of patient care. | Associate Director of Quality and Associate Director of Operations. 27 January 2012. | | 6. An amended escalation policy is defined which contains a quality impact assessment; and escalation process to the appropriate person where capacity challenges potentially compromise quality of care. 31 January 2012. |
| | | 7. Review effectiveness of Care Rounding Process. | Assistant Chief Nurse. 23 February 2012. | | 7. Review complete, actions agreed with implementation plan to the Trust Board as part of the Quality Report on |

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| | | | | 29 March 2012. |
| | | **Corporate Actions – outcome 01** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | 8. Test clinical area compliance with Outcome 1. | Chief Nurse with Heads of Nursing.<br><br>February 2012. | | 8. Review clinical area compliance with Outcome 1 using CQC Compliance in Practice Review Tool and report to Trust Board. February 2012. |

## Compliance Action Plan – Outcome 04

| Regulated Activity | Regulation | Outcome 04 | Corporate Actions | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| **Treatment of Disease, disorders or injury.** | **Regulation 9**<br><br>**HCA 2008 (Regulated Activities) Regulations 2010.**<br><br>**How this Regulation is not being met (major concerns):**<br><br>**Proper steps have not been taken to ensure people using the service are protected against the risks of receiving unsafe or inappropriate care or treatment.** | **Outcome 04: Care and Welfare of people who use services.** | 1. To protect patients from the potential consequences of inappropriate use of the Day Surgery Unit Chief Executive Officer to mandate that under no circumstances is the St Peters DSU to be used as an escalation area without his direct approval and on the recommendation of the Deputy Chief Executive and the Chief Nurse to manage safety concerns related to exceptional demand on capacity. Monday 16 January 2012. | 1. Chief Executive and Head of Communications – January 2012. **Complete.** | 1. St Peters DSU now closed to overnight and in-patient stays. | 1. Days St Peters DSU used for escalation - n – to be monitored via CoC meetings weekly.<br><br>1.1 Any opening of DSU for escalation to be treated as an SI and a full Root Cause Analysis to be undertaken and reported to Trust Board in accordance with the routine management procedures for Sis. |

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| | | | **Corporate Actions – outcome 04** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | | 2. Design a 24 hour observational audit of hospital to observe operational management and care delivery. | Associate Director of Quality. 28 February 2012. | | 2. Design of 24 hour audit approved by Trust Executive Committee February 2012.<br><br>2.1 Execute audit March 2012 and repeat October 2012. |
| | | | 3. Implement Phase 2 Best Care Programme. Dedicated improvement projects to improve Nursing Documentation and Care Planning and Patient Monitoring. | 3. Deputy Chief Nurse and Head of Patient Safety – 27 January 2012.<br><br>3.1 Project Definitions to February 8 Programme 1 Board.<br><br>3.2 Commencement of project implementation 15 February 2012. | | 3. Improvements to be monitored via Best Care Dashboard to Trust Board monthly.<br><br>3.1 Care plans and evaluations relating to the risks associated with nutrition, manual handling and coordinating / maintaining care plans to improve to at least 95%.<br><br>3.2 Nursing documentation should be clearly recorded, dated and signed to improve to at least 95%. |

| | | | Corporate Actions – outcome 04 | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| | | | 4. Review medicines management and monitoring protocols to support embedded best practice. | Chief Pharmacist and Medical Director<br>February 2012. | | 4. Audit of medicines prescribing, administration and monitoring monthly and reported via Best Care Dashboard to Trust Board. |
| | | | 5. Test clinical area compliance with Outcome 4. | Chief Nurse and Heads of Nursing February 2012. | | 5. Review clinical area compliance with Outcome 4 using CQC Compliance in Practice Review Tool and report to Trust Board. February 2012. |
| | | | 6. Develop formalized “Clinical Day Programme” – senior nurses and clinicians to return to the wards and clinical areas, primarily to role model and share | Operational Lead – Chief Nurse’s Office with Heads of Nursing, Medical Director, Divisional Directors and Clinical Specialty | | 6. Design complete and agreed with implementation plan agreed 31 March 2012. |

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| [redacted] | knowledge with colleagues and to receive feedback and comments directly from staff and patients. | Leads. Design phase to commence January 2012. | | |
| | **Divisional Actions – outcome 04** | **Lead and Timescale** | **Divisional Actions Update** | **Test of Effectiveness** |
| | 1. Capacity Escalation Policy to incorporate key quality performance indicators. | Anaesthetics, Critical Care & Theatres Division General Manager and AD of Operations. 25 February 2012 | | 1. Revised policy ratified in Clinical Governance Committee on 1/3/12. |
| | 2. Appoint new Ward Manager to Falcon Ward. | Head of Nursing Surgery and T&O.<br>**Completed.** | 2. New Ward Manager appointed and in place. | 2. Falcon Ward to demonstrate compliance with Outcome 4 using the CQC Compliance in Practice Review Tool. February 2012. |

| | | | Divisional Action – outcome 04 | Lead and Timescale | Divisional Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| | | | 2.1 Falcon Ward Manager to review and accelerate improvements identified through Best Care Audit to address non-compliance with Outcome 4. | Falcon Ward Manager supported by Matron for Surgery and Head of Nursing. January 2012. | | 2.1 Falcon Ward to demonstrate compliance with Outcome 4 using the CQC Compliance in Practice Review Tool. February 2012. |

## Compliance Action Plan – Outcome 14

| Regulated Activity | Regulation | Outcome 14 | Corporate Actions – outcome 14 | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| **Treatment of Disease, disorders or injury** | **Regulation 23**<br><br>**HCA 2008 (Regulated Activities) Regulations 2010**<br><br>**How this Regulation is not being met (moderate concerns):**<br><br>**The provider has systems in place for staff to receive the necessary training and support to care for** | **Outcome 14: Supporting Staff** | 1. Strengthen Leadership Development Programmes (including Ward Sister Development Programme) to emphasise leadership responsibility for ensuring staff receive training for role and are appropriately supervised. | Head of Education and Training. February 2012. | 1. Clinical Team Leadership Development Programme drafted; to commence delivery in March 2012. | 1. Revised Programme in place and dates identified for delivery.<br><br>1.1 Mandatory Training Records Audit February and March 2012 demonstrating 60 and 70 % achieved and recorded. |
| | | | 2. Design and disseminate a one-page template to facilitate and document regular ward level 1:1 management / | Deputy Director of Workforce. 27 January 2012. | 2. 1-1/supervision template drafted and disseminated for feedback | 2. Template in use and stored electronically on T-Drive. |

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| | **people who use the service, but has not demonstrated that all staff has received training for their role or that they have been appropriately supervised.** | | supervision sessions; to contain: progress on PDP objectives, reflective practice, professional goals and welfare issues. | | | |
| | | | **Divisional Actions – outcome 14** | **Lead and Timescale** | **Divisional Actions Update** | **Test of Effectiveness** |
| | | | 1. Quarterly review of the objectives set in personal development plans to ensure they are SMART, and are being followed-through. | Heads of Nursing. February 2012. | 1. To commence in February 2012 | 1. Evidence of the first quarterly review can be found on T-drive in March 2012. |
| | | | 2. Action plans in Divisions to ensure completion of attendance at mandatory training updates by end of March 2012. | Divisional General Managers. 31 January 2012. | 2. Reviews of mandatory training compliance and reports held with all divisions in December 2011. | 2. Minimum 70 % compliance with mandatory training by 31 March 2012.<br>2.1 100% compliance by July 2012. |

| | | | Divisional Actions – outcome14 | Lead and Timescale | Divisional Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| | | | 3. Hold regular 1 to 1 meetings with staff at ward level to facilitate clear line management and supervision. | Ward Managers. 1 February 2012 and on-going. | 3. To monitor from February 2012 onwards | 3. Regular 1-1 meetings completed, recorded on template. Audit reflects 85% compliance by July 2012. |

## Improvement Action Plans – Outcome 02

| Regulated Activity | Regulation | Outcome 02 | Corporate Actions | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| **Treatment of Disease, disorders or injury.** | **Regulation 18**<br><br>**HCA 2008 (Regulated Activities) Regulations 2010.**<br><br>**This regulation is being met but CQC has concerns relating to sustained compliance (minor concern) Procedures are in place to ensure patients are able to give** | **Outcome 02: Consent to care and treatment.** | 1. Re-launch Consent to Treatment Policy to include:<br>• Policy dissemination via Aspire<br>• Awareness raising via; Team Brief; Senior Nursing and Midwifery Leadership Team meetings, Clinical Governance Committee and Trust Executive Committee. | Head of Patient Safety. 24 February 2012. | | 1. Re-launch complete. February 2012. |
| | | | 2. Launch a monthly by ward and clinical area Consent Audit to be recorded via Best Care Dashboard. | Head of Clinical Effectiveness. 24 February 2012.<br><br>Clinical Effectiveness and National Audit | | 2. Monthly consent-to-treatment spot check and the results added to the Best Care dashboard March 2012. |

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| | **their informed consent to care or treatment but in one case these had not been followed.** | | Review group (CENARG) meeting in January to agree and minute action to add to Best Care Dashboard from February 2012. | | |
| | | **Corporate Actions – outcome 02** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | 3. Review the CQC Essential Standard Owner on Health Assure to include a Surgeon. | Associate Director of Quality and Divisional Director for Surgery. 31st January 2012 | | 3. Trust Exec Committee agenda item, discussed and decision recorded in minutes. Divisional Director for Surgery will nominate new Standards owner and disseminate decision. |
| | | 4. Test compliance with Outcome 2. | 4. Chief Nurse and Heads of Nursing February 2012 | | 4. Review clinical area compliance with Outcome 2 using CQC Compliance in Practice Review Tool and report to Trust Board. February 2012 |

| | | | Divisional Actions – outcome 02 | Lead and Timescale | Divisional Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| | | | 1. Circulate the Consent Policy to all wards and Clinical Specialty Leads within each Division and discuss at Local Clinical Governance meetings | Divisional Clinical Governance Managers. 24th February 2012. | | 1. Policy circulated February 2012. |
| | | | 2. Audit of Integrated Care Pathway (ICP) to include:<br>• Form prior to patient leaving the ward<br>• Pre op checklist<br>2.1 Review of the ICP to include a check on legibility of the consent form. | Anaesthetics, Critical Care & Theatres Division Head of Nursing supported by Head of Patient Safety through Senior Nurse Leadership Meeting. March 2012 | | 2. Monthly re-audit shows improvement month on month by June 2012 and consistent improvement towards 95% outcome achievement on legibility. |

## Improvement Action Plans – Outcome 07

| Regulated Activity | Regulation | Outcome 07 | Corporate Actions | Lead and Timescale | Corporate Actions Update | Test of Effectiveness |
|---|---|---|---|---|---|---|
| **Treatment of Disease, disorders or injury.** | **Regulation 11**<br><br>**HCA 2008 (Regulated Activities) Regulations 2010.**<br><br>**This regulation is being met but CQC has concerns relating to sustained compliance (minor concern)**<br><br>**People who use the service are safeguarded against** | **Outcome 07: Safeguarding people who use services from abuse.** | 1. Mental Capacity and DoLs training that was undertaken this year to be strengthened and provided by specialist trainers. | Associate Director of Quality / Deputy Chief Nurse 31st January 2012 | | 1. 100% training achieved by 26th July 2012. |
| | | | 2. Awareness raising campaign to be strengthened and to include circulation of information to all staff via Aspire and with payslips. | Deputy Chief Nurse and Head of Communications supported by Operational Lead Chief Nurses Office February and March 2012. | | 2. Information materials produced and circulated March 2012. |
| | | | 3. Continued and focused delivery of the action plan that the Safeguarding Steering Group has been working from since May 2011 and monitoring of progress to date. | Deputy Chief Nurse. | | 3. Action plan on trajectory at each Gantt chart checkpoint. |

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| | **abuse or the risk of abuse, but there is a general lack of awareness of the MCA and DoLS.** | 4. Safeguarding training leadership programme to be attended by Trust Safeguarding Lead from January 2012. | Deputy Chief Nurse. Week beginning 16/1/12. | | 4. Training records as evidence of Trust Safeguarding Lead attended training. |
| | | **Corporate Actions – 07** | **Lead and Timescale** | **Corporate Actions Update** | **Test of Effectiveness** |
| | | 5. Appointment of Operational Lead Nurse for Older People, Safeguarding Vulnerable Adults and Mental Health. From April 2012. | Chief Nurse April 2012 | | 5. Appointee in post. April 2012. |
| | | 6. Test compliance with Outcome 7. | Chief Nursing and Heads of Nursing. February 2012. | | 6. Review clinical area compliance with Outcome 7 using CQC Compliance in Practice Review Tool and report to Trust Board. February 2012 |

**APPENDIX ONE**

**Trust Executive Committee: Development Session**
**Friday 13 January 2012**

**Aims**:

1. To facilitate divisional and corporate team reflections on the CQC Review of Compliance.
2. To inform the corporate level action plan and facilitate divisional level response and planning.
3. To ensure corporate and divisional teams are focused on continuing compliance activity across 16 Essential Standards.

**Outputs**:

1. A written report of the organisational reflection that will enable a conversation throughout the organization at corporate, divisional and ward / unit level, which will underpin the sustainable improvements to achieve and maintain full CQC compliance;
2. Responsive action plan for submission to CQC that has benefited from divisional input;
3. Engagement, support and understanding of accountabilities for delivering the action plan;
4. Ownership of plans within the corporate and divisional teams to deliver the ground level improvements.

**Agenda**:

(1) Introductions and welcome (Suzanne)
2.00pm
(2) CQC inspection and report overview – context (Suzanne)
2.05pm
(3) Group work scene setting (Heather)
2.15pm
(4) Small-group work for each group :
2.20pm

**Groupings: 1 Corporate Team; 7 Divisional Teams – looking at the report consider the following from your division's/team perspective:*

- Where there surprises in the report in relation to your division? If so why?
- What are the underlying ways of working, systems and processes within your division that were contributory factors?
- What are the underlying ways of working, systems and processes within the Trust and at corporate level that were contributory factors?
- What will you do differently as a leadership team in the future that will address the areas identified?
- How will you engage your team and divisional colleagues in this debate – what is your engagement plan?
- What 3 actions for improvement and sustained compliance are you committing to today?

(5) Feedback/plenary (Mike to facilitate)
3.20pm

(6) Draft Corporate action plan overview and discussion (Heather)
3.50pm

**Attendance**

(1) Divisional Triumvirates: Divisional Directors; Divisional General Managers; Divisional Heads of Nursing
(2) Trust Executive Committee Members
(3) Scribe

**APPENDIX TWO**

## NORTH WEST SURREY URGENT CARE CAPACITY PROGRAMME BRIEF

**VERSION:** v1.8 **DATE:** 16th January 2012

## 1 BACKGROUND

The Urgent Care Capacity Programme is an integrated programme of work aiming to deliver unscheduled care across the local health economy in a responsive, coordinated and flexible way.

The primary focus of the programme is to address the current issues facing patients and providers of unscheduled care in North West Surrey, and specifically resolve the urgent care capacity issues facing Ashford and St Peter's NHS Foundation Trust (ASPH).

This is a cross-organisational programme responsible for achieving the maximum patient care and flow through service provision in the community and delivering pathways based on patient needs across organisational boundaries.

The programme team detailed in section 5.1 is tasked with providing a continued focus on delivery and driving progress of the programme.

## 2 VISION STATEMENT

Through the delivery of the programme, the North West Surrey healthcare providers will improve the appropriate levels and use of urgent care capacity and deliver care that is:

- Responsive, coordinated, flexible and efficient
- Ensuring the right care by the right providers at the right time for the patient
- Increasing capacity, but also improving the flow and the pathways
- Helping to guarantee rapid access to the most appropriate models of urgent care
- Ensuring safe patient care at all points of care delivery in the system

## 3 WORKSTREAMS

The workstreams below have been identified as urgent areas for improvement which, when completed, will collectively deliver the vision statement of the programme.

## 3.1 GP URGENT REFERRALS

To reduce A&E attendances and ensure the right care is delivered by the right providers; by ensuring GP urgent referrals are appropriate and that robust triage processes are in place.

### 3.1.1 WORKSTREAM LEADS

- Valerie Bartlett
- Peter Radoux
- Liz Lawn
- Jacqui Smart
- Mike Baxter

### 3.1.2 DESIRED OUTCOMES AND INITIAL OBJECTIVES

| Desired Outcome | Objective | Lead |
|---|---|---|
| Understanding existing profile of GP urgent referrals for conveyance to A&E | Complete analysis of current GP urgent referrals for conveyance to A&E and establish profiles and patterns (days, times, practices, etc) | PR |
| | Establish if GPs are routinely seeing patients before referring to A&E | PR |
| Reducing inappropriate GP urgent referrals to A&E | Audit and measure of inappropriate GP urgent referrals | VB |
| | Identify GPs to review information | LL |
| | Feed-back analysis of current urgent referrals profile to GPs in order to question and review referral routes and alternatives | LL |
| Establishing a GP presence in A&E | Identify GPs to spend time in A&E to help treat and redirect future activity, and to increase system understanding of A&E workload | LL |
| | Liaise with A&E and GPs to agree schedule and duration of GP presence and implement | VB |
| Implementing a triage process via Rapid Access Centre | Design of a single-point-of-contact for alternatives to acute referral | JS |
| | Implement triage process via Rapid Access Centre for GP urgent referrals | JS |
| Implement revised protocol for nursing homes | Revise protocol for nursing homes to contact GPs as an alternative to calling 999 | VB / LL |
| | Review progress of Nursing Home project and options for expanding to cover all nursing homes | MB |

### 3.1.3 BENEFITS

| Description of Benefit | How will it be measured | Frequency |
|---|---|---|
| Reduced number of GP urgent referrals to A&E | Number of GP urgent referrals received by A&E | Weekly |
| Increased appropriateness of GP urgent referrals to A&E | Audit of GP urgent referrals received by A&E | Monthly |
| Increased proportion of activity in Rapid Access Clinic | Number of patients attending Rapid Access Clinic | Weekly |
| Reduced number of avoidable A&E attendances as a result of GP urgent referrals | Audit of A&E attendances as a result of GP urgent referrals | Daily |
| Improved A&E performance | Existing measure against 4 hour performance target | Weekly |

## 3.2 COMMUNITY HOSPITALS AND STEP-DOWN BEDS

To increase the availability and use of community hospital beds as an alternative to admission and to enable improved patient flow out of the acute setting.

## 3.3 WORKSTREAM LEADS

- Cynthia Dwyer
- Jacqui Smart
- Liz Lawn
- Michelle Head

## 3.4 DESIRED OUTCOMES AND INITIAL OBJECTIVES

| Desired Outcome | Objective | Lead |
|---|---|---|
| Increasing capacity in Community Hospitals | Increase the number of open community hospital beds for continuing care patients in ASPH | CD |
| | Identify further capacity to be made available in community hospital sites | CD |
| | Agree funding arrangements for increasing community hospital capacity | JS |
| | Implement GP cover for additional beds at Brockhurst | LL |
| | Ensuring social care support for discharge management is in place within community hospitals | MH |
| | Commissioning of Burwood Ward, Walton to be in | |

| | | |
|---|---|---|
| | place in January 2012 | CD |

| | | |
|---|---|---|
| Reviewing and re-launching the referral criteria and process | Review and amend existing criteria for referral from ASPH to community hospitals<br><br>Agree changes to referral criteria with all stakeholders<br><br>Review and streamline process of referral to community hospitals<br><br>Review and re-launch the pathways / directory of service information for the community hospitals | CD<br><br>CD<br><br>CD<br><br>CD |

### 3.4.1 BENEFITS

| Description of Benefit | How will it be measured | Frequency |
|---|---|---|
| Reduced number of empty beds in community hospitals | Bed occupancy reports from identified sites | Weekly |
| Increased number of available step-down beds in community hospitals | Number of available step-down beds in identified sites | Weekly |
| Reduced delays for patients on complex discharge pathways | Existing measures of complex discharge pathways from ASPH | Weekly |

## 3.5 ADMISSION AVOIDANCE IN A&E

To reduce the admission conversion rate in A&E through the implementation of an integrated admission avoidance team; and an improved process for use of Outpatient appointments.

## 3.6 WORKSTREAM LEADS

- Valerie Bartlett
- Michelle Head
- Peter Redoux

## 3.7 DESIRED OUTCOMES AND INITIAL OBJECTIVES

| Desired Outcome | Objective | Lead |
|---|---|---|
| Designing and implementing an integrated admission avoidance team in A&E/ MAU | Identify team roles, responsibilities, arrangements and admission avoidance options<br><br>Understand available pathways for admission avoidance and best practice from elsewhere<br><br>Secure funding for admission avoidance team based on specification<br><br>Implementation of admission avoidance team into A&E / MAU | VB<br><br>MH<br><br>VB<br><br>VB |
| Increase availability and take up of outpatients appointments as an alternative to admission | Establish the requirement for dedicated outpatient slots by specialty and number<br><br>Agree dedicated slots and redesign of clinical templates with Outpatient department<br><br>Establish and implement an outpatient booking processes in A&E | VB<br><br>VB<br><br>VB |
| Increase conveyance to walk-in centres | Re-launch ambulance crew criteria for conveyance of patients to walk-in centres | PR |

### 3.7.1 BENEFITS

| Description of Benefit | How will it be measured | Frequency |
|---|---|---|
| Reduced non-elective admission conversion rate | Conversion rate of A&E attendees to admissions | Weekly |
| Increased use of dedicated slots in Outpatients | Number of dedicated Outpatient slots utilised by | Weekly |

## 3.8 REDUCING DELAYED TRANSFERS OF CARE

To reduce identify, review and plan discharge for those patients in ASPH with a long-stay (with length of stay greater than 15 days), and maximising the use of community support reduce delayed transfers of care.

### 3.8.1 WORKSTREAM LEADS

- Valerie Bartlett
- Cynthia Dwyer
- Mike Baxter

### 3.8.2 DESIRED OUTCOMES AND INITIAL OBJECTIVES

| Desired Outcome | Objective | Lead |
|---|---|---|
| Identifying and reviewing, with each ward, the long-stayers at ASPH and agreeing an outcome for each | Identify those long-stayers that are medically fit for transfer<br><br>Review long-stayers by ward and plan outcomes for each patient with host wards<br><br>Embed process of analysis and review of long-stayers into daily / weekly processes at ASPH | MB<br><br>MB<br><br>VB |
| Establishing the skills required for community support for long-stayers and the requirement for a review of long-stayers in community hospitals | Establish skills required for community support for long-stayers<br><br>Analysis and review of long-stayers in community hospitals | MB<br><br>CD |

## 3.9 DEVELOPING COMMUNITY URGENT CARE DASHBOARD

To design, develop and agree a comprehensive dashboard report as required to support the workstreams within the programme and monitor improvements in key performance indicators.

### 3.9.1 WORKSTREAM LEADS

- Valerie Bartlett

### 3.9.2 DESIRED OUTCOMES AND INITIAL OBJECTIVES

| Desired Outcome | Objective | Lead |
|---|---|---|
| To design, develop and agree a comprehensive dashboard report as required to support the workstreams within the programme. | Data definitions and initial design of dashboard<br><br>Draft dashboard for circulation to stakeholders<br><br>Sign-off and production of regular dashboard information | VB |

## 4 TIMELINE AND TRANSITION ARRANGEMENTS

An outline of the action plan and timeline for implementation are included in appendix A. The programme team detailed in section 5.1 will be responsible for implementing the changes across the North West Surrey health economy. Interfaces and interdependencies with existing projects and programmes will be monitored by the PMO and managed by the programme team.

## 5 PROGRAMME ORGANISATION

Weekly meeting will be conveyed initially to review objectives and progress against plan. A dashboard of activity information will be provided once the relevant measures have been identified.

The programme team detailed here is tasked with providing a continued focus on delivery and driving progress of the programme, as well as ensuring:

- Delivery of the programme objectives within the agreed parameters
- The programme, its objectives and outcomes are effectively communicated across organisations
- Adequate and appropriate resources are committed to delivery of the programme
- Progress against key milestones and agreed objectives is continually reviewed and promoted
- All strategic issues are resolved where necessary

## 5.1 PROGRAMME TEAM

Outlined below are the team members, including key stakeholders.

| Name | Organisation |
|---|---|
| Alison Edgington | Surrey PCT |
| Andrew Liles | Ashford and St Peter's NHS Foundation Trust |
| Claire Braithwaite | Ashford and St Peter's NHS Foundation Trust |
| Cynthia Dwyer | Surrey PCT |
| Fiona Edwards | Surrey and Borders Partnership NHS Foundation Trust |
| Helen Atkinson | Surrey PCT |
| Jacqui Smart | Surrey PCT |
| Jayn Hughes | Surrey PCT |
| Jayne Reynolds | Surrey and Borders Partnership NHS Foundation Trust |
| Kathleen Ely | Surrey PCT |
| Liz Lawn | Northwest Surrey Clinical Commissioning Group |
| Mary Probert | Surrey PCT |
| Mike Baxter | Ashford and St Peter's NHS Foundation Trust |
| Paul Sutton | South East Coast Ambulance Service |
| Peter Radoux | South East Coast Ambulance Service |
| Sarah Mitchell | Surrey County Council |
| Valerie Bartlett | Ashford and St Peter's NHS Foundation Trust |

# 6 DOCUMENT HISTORY

## Author(s):

| Version | Date | Author | Amendment History |
|---|---|---|---|
| V0.1 | 06/12/2011 | Mark Hinchcliffe | Initial draft |
| V1.0 | 09/12/2011 | Mark Hinchcliffe | Further draft |
| V1.1 | 12/12/2011 | Mark Hinchcliffe | Vision statement updated |
| V1.2 | 13/12/2011 | Mark Hinchcliffe | Updated objectives |
| V1.3 | 19/12/2011 | Mark Hinchcliffe | Further draft |
| V1.4 | 21/12/2011 | Mark Hinchcliffe | Updated objectives |
| V1.5 | 09/01/2012 | Mark Hinchcliffe | Updated objectives |

## Reviewer(s):

| Name | Job Title / Responsibility | Date | Version |
|---|---|---|---|
| Claire Braithwaite | Associate Director Performance Improvement | 09/12/2011 | V1.0 |

## Approver(s):

| Name | Job Title / Responsibility | Date | Version |
|---|---|---|---|
| Valerie Bartlett | Deputy Chief Executive | 12/12/2011 | V1.1 |