Kingston Hospital NHS
NHS Foundation Trust

CQC Inspection – 'Must do' actions

Trust Board	**Item: 11**
Date: 28th September 2016	**Enclosure: G**

Purpose of the Report:

On the 14th July 2016 the CQC published its report of the planned inspection of the Trust. The inspection took place during January 2016. The CQC held the Quality Summit with the Trust and partner organisations on 19th September 2016. The Trust has 28 days from the date of the Quality Summit to submit its action plans to the CQC on the 7 MUST do actions. This report therefore provides an update on the Quality Summit and the action plans for submission to the CQC.

For: Information ☐ Assurance ☐ Discussion and input ☐ Decision/approval ☒

Sponsor (Executive Lead):	Duncan Burton, Director of Nursing and Patient Experience
Author:	Duncan Burton, Director of Nursing and Patient Experience
Author Contact Details:	Ext 3855
Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Reputational CQC Risk Profile
Legal / Regulatory / Reputation Implications:	Regulatory/Reputational

Link to Relevant CQC Domain:
Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒

Link to Relevant Corporate Objective:	Strategic Objective 1 – To ensure that all care is rated amongst the top 20% nationally for patient safety, clinical outcomes and patient experience
Document Previously Considered By:	N/A

Recommendations:
The Trust Board is asked to:

- **Note** the Quality Summit has taken place and outputs from this
- **Approve** the action plans for the 'Must do' areas

CQC Inspection Report – Quality Summit & Action Plan

1. Introduction

1.1 On 14th July 2016 the CQC published its inspection report of the Trust. The report is based on a three day hospital-wide inspection that was carried out between the 12th and 14th January 2016 and follow up unannounced visit 25th January 2016.. The report can be accessed via the following link.

http://www.cqc.org.uk/sites/default/files/new_reports/AAAF0781.pdf

2. Quality Summit

2.1 On 19th September 2016 the Trust's Quality Summit was held. The summit was attended by the CQC, the Trust, NHS Improvement, NHS England, Richmond, Kingston and Wandsworth CCG's, Healthwatch Kingston and Richmond, the General Medical Council, Health Education South London (HESL) and the Chairs of the Health Overview & Scrutiny Panels for Kingston and Richmond and the Chair of the Health & Wellbeing Board for Kingston.

2.2 The Summit considered the findings of the inspection; the planned actions across the Trust in response to the findings, and discussed areas where the assembled partners could potentially provide support. These discussions were primarily focused on the following areas;

- **A&E Workforce** – addressing national shortfalls in workforce elements; creating better working environments and resilience for staff, and training & development opportunities. Further discussions will take place with HESL representatives and the Trust, as there was a clear commitment to further support this work.
- Improving **patient flow across the health & social care economy** to alleviate pressure within the Emergency Department. The newly created local A&E Delivery Board was seen as an important vehicle to drive these changes.
- Addressing the **capital investments** required in order to address some of the 'should do' items in the report – such as the Critical Care unit, the A&E department and to support any further expansion of services such as the maternity unit. This was in the context of a climate of reduced availability of capital and competing sector wide priorities for this.

3. Board Assurance

3.1 As described in the report to the Trust Board in July 2016, the Quality Assurance Committee (QAC) has now commenced its programme of 'deep dives' into the 8 core services as defined by the CQC. These have been structured on the basis of the findings and include focus on areas that 'require improvement' as well as how services are can move from 'good' to 'outstanding'. The Quality Assurance Committee (QAC) on 15th September 2016 received reports from maternity, surgery and orthopaedic services.

4. **Areas for improvement**

4.1 The CQC have identified seven 'Must do' actions in the report which are shown below:

1. Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint and that this information is recorded in the patient record.
2. Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures.
3. Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.
4. Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that records are kept.
5. Ensure the management, governance and culture in A&E, supports the delivery of high quality care.
6. Improve the quality and accuracy of performance data in A&E, and increase its use to identify poor performance and areas for improvement.
7. Ensure all identified risks are reflected on the A&E risk register and timely action is taken to manage risks.

4.2 The Trust has to formally respond by 28 days following the Quality Summit on the actions it intends to take to meet the 'Must do' actions identified by the CQC. These are shown in the report as 'Requirement notices' against the CQC fundamental standards. The response is a prescribed format and in line with the regulatory framework. Appendix 1 provides the intended response to each of the areas where a formal response is required by the Trust.

4.3 The Trust will meet with the CQC in line with standard regular meeting processes following the submission to review any issues raised as a result of the action plans. The Trust will be expected to inform the CQC when these actions have been completed and/or discuss any variation that is required during the period of implementation.

5. **Recommendations**

5.1 The Trust Board is asked to:

- **Note** the Quality Summit has taken place and outputs from this
- **Approve** the action plans for the 'Must do' areas

Appendix 1 – Reports on actions planned to take

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it.
Failure to send a report may lead to enforcement action.

Account number	RAX
Our reference	SPL1-2182576457
Location ID	RAX01
Trust name	Kingston Hospital NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Regulation 20 (1) (2) (d) & (e)
	How the regulation was not being met:
	A formal apology was not always included in all letters written to relevant persons during and following the safety incident review process.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1) The requirement has been communicated to staff via team and trust wide communications to raise awareness of this requirement
2) Template letters for patients have been developed & rolled out across the Trust
3) The Duty of Candour was subject to internal audit and the actions from this are being tracked through the Trusts Audit Committee
4) Additional Duty of Candour training for senior managers & clinicians has been commissioned and is taking place in quarter 3 2016/17.
5) A Moderate Incident tracker has been put in place to supplement the existing Serious Incident Tracker
6) A Duty of Candour audit has been designed with audits planned for quarter 3 of 2016/17
7) Revision of Duty of Candour elements of the Trusts Incident Reporting Policy taking place in September 2016; for launch with trust wide awareness raising in October 2016
8) Progress with Duty of Candour requirements will be tracked through the Trusts weekly Serious Incident Group, and the Clinical Quality Improvement Committee, Chaired by the Medical Director

Who is responsible for the action?	Jane Wilson, Medical Director

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
1) An internal audit of Duty of Candour requirements which was completed in 2015/16 with associated identified actions are tracked through the Trusts Audit Committee for completion. 2) A further Duty of Candour audit has been developed and is being used to ensure that improvements are sustained, for all incidents meeting the requirements of the Duty of Candour. An audit is planned to take place in quarter 3 of 2016/17. 3) The Trust Duty of Candour guidance has also been reviewed and will launched again to staff in October to ensure the process is better understood by staff. This training is being used as an opportunity to get feedback from staff on the process. 4) The Trusts Quality Assurance Committee (a Board sub-committee) has in place a programme of review of progress against actions.

Who is responsible?	Jane Wilson, Medical Director

What resources (if any) are needed to implement the change(s) and are these resources available?
Resources that are required to deliver this include additional training and tracking of compliance with the requirements. These resources are available and are being provided by the central Quality Governance team.

Date actions will be completed:	31st December 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The current risk to patients being affected by this is low. Immediate action was taken on Duty of Candour post visit, when the issue was identified, with the need to document an apology in letters as well as in person made clear. The revised letter template which is now in place includes an apology and is sent to every investigation lead for moderate and serious incidents.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing & Patient Experience
Date:	25th September 2016

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it.
Failure to send a report may lead to enforcement action.

Account number	RAX
Our reference	SPL1-2182576457
Location ID	RAX01
Trust name	Kingston Hospital NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2), (4) (b), (5) & (7) (b)
	How the regulation was not being met:
	Individuals who lacked capacity were not always subject to a mental capacity assessment. Individuals were being restrained without evidence of mental capacity assessment or best interest decisions having been formally made and recorded. Systems and processes were not sufficiently established around training of staff with regard to the Mental Capacity Act (2005) and Deprivation of Liberties Safeguarding.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The following actions are being undertaken to ensure compliance with the Mental Capacity Act and Deprivation of Liberty (DoL) Safeguarding:

1) Remind all staff of the requirements through Trust wide CQC briefings
2) Critical Care to identify the place in clinical documentation to record capacity assessments
3) Undertake 'Grand Round' session for medical & nursing staff on the Mental Capacity Act & Deprivation of Liberty Safeguards
4) Matron led checks established for supply of 'mittens' to confirm appropriate documentation of Mental Capacity Act and best interests decision
5) Ensure compliance with adult safeguarding training (which includes Mental Capacity Act & Deprivation of Liberty Safeguarding awareness) meets required minimum compliance across all clinical areas
6) Provide additional Mental Capacity & Deprivation of Liberty Safeguards Training sessions targeted to medical service areas
7) Review and amend safety checklist for 'mitten' use with the addition of a section to confirm that a patient's capacity has been assessed prior to their use in accordance with the policy.
8) Add 'mittens' safety check list as an appendix to restraint policy

9) Create plan to transfer 'mitten' safety checking documentation to electronic records by end of financial year 2016/17. 10) Establish Safeguarding/Mental Capacity Act and DoL's link nurses in each ward 11) Improve quality of and accessibility of Mental Capacity Act and DoL's information for staff on the Trust intranet.

Who is responsible for the action?	Duncan Burton, Director of Nursing & Patient Experience

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
1) A Trust wide assurance audit will be undertaken in quarter 3 2016/17. 2) Mandatory training compliance will continue to be monitored to ensure thresholds are consistently met across all areas. 3) The Trusts Quality Assurance Committee (a Board sub-committee) has in place a programme of review of progress against actions.

Who is responsible?	Duncan Burton, Director of Nursing & Patient Experience

What resources (if any) are needed to implement the change(s) and are these resources available?
Resources are required for additional training provision and audit of compliance. These resources are available. Additional specialist safeguarding nursing resource to support Mental Capacity & Deprivation of Liberty Safeguarding and a nutrition nurse have been budgeted for and are being recruited to.

Date actions will be completed:	31st December 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The risk is identified as low to patients. Immediate action was taken to ensure that where patients require restraint through the use of 'mittens' that a check by the Matrons to confirm compliance with the Mental Capacity Act requirements is undertaken and documented. The Trusts Safeguarding Adults Lead is checking compliance with the requirements.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing & Patient Experience
Date:	25th September 2016

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it.
Failure to send a report may lead to enforcement action.

Account number	RAX
Our reference	SPL1-2182576457
Location ID	RAX01
Trust name	Kingston Hospital NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (e) & (g)
	How the regulation was not being met:
	Systems and processes were not established or operated effectively to ensure the safety of service users. This was because; • Equipment in use by patients had not always been serviced and safety checked. • Resuscitation trolleys were not always checked to ensure they were fit for use. • Medicines were not always stored safely and could be accessed by unauthorised individuals. • Temperature checks on storage units were not always carried out.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The following actions are being undertaken to address the identified issues:

Medication Safety

1) Remind all staff of the requirements through Trust wide CQC briefings
2) Create Quality Improvement Project for medication safety
3) Secure all drug trolleys and make any changes to medication storage as identified in the report
4) Ensure medication room thermometers are in place, with checking process
5) Review mitigation requirements for deviation of room temperatures from normal range, including any infrastructure requirements, such as cooling mechanisms,
6) Increase medication audit frequencies to monthly across all areas of Trust, this is to include fridge and medication storage room temperatures
7) Test compliance has been sustained through audit process

Medical equipment

1) Remind all staff of the requirements through Trust wide CQC briefings, including need to ensure release of equipment at local level to allow maintenance to be carried out
2) Review the staffing resource within the medical physics team to ensure delivery of timely medical equipment checks

3) Recruit to new posts within the medical physics team
4) Undertake complete review of the medical equipment asset register and all other equipment (high and low risk items) by end of Dec 2016
5) Complete maintenance check of all OPD trolleys and ensure ongoing mechanism in place for regular checks
6) Implement revised reporting arrangements to the Medical Device Committee to track ongoing compliance with medical equipment checking processes

Resuscitation Trolleys

1) Remind all staff of the requirements through Trust wide CQC briefings
2) Increase random spot checks on resuscitation trolleys by Matrons and resuscitation officers

Who is responsible for the action?	Duncan Burton, Director of Nursing & Patient Experience

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

To check sustainability of actions the Trust has put in place the following:

1) Revised reporting arrangements on medical equipment checks to the Medical Device Committee & service lines
2) Recruit to additional medical physics department staffing resource
3) The Trusts Internal Auditors will be commissioned to undertake in Q1 2017/18 a review of medical device processes
4) Monthly medicines safety audits which take into consideration medication safety elements and temperature checks
5) Increase random spot checks on resuscitation trolleys by Matrons
6) The Trusts Quality Assurance Committee (a Board sub-committee) has in place a programme of review of progress against actions.

Who is responsible?	Duncan Burton, Director of Nursing & Patient Experience

What resources (if any) are needed to implement the change(s) and are these resources available?

The additional resources that are required to implement the change are as follows:

1) In reviewing the medical device requirements the Trust identified the need to increase the establishment of the medical physics team. Further posts have been created and are being recruited to. Temporary interim provision is being funded whilst these posts are recruited to ensure delivery within timeframes.
2) Equipment needed to improve medication safety such as chains for drug trolleys and room thermometers have been purchased by the Trust.
3) Additional audit provision to address requirements are available from within existing resource
4) Any infrastructure requirements to cool medication rooms in periods of high temperatures will need to be identified and costed in order to identify funding stream.

Date actions will be completed:	31st December 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The risk to patients is low. The Trust took immediate action on medical equipment in high risk areas when this was raised. Immediate action was taken on resuscitation equipment checking and medication storage in areas identified in the report. Room temperature checks have been put in place. The likelihood of temperatures deviating above the range in high temperature weather conditions is highly unlikely until the Summer of 2017, which allows time for mitigations to be put in place.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing & Patient Experience
Date:	25th September 2016

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it.
Failure to send a report may lead to enforcement action.

Account number	RAX
Our reference	SPL1-2182576457
Location ID	RAX01
Trust name	Kingston Hospital NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures Nursing care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) & (b)
Surgical procedures	**How the regulation was not being met:**
Treatment of disease, disorder or injury	Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided in ED because; • The quality and accuracy of performance data and its use in identifying poor performance and areas for improvement was not adequate. • The management, governance and culture in ED, did not support the delivery of high quality care. • Risks in the ED service were not always identified, analysed and managed.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

In order to meet the regulation the following actions are being taken:

1) Creation of an Emergency Care Programme Board (ECPB), Chaired by the Chief Operating Officer, with a number of improvement work streams.
2) The A and E workforce stream includes a focus on addressing recruitment to middle grade roles and development and recruitment to alternative roles.
3) Team development sessions for nursing & medical staff commissioned to take place aimed at improving team working and engagement
4) Increase leadership provision in department through consultant recruitment and additional Matron
5) Undertake a review of progress in quarter 3 of 2016/17 by Internal Audit focused on 'must do' and 'should do' actions.
6) Review risk register and mitigating actions
7) Improve Friends & Family (FFT) response rates
8) Utilise daily 'Kingston Day' Performance Pack for improvement and weekly review at ECPB
9) Complete technical changes within CRS to deliver full set of required metrics
10) Increase capacity and performance through creation of Clinical Decisions Unit

11) Review and implement changes to Governance meetings and processes in Emergency Department
12) Enhance learning from complaints and clinical audit
13) Improve delayed transfer of care (DTOC) meetings
14) Undertake more risk and incident reporting training with staff key staff within the Emergency Department
15) Deliver compliance with hand hygiene requirements, resuscitation equipment checks and medication safety requirements

Who is responsible for the action?	Rachel Williams, Chief Operating Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

1) The Trusts Internal Auditors have been commissioned to undertake a review of progress against the actions arising from the CQC report during quarter 3. This includes unannounced and announced inspections with clinical and non-clinical staff.
2) The Trusts Quality Assurance Committee (a Board sub-committee) has in place a programme of review of progress against actions.

Who is responsible?	Rachel Williams, Chief Operating Officer

What resources (if any) are needed to implement the change(s) and are these resources available?

1) Additional project management resource has been identified and funded to support ECPB work streams and release leadership capacity.
2) An additional part time A&E Matron post has been funded and recruited to.
3) The building costs of the new Clinical Decisions Unit, and associated increase in staffing to the department has been funded. Recruitment to posts is taking place. The unit is planned to open in November 2016.
4) Minor environmental improvement & equipment requirements have been funded.
5) Audit and business intelligence capacity is available and being provided to support identified work streams
6) Team development programmes have been commissioned and funding identified
7) Further work and funding to develop alternatives to support workforce development and alternatives to middle grades is being explored with Health Education England representatives as a result of the Quality Summit

Date actions will be completed:	31st December 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Actions had already been in place to improve the A&E service prior to receipt to the CQC report. These included strengthening of leadership, governance systems and the use of performance information within the department. Immediate action has also been taken to improve such areas as checking of resuscitation equipment. Performance monitoring is in place to identify any emergent risks to patients whilst actions are completed.

Completed by: (please print name(s) in full)	Duncan Burton
Position(s):	Director of Nursing & Patient Experience
Date:	25th September 2016