Agenda Item:

11

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	10 September 2014
Officer	Director for Adult and Community Services
Subject of Report	**Update report from Dorset County Hospital NHS Foundation Trust following Care Quality Commission unannounced inspection in June/July 2013**
Executive Summary	The Care Quality Commission (CQC) undertook an unannounced inspection of Dorset County Hospital over four days in June/July 2013. As a result of their findings the Trust provided a detailed response and developed an action plan to address the shortfalls in standards identified. The action plan was scrutinised by the Trust's Quality Committee, Senior Management Team and Trust Board to ensure the actions prescribed were being met in the timescales set. A second inspection was undertaken in October 2013 to review the medication storage concern identified and this was signed off by the CQC as all actions being completed and the Trust compliant with that standard. The Trust expected a further unannounced visit from the CQC to assure themselves that the remaining actions had been undertaken to achieve compliance against the CQC standards, but this has not yet happened. The Deputy Director of Nursing for the Trust will attend the Committee in relation to this report, which provides an update against actions identified, as at August 2014 (Appendix 1). In addition to the internal report, an external audit of the Trust's compliance and progress against the action plan was undertaken by auditors KPMG, to provide further assurance. This report is attached as Appendix 2.

Impact Assessment	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset County Hospital NHS Foundation Trust.
	Budget: None for Dorset County Council.
	Risk Assessment: Not applicable. Current Risk: LOW Residual Risk: LOW
	Other implications: None.
Recommendation	That the Committee note the updated action plan detailing the work undertaken to address any shortfalls in standards identified through the CQC inspection.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and enrich the health and wellbeing of Dorset's most vulnerable adults and children.
Appendices	1. CQC Assurance and Evidence of Actions Summary, August 2014 2. CQC Action Plan – Report by KPMG, June 2014
Background Papers	1. Dorset Health Scrutiny Committee, 10 March 2014: Care Quality Commission unannounced inspection Action Plan for Dorset County Hospital NHS Foundation Trust: http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/ABA512699146EE1F80257C8D003FB46F?OpenDocument
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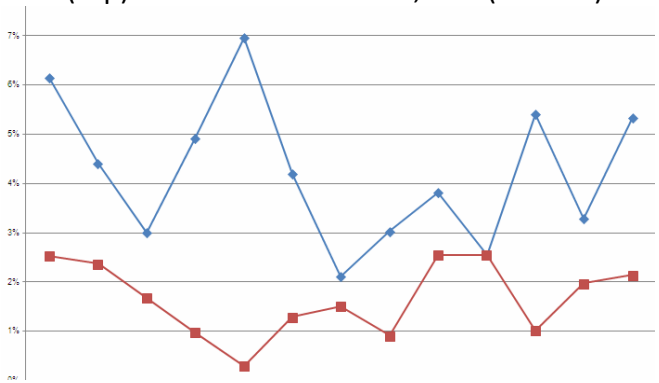
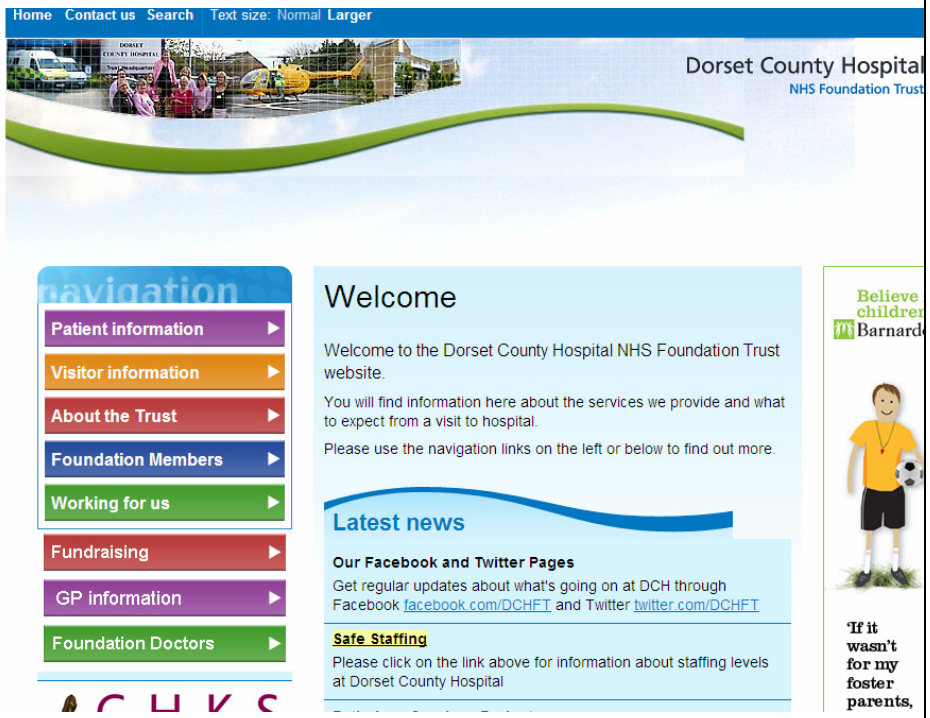
Appendix 1

Outcome and Generic Issue	CQC Findings on Inspection (June/July 2013)	Actions listed	Target completion date	What would they find if visited today? What has changed?
(Outcome 4 +21)Pressure Ulcers ***(DoN/DDoN)***	• Had been a rise in pressure ulcers identified via Safety Thermometer in June/July 2013	• Ongoing monitoring • Increase education • Development/launch of Pressure Ulcer Guidelines • Audit against Guidelines	Ongoing, Audit of practice against policy	Blue (top) = Old Pressure Ulcers, Red (bottom) =New Pressure Ulcers.  -Pressure Ulcers have remained an area of concern. Education, equipment and training has been provided. DoN/DDoN met with the matron team to identify what difficulties were being experienced. -Staff safety briefings have been altered to identify patients 'at risk' so that communication amongst the team at handover is increased. Matrons/DDoN have been visiting wards daily to ascertain if assessments have been completed and are accurate. - Monitoring record has been developed to identify recurrent themes/trends. - Action plan has been developed and incorporated into new documentation to 'recommend' preventative measures that can be implemented when a patient is assessed as 'at risk'.
(Outcome 4 +21) Documentation	• Poor documented compliance of patients	• Review of current documentation • Establish new documentation	June 2014	-Final version has now been produced, to go to HRDG on 13th August, where it is anticipated that it will be agreed. - All relevant specialisms have now commented and feedback incorporated.

(DoN/DDoN)	assessed for risk factors (falls, nutrition, pressure area damage etc) • Inadequate documentation regarding patients capacity to consent	• Liaise with other organizations and VitalPac • Audit for compliance and improvement		- Old inpatient record has been stopped from printing in anticipation of roll-out plan of new document. - VitalPac 'road Map' now available, so upcoming modules and features are available to staff to guide improvements. - Capacity to consent/safeguarding/DoLs currently very high on national agenda and formal letter sent to CCG. Awaiting further National guidance. - In hospital flow chart approved to support staff in clinical decision making.
(Outcome 9) Medications/ Storage ***(DoO/ Chief Pharmacist)***	• Unsecure storage of IV Fluids • Poor recording of min/max fridge temperatures • Anticoagulation medications on bottom of drugs trolleys	• Ensure fluids are locked • Implement cold storage WiFi probes • Revise the cold storage of medicines policy	August 2013	-WiFi Probes in place in ward fridges/Clinical Areas and recorded in folder in Pharmacy. Any deviations from limits are monitored daily and electronically captured. - Informal walk-arounds have been able to demonstrate 100% compliance with drug cupboards/fluid cupboard storage.
(Outcome 13) Temporary Staffing	• Staffing levels at times fall below identified standards	• Staffing levels reviewed on shift basis. Safety issues escalated to	Immediate effect	- Staffing levels high on public agenda, now uploaded and reported publically to UNIFY. - Exception reporting to Trust Board to commence July – completed. - Staffing shortages recorded on daily Situation reports

(DoHR/ Head of Recruitment/ DDoN & Matrons)	• Staffing of escalation area by agency staff • Inadequate arrangements in place to ensure temporary staff have right skills	DoN/DDoN • Specials Criteria • Substantive staffing of escalation area • Annually review SLA to ensure mandatory training requirements are explicit • Conduct annual checks on all agency staff to ensure all elements of mandatory training have been completed	Criteria to be available by January 2014	-Exception reporting and staffing information available on intranet:  - 1 X Signed SLA for all supplying agencies. Any agency that has not signed the SLA has been removed. - Any agency member of staff who has worked in the Trust since February 2014 has a completed checklist with supporting documents to ensure compliance. (Folders of this information are available in bank office).
(Outcome 14) Training	• Inadequate uptake of mandatory	• Review requirements for core and non-core	April 2014	- Signed up for UK Core Skills framework with HEW (standardization of training) Mapping process completed = compliant - Divisional/trust board reports are available to demonstrate

(DoHR/ HoE)	training (Conflict resolution, safeguarding adults/children) • Inadequate dementia awareness in clinical areas • Clinical supervision not evidenced in all clinical settings	mandatory training • Monthly reports to divisions and trust board • Dementia training • Establish dementia champions • Register of coaches/mentors		compliance - Safeguarding children training action plan in place. - Dementia awareness training target 30% by March 2014 – Achieved. Target 80% by March 2015. Reported to HEW. - Dementia champions supported in each ward area, although list of people not currently available (being actioned NT). - Register of nurse mentors/supervisors available at education centre - Clinical Supervision policy has been amended, agreed at the education Committee and has now been to CGC; has now been publicised in CEO brief and available on intranet. Further cascading to take place. - Staff supported to undertake the Thames Valley Leadership Academy programmes of study
(Outcome 16) Audit and Risk Register ***(DoN/DDoN/ Clinical Audit Team)***	• Inability to track audits that are taking place, progress, results on clinical audit database • Inconsistency in how risk register used, updated and presented to Trust Board	• Produce a GAANT chart demonstrating audits started, completed and progress • Produce a forward planner with timescales for completion of the risk register and approval mechanisms	February 2014	- GAANT chart available on local drive. Annual Audit plan delivered to quality committee 16th July 2014. -Review and revalidation standard of the Trusts Risks Register available, with Meeting dates of upcoming SMT, Audit Committee, Trust Board. Copies of previous minutes of discussions available. Risk leads meeting every Friday, Committee each month (minutes available

KPMG

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CQC Action Plan

June 2014

Contents

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Status of report

- Discussion draft issued to Executive Lead and Auditees — 30 May 2014
- Executive Lead to provide responses to draft — 9 June 2014
- Final report issued to Executive Lead and Auditees — 10 June 2014
- Report presented to Audit Committee — 17 June 2014

Distribution

To (for action):

- Alison Tong – Director of Nursing and Quality
- Neal Cleaver – Deputy Director of Nursing

Cc (for information):

- Libby Walters – Director of Finance and Resources

Section one

Executive Summary

Background to the Review	During June/July 2013, the Trust received an unannounced inspection from the CQC. The inspection led to a number of recommendations, for example related to medicines management, records and staffing. Since this date, the Trust has developed a number of processes to monitor the implementation of the action plans, including a monthly oversight by the senior management team and bi-monthly reports to the Quality Committee. Our work focused on reviewing the action plan and a sample of completed actions to provide assurance that the current status of the action plan is supported by relevant evidence and that the recommendations raised have been addressed appropriately. The review also considered the processes in place to monitor the implementation of those plans and future actions.
Overall Conclusion	Based on the findings of our work, we conclude that the governance arrangements and progress with the CQC Action Plan provide **high assurance**. The action plan arising from the CQC report is regularly monitored by senior managers and the Board. Roles and responsibilities for delivering the actions are well understood, and recent improvements have been made to the action plan update reports to more clearly identify the status of actions. The vast majority of actions reviewed can be evidenced as complete or progress is as stated in the update report. Only one action, regarding publicising of the mentoring programme, had not been completed sufficiently to meet the action plan requirement. We have raised three recommendations in this report.
Summary of Recommendations	We raised 3 recommendations as a result of our review (high priority represents the most urgent and high risk category) :

Priority Rating	Number of Recommendations
High Priority	0
Medium Priority	0
Low Priority	3
Total	**3**

Section two

Review of Objectives

Scope of work

The following objectives were agreed with management within our terms of reference:

Objective	Description	Work Performed
Objective 1: Design of Processes	We will consider the process and governance arrangements in place to monitor the implementation of the action plan. This will include consideration of how relevant officers are held to account for implementation of schemes, review of which committee is responsible for reviewing the status of action plans and providing assurance to the Board and how it completes this task through the reporting that is received.	■ Interviews with relevant officers responsible for delivering actions in the CQC action plan ■ Review of the CQC action plan, relevant update reports and related papers
Objective 2: Review of Status of Action Plan	We will select a sample of recommendations raised by CQC in June/July 2013 and test the actions completed to provide assurance that: • Detailed action plans are in place and progress is being made to address the recommendations; • The status of the implementation of the action plans is appropriate; and • The action plans are regularly revisited and monitored to ensure the necessary level of accountability.	■ Review of specific CQC actions and relevant evidence to confirm status of actions.

Overall Arrangements to manage action plans

Areas of Good Practice

✓ The format of CQC action plan updates has recently been strengthened to more clearly identify current status of actions and available evidence to support this. This is a significant improvement on the previous version of the action plan where the status of actions was difficult to identify and assurance on completion was therefore not robust.

✓ Roles, responsibilities and accountabilities for progressing the Action Plan are clear. The Director of Nursing is the Executive Lead with the Deputy Director of Nursing taking the day-to-day coordinating role. Executive Leads oversee Outcome areas relevant to their portfolio of responsibility. This is well understood amongst Trust staff interviewed.

✓ The status of actions is regularly reported in a number of fora across the Trust which has helped raise awareness amongst Trust staff to the issues raised by CQC and the actions the Trust is taking to address them.

✓ Any slippage or potential slippage in expected completion dates to meet actions has to be agreed with the lead Executive Director and approved by the Quality Committee. This has helped to keep actions on track, with only one major change in completion date so far (related to documentation).

✓ The Director of Nursing and her Deputy have undertaken spot checks on wards to ensure compliance with actions such as medicines storage.

✓ The system for tracking completion of clinical audits and to monitor outcomes has been strengthened.

Areas of Good Practice (continued)

✓The Trust is keeping CQC inspection requirements and the action plan in focus through team briefings and ward newsletters.

Areas for development

▪ Though the format of the CQC action plan updates is much improved, because of its summarised nature it still needs to be read alongside the original action plan so that lead responsibility and expected outcomes can be understood [Recommendation 1].

Action Plan assurance

As part of the review, we have assessed the CQC Action Plan (April 2014 version). For a sample of actions noted within the Action Plan, we have reviewed the evidence in place in order to confirm if they have been appropriately addressed (see Appendix 1).

Areas of Good Practice

✓Our review of a sample of actions arising from the June/July 2013 CQC report (April 2014 version of the resulting action plan), showed that all of the actions (except one) had supporting evidence to demonstrate they had progressed as stated. We have provided further detail of our review of the action plan in appendix one.

✓ Temporary staffing: The Trust has reduced the need for temporary staff. In the first three months of 2014/15 the use of (and demand for) temporary staff has been significantly less than the same period in 2013/14**.**

✓Documentation – The Trust has developed a new patient record form with the help of wide staff consultation, learning from other Trusts, and trialling in a number of wards. Though this approach has delayed roll-out of a new record form, it should ensure the new form is more user-friendly and that implementation is more successful

✓ Medicines management – rapid implementation of electronic fridge temperature monitoring and installation of keypad door locks has improved the safe storage of medicines.

Areas of Development

▪ Staff Training: Child Protection Training is a key area of mandatory training with low staff attendance. Some Trusts have undertaken risk assessments to identify which level of training is most appropriate for which post holders. Such an assessment has not been undertaken at the Trust to date, and this may mean that many staff are being required to attend a level of training that is not relevant for their particular post. In Trusts where risk assessments have been done it has been found that the number of staff needing to attend higher level training can be reduced. [Recommendation 2]

▪ The Mentoring Policy and a register of trained mentors is in place but has yet to be publicised to staff (original deadline April 2014) [Recommendation 3]

Section three

Recommendations

This section summarises the recommendations that we have identified from our work. We have given each of our recommendations a priority rating (as explained below) and agreed with management what action will be taken.

Priority rating for recommendations raised		
High Priority: A significant weakness in the system or process which is putting you at serious risk of not achieving your strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any recommendations in this category would require immediate attention.	**Medium Priority:** A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving your strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.	**Low Priority:** Recommendations which could improve the efficiency and/or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

#	Priority	Recommendation	Management response/Officer /Deadline
1	Low Priority	**Recommendation1:** Though the format of the CQC action plan updates is much improved, because of its summarised nature it still needs to be read alongside the original action plan so that lead responsibility and expected outcomes can be understood. If the new format Action Plan update is to be a stand-alone document it should include reference to the relevant lead officers for each action and the expected outcome of those actions.	**Accepted.** Cross reference to the original action plan will be made. The action plan will be located in a central location (on intranet) and contain the entire summary of actions to date **Deadline:** Completed
2	Low Priority	**Recommendation 2:** Child Protection Training is a key area of mandatory training with low staff attendance. Some Trusts have undertaken risk assessments to identify which level of training is most appropriate for which post holders. The Trust should undertake such an assessment to determine the most appropriate level of training for each staff member. Mandatory training registers should then be amended accordingly.	**Accepted.** Trust wide review of Level 2 safeguarding training levels is being undertaken by the Named Nurse for safeguarding. Level 3 training is being reviewed by the LSCB and we are awaiting their outcome on how it progresses moving forward. We are however looking at different modalities for undertaking the training and capturing and recording the competence of clinicians. **Deadline:** TBC
3	Low Priority	**Recommendation 3:** A register of trained mentors is available at the Trust's education centre. A mentoring policy has also been developed, but has not yet been publicised. In order to meet the requirements of the Action Plan (and to encourage take up of mentoring/coaching opportunities) the Trust should clearly publicise the mentoring support	**Accepted.** Publicising the register of mentors will be reviewed as uptake has been very low. A bid to train staff in facilitation skills is being put together for TVWLA and once key individuals have been trained as facilitators they will be setting up action learning sets. **Deadline:** TBC

Appendix One

Review of CQC Action Plan

Below we set out our assessment of the progress the Trust has made in implementing the CQC action plan.

Assessment	Explanation
Agree	From the evidence available we are able to agree the action noted within the CQC report is implemented appropriately
Work Ongoing	From the evidence provided it is our assessment the actions in the plan are ongoing.
Unsubstantiated	The organisation has not provided enough evidence to confirm the action recorded is complete.

CQC Outcome Ref:	Action Description	Trust status	Audit assessment	KPMG Comment
4 and 21	Documentation			Improving patient record keeping is still an area in progress. New patient record forms have been designed to improve the ease of record taking and reduce duplication between systems following comprehensive consultation (with staff and patients), learning from other Trusts, and trialling on some wards. The forms include checklists and risk assessment tools for easy reference. The new system, is currently being piloted. It is not fully rolled out yet across the Trust, though a plan is in place to do so.
9	Medications storage			The Trust has agreed and publicised a revised Cold Storage of Medicines Policy and introduced an automated alert system for cold storage of medicines. An electronic temperature log for each fridge is regularly reviewed centrally by the Pharmacy team and outliers investigated. An audible alert is sounded if temperatures vary outside of excepted levels. Ward nurses are then notified by the Pharmacy team to take action. Safe storage of IV fluids has been provided through the installation of secure keypad locks on relevant doors. Physical spot checks are undertaken by the Director of Nursing and the Deputy Director of Nursing, as well as Pharmacy staff. Reporting lines are clear and roles understood

Appendix One

Review of CQC Action Plan (continued)

Below we set out our assessment of the progress the Trust has made in implementing the CQC action plan.

Assessment	Explanation
Agree	From the evidence available we are able to agree the action noted within the CQC report is implemented appropriately
Work Ongoing	From the evidence provided it is our assessment the actions in the plan are ongoing.
Unsubstantiated	The organisation has not provided enough evidence to confirm the action recorded is complete.

CQC Outcome Ref:	Action Description	Trust status	Audit assessment	KPMG Comment
13	Temporary staffing			The Trust has reduced the need for temporary staff. In the first three months of 2014/15 the use of (and demand for) temporary staff has been significantly less than the same period in 2013/14. Two review groups have been established to review staff issues i.e. nursing establishment and E-rostering. An action plan for e-rostering is in place with actions to increase accuracy of the roster and to help speed up recruitment of staff. The Trust has agreed (starting in June 2014) to over recruit staff to realistically cover for sickness and winter pressures. The Trust has now documented its safer staffing process which was successfully tested during a 'moderate risk' event in the Winter. The Trust has emphasised the need for temporary staff to receive mandatory training through revised SLAs that it has agreed and signed off with all its current providers. Providers not agreeing to the revised SLA will not be used in future to provide staff. The SLA includes the provision for auditing against the training requirement. An audit of three providers has already been undertaken and follow-up and further audits are planned. Two out of the three were found to be fully compliant for staff training. Importance of checking the competence of temporary staff has been reinforced through matrons and ward cascades. Though this audit has not checked that level of awareness. A new Enhanced Nursing Risk Assessment Tool has been developed to support the request for additional staff, so called 'specials criteria'

Review of CQC Action Plan (continued)

Below we set out our assessment of the progress the Trust has made in implementing the CQC action plan.

Assessment	Explanation
Agree	From the evidence available we are able to agree the action noted within the CQC report is implemented appropriately
Work Ongoing	From the evidence provided it is our assessment the actions in the plan are ongoing.
Unsubstantiated	The organisation has not provided enough evidence to confirm the action recorded is complete.

CQC Outcome Ref:	Action Description	Trust status	Audit assessment	KPMG Comment
14	Staff training			The Trust has a good electronic system to RAG rate individuals status regarding mandatory training. This easily identifies training completed or needed. The status of mandatory training is regularly reported to the Education Committee. Reports can identify non-compliance to a granular level e.g. individual, ward or type of course. Non-compliance or non-attendance can be escalated to line managers or (for repeat offenders) the Education Committee. To encourage greater compliance with mandatory training, from 1 April 2014 completion has to be signed off as part of the annual appraisal process and non-compliance means the staff member will not be entitled to annual pay increments. Each line manager has also been set a target regarding compliance of his or her staff attending mandatory training. It is too early in the year to see what effect this new system will have on compliance, but it is expected to increase the uptake of mandatory training. The Trust has exceeded its March 2014 target for the percentage of staff receiving Dementia Awareness training. Dementia champions have been identified across the Trust, and the list of champions is currently being developed by the Dementia coordinator into a register Child Protection Training (levels 2 and 3) is a key area of mandatory training with low staff attendance. Some Trusts have undertaken risk assessments to identify which level of training is most appropriate for which post holders. Such an assessment has not been undertaken at the Trust to date, and this may mean that many staff are being required to attend a level of training that is not relevant for their particular post. [Recommendation 2] Registers of potential mentors/coaches are available at the Education Centre and a Mentoring policy is in place. However these have not yet been publicised to staff to encourage take-up [Recommendation 3] A Clinical Supervision Policy is awaiting approval by the Clinical Governance Committee at its next meeting.