CQC Unannounced Visit – Conditions in place Section 31 Health and Social Care Act

Author: Julie Smith, Chief Nurse: Andrew Furlong, Acting Medical Director

Trust Board paper F

Executive Summary

Context

On Monday 30 November 2015 the CQC undertook an unannounced inspection of the Emergency Department at the Leicester Royal Infirmary. On Friday 04 December 2015 the Trust was issued with a notice of decision to impose conditions on University Hospitals of Leicester NHS Trusts registration as a service provider; in respect of the regulated activities set out below, under Section 31 of the Health and Social Care Act 2008. These conditions upon our license have been added to the Trust's risk register.

In addition a risk summit was held on Friday 18 December by NHS England and The Trust Development Authority in response, progress by the Trust was noted and further actions agreed.

This paper provides an update on:

- Monitoring and Reporting
- Details of the conditions in place under the Health and Social care Act 2008, reporting requirements, actions and progress to date
- Summary of the Risk Summit held in response and the actions arising
- Risk Assessment as detailed on the Trust risk register
- Conclusion and next steps

Input Sought

1. The Board are asked to acknowledge that conditions have been placed on Trusts license in respect of Section 31 of the Health and Social Care Act 2008

2. To **note** progress in relation to the actions taken in response to the conditions

3. To **note** the outputs and additional actions from the Risk summit on 18th December 2015

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes /No /Not applicable]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: TBC

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

REPORT TO: **Trust Board**

DATE: **7 January 2016**

REPORT BY: **Julie Smith (Chief Nurse) , Andrew Furlong (Interim Medical Director)**

SUBJECT: **Care Quality Commission (CQC)**

Care Quality Commission

Health and Social Care Act 2008

Urgent notice of decision to impose conditions on your registration as a service provider in respect of the regulated activities set out below, under S31 of the Health and Social Care Act 2008

1.0 Introduction

On Monday 30 November 2015 the CQC undertook an unannounced inspection of the Emergency Department at the Leicester Royal Infirmary. On Friday 04 December 2015 the Trust was issued with a notice of decision to impose conditions on University Hospitals of Leicester NHS Trusts registration as a service provider; in respect of the regulated activities set out below, under Section 31 of the Health and Social Care Act 2008. These conditions upon our license have been added to the Trust's risk register.

This paper includes:

- Section 2 - Monitoring and Reporting
- Section 3 - Details of the conditions in place under the Health and Social care Act 2008, reporting requirements, actions and progress to date
- Section 4 - Summary of the Risk Summit held in response to the imposed conditions and the actions arising
- Section 5 - Risk Assessment as detailed on the Trust risk register
- Section 6 - Conclusion and next steps

2.0 Monitoring and Reporting

Internal

An executive group (CQC Rapid Response Group) meet 3 times per week to oversee the action plan and progress with the operational team, the action plan is in turn reviewed weekly at the Trust executive team meeting. The new ED dashboard will also be monitored weekly via the executive team from 5th January 2016. The

Trust Board's - Quality Assurance Committee will provide the Board with overall assurance of adequate progress.

Care Quality Commission

Reporting is in place on a weekly and monthly basis as set out in conditions. The Care Quality Commission is also part of the Risk summit and the Clinical Quality Oversight Group.

External Agencies

The overview from all partner agencies is via the risk summit led by NHS England and the Trust Development Authority. The Clinical Quality Oversight Group led by the Trust Development Authority monitor progress on behalf of the risk summit between risk summits.

3.0 Conditions in place, reporting requirements, actions and progress to date

The conditions (10) fall into three areas and the following section outlines the conditions that align to each area and the improvement progress made to date.

Area 1: Time to initial assessment on arrival at the Emergency Department

Condition 1

The Registered Provider must operate an effective system which will ensure that all patients attending the Emergency Department (ED) have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the ED in such a manner that is in line with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" ("the CEM standard") dated April 2011, a copy of which is attached to this condition or such other recognised professional processes or mechanisms as the Registered Provider commits itself to.

Condition 3

The Registered Provider shall, as soon as is reasonably possible and in any event by 5pm on 9 December 2015, describe the system operated by the Registered Provider is operating its Emergency Department at Leicester Royal Infirmary so as to comply with the standards set out in condition 1 and shall:

a. Publicise the content of the said system for the staff of the Emergency Department; and
b. Provide a copy of the document describing the said system to the Care Quality Commission.

Condition 4
As part of the description of the system as required by condition 3, the Registered Provider shall explain how the Registered Provider:

a. Records the arrival time of each patient at the Emergency Department;
b. Records the time at which each patient is registered as having arrived at the Emergency Department; and
c. Records the time at which an initial clinical assessment is commenced for each patient and by whom the assessment is being undertaken.

Condition 5 (Reporting weekly)
From 11 December 2015 and on the Friday of each week thereafter, the Registered Provider shall report to the Care Quality Commission on how many occasions the Registered Provider has failed to provide a service to a patient which fails to meet the standards set in condition 1 and, in respect of each such occasion:

a. A unique identifier for the patient;
b. The time taken between arrival and the commencement of an initial clinical assessment;

c. The reason that the standard was not met for this patient; and
d. The consequences (if any) for the individual patient of the delay in initial clinical assessment.

Condition 6 (Reporting Monthly)
On the 28th day of each month from 28 December 2015, the Registered Provider shall submit a report to the Care Quality Commission which identifies the root causes for failure to meet the CEM standard or such other recognised professional processes or mechanisms as the Registered Provider commits itself to and explains how the Registered Provider will address these causes in the form of an action plan. The subsequent month's report must:

a. Repeat this root cause analysis for any new failures to meet the CEM standard or such other recognised professional processes or mechanisms as the Registered Provider commits itself to,
b. Re-evaluate the action plan considering these new failures,
c. Indicate progress made against the action plan.

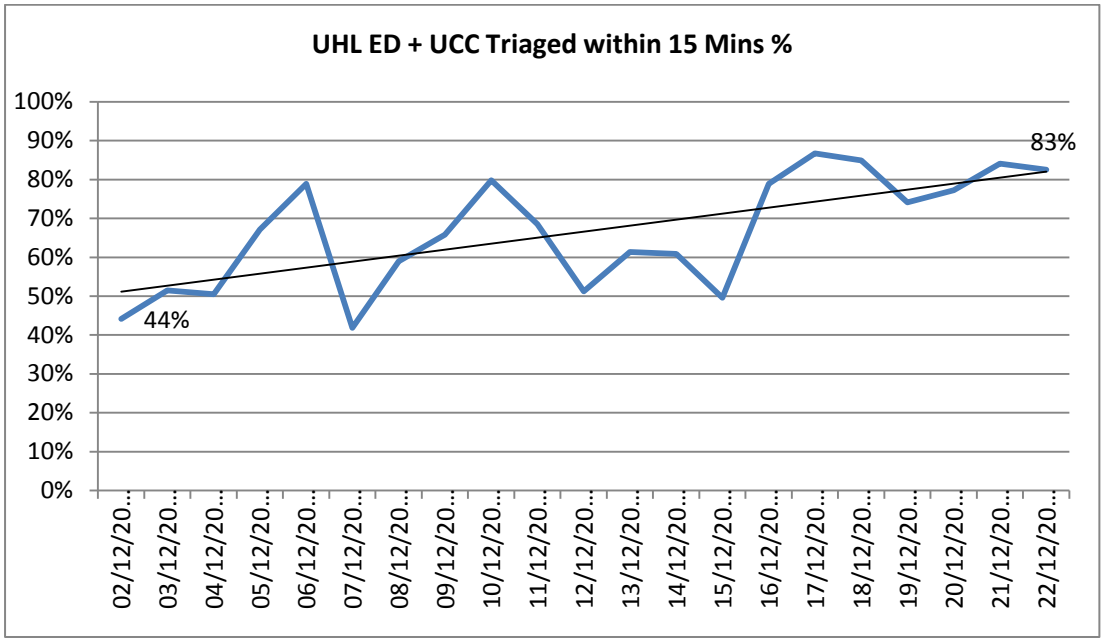
Actions and progress to date

UHL had a triage process in place this is known as the Dynamic Priority Scoring (DPS) System, which was introduced approximately 18 months ago to ensure the safety of all patients attending the emergency department. There was not systemic or standardised recording and monitoring of this initial assessment. The Trust has

now developed with the clinical teams a process for ensuring that the time that the assessment is undertaken is recorded consistently, and is reported on a daily basis. Oversight of the DPS can also be viewed live for all patients on the Emergency Department Information System (EDIS).

Since the introduction of the standardised recording of assessment timings performance has improved on an upward trajectory (44% to 83%) since reporting commenced on 02 December 2015 (see figure 1 below).

Figure 1: Daily performance trend 02/12/15-22/12/15



The root cause analysis for non-achievement of the standard consists of the following two areas and is described in more detail on the following page:

- Data reporting/quality
- Clinical pathway

Data reporting/quality

The Trust believes that up to 90% of patients are routinely being assessed within the 15 minute standard. However, issues with data recording /quality mean that the Trust is not recording this accurately. The main issue is that staff members are recording the time the data entry is made instead of the time the patient is seen and this has been supported by 4 manual spot checks which concluded the following:

- 76% achieved on 12/12/15 on a sample size of 29 patients

- 87% achieved on 13/12/15 on a sample size of 23 patients
- 85% achieved on 14/12/15 on a sample size of 89 patients
- 91 % achieved on 17/12/15 on a sample size of 81 patients

To improve performance in this area the Trust completed a process redesign session on 17/12/15 for all entry areas (UCC/Adults/Paediatrics) to ensure that the pathway (clinical and information) supports the accurate capture of the assessment time. The session was well received and resulted in a revised process being produced, which is being used from 23/12/15 to ensure staff understand and practice their responsibilities in relation to data accuracy. This area will be closely monitored and areas of non-compliance will be dealt with accordingly

Clinical Pathway

The Trust recognises that there are areas for pathway improvement, specifically at times of activity surge. In response a number of changes have been made to the assessment clinical pathway and include:

- New UCC 2nd triage process
- New Nurse triage role in adults
- Reinforcement of Nurse in Charge/Duty Manager escalation process

In addition, the Trust has confirmed that no harm has been evidenced as a result of triage breaches in the reporting period 02/12/15-22/12/15. The Trust is using a comparison of datix reported incidents against 15 minute breaches as the methodology and completing a root cause analysis on any matches. In the reporting period (02/12/15-22/12/15) 2 patients were reported as exceeding the 15 minute standard with a corresponding datix entry. However, the root cause analysis concluded that one patient was triaged within 15 minutes and that a data recording issue had inaccurately recorded the time of triage. The second patient was concluded to have no harm as a result of the delay in triage and that the datix form was not related to this.

A supporting action plan is in place that details all activities that are complete, underway and planned to address the causes of failure to meet the 15 minute target. The actions associated with this report are reviewed by the Executive Director Leads of the CQC Rapid Response Group.

The Trust has complied with the weekly and monthly reporting as set out in conditions 5 and 6 above. As yet the Trust has not received any feedback or response from the Care Quality Commission in this regard.

Area 2: Appropriate Staffing

Condition 2
The Registered Provider shall ensure that sufficient numbers of appropriately qualified clinical staff are employed by the Registered Provider so as to enable the Registered Provider to operate the system required by condition 1.

Condition 7
The registered provider must ensure that there is an effective system in place to ensure an appropriate skill mix to provide a safe standard of care to patients who require care and treatment within the ED at the Leicester Royal Infirmary

Condition 8 (Reporting Weekly)
From 11 December 2015, and on the Friday of each week thereafter, the Registered Provider shall report to the Care Quality Commission the staffing level and skill mix of staff on duty for the day and night shifts within the ED at the Leicester Royal Infirmary.

Actions and progress to date

The Trust has provided the CQC with a detailed description of how both nursing and medical staffing, skill mix and numbers are set monitored and reviewed within the Emergency Department. The Trust has also provided the CQC with a weekly report on a shift by shift basis of the numbers and skill mix of both nursing and medical staff within the Emergency Department and the actions taken when optimum levels have not been met. Skill mix and staffing numbers are reviewed 4 times per day via the Trusts Gold command structure.

The Trust has complied with the weekly reporting as set out in condition 8 above. As yet the Trust has not received any feedback or response from the Care Quality Commission in this regard.

Area 3: Sepsis management

Condition 9
The registered provider must ensure that there is an effective system in place to deliver sepsis management, in line with the relevant national clinical guidelines. So as to identify patients with sepsis, stratify sepsis risk, determine appropriate levels of care and treatment and continue to provide appropriate care and treatment for patients with sepsis attending Leicester Royal Infirmary Emergency Department.

Condition 10 (Reporting weekly)
From 11 December 2015, and on the Friday of each week thereafter, the Registered Provider shall report to the Care Quality Commission describing the actions taken to

ensure that an effective sepsis management system, in line with national clinical guidelines, is in place and how clinical outcomes are being audited, monitored and acted upon.

Actions and progress to date

A revised sepsis pathway has now been rolled out commencing in the Emergency Department from 11 December 2015. A daily audit is being undertaken to monitor and identify areas for improvements. The pathway, audit results and supporting action plan have been reported to the CQC weekly as set out in condition 10 above. As yet the Trust has not received any feedback or response from the Care Quality Commission in this regard.

4.0 Summary of the Risk Summit held in response and the actions arising

Risk summits are a tried and tested approach to understanding and mitigating risks within the health community. They aim to address potential or actual service quality problems which may mean a provider is failing to meet the essential standards of quality and patient safety. Such problems may relate to a specific service or be indicative of more serious and systemic problems within a provider organisation.

A risk summit may be triggered in a number of ways. It could be the result of regular performance and quality reviews between the provider and commissioners, an external regulator (such as the Care Quality Commission or Monitor) or from concerns raised by staff, patients or other parties.

When a risk summit is held, it brings together representatives from the provider organisation, commissioners, key clinical leaders, and other regulatory and stakeholders to explore and understand the issue. Together they agree what interventions, if any, may be necessary to ensure patient safety and quality can be guaranteed in the short, medium and longer term, and whether further risk summits are required.

On Friday 18 December 2015, the Trust Development Authority (TDA) and NHS England hosted a risk summit for University Hospitals of Leicester NHS Trust (UHL) regarding its Accident and Emergency Department.

The key areas of risk that triggered the risk summit were:

- Patient triage and risk assessment within the Emergency Department
- Competence of staff undertaking clinical assessment in the Emergency Department

- Management and escalation of the deteriorating patient within the department, including patients who trigger for the Systemic Inflammatory Response Syndrome (SIRS) criteria
- Delayed ambulance handovers at the Emergency Department.

All key partner agencies were represented at the summit.

It was agreed that a range of actions are already being undertaken both by University Hospitals of Leicester (UHL) and across the LLR health system, and progress has been made. Some further actions were identified; some of these were for UHL individually, others in association with health partners (such as the TDA, Care Quality Commission, East Midlands Ambulance Services NHS Trust and the Leicester, Leicestershire and Rutland System Resilience Group), and some for individual NHS organisations attending the risk summit. The 8 agreed actions from the Risk Summit for UHL are complimentary to the work already underway as outlined in section 3 and detailed on the following page:

No	Area	Action	Owner	Deadline	Update
1.	**Sepsis in A&E**	The Trust are to note feedback received from A&E staff during a recent CCG visit: i. A&E staff are able to articulate the appropriate sepsis risks and associated activities needed. ii. Additional leadership support recently put in place is much appreciated, but there are concerns over its sustainability as it is reliant on small number of people with the appropriate skills. The Trust is expected to provide an update on how they will ensure leadership support within A&E is delivered sustainably at the next Risk Summit.	The Trust Executive	Next Risk Summit	Revised Leadership arrangements in place for up to 6 months whilst substantive arrangements are put into place
2.	**A&E Triage**	The Trust is expected to provide their first report and RCAs for triage breaches to CQC on 28 December 2015. This first report should include comprehensive details of the triage process they expect staff to follow.	The Trust Executive	28 December 2015	Complete
3.	**Handover Delays**	With appropriate support from the TDA and other partners, the Trust is to produce detailed arrangements of how they will ensure no ambulance handover delays will occur including how the Trust will staff and manage any cohorts of patients, and in which appropriate setting this will take place.	The Trust Executive	14 January 2016 Clinical Quality & Safety Oversight Group meeting	A protocol has been devised for implementation from the 29/12/2015 this has been shared with TDA
4.	**Demand & Flow**	Supported by the TDA and CCGs, the Trust is to review current arrangements for reducing elective capacity and identify options for reducing beyond	The Trust Executive	14 January 2016	UHL along with all other trusts were asked to submit plans to TDA/ Monitor to have 20% of

		the nationally expected 20% target in order to liberate bed space for A&E flow and redeployment of staff.			our bed base empty on Christmas Eve. By 1600 on Christmas Eve we had 26% of our bed base empty. We are reducing our elective throughput from 29 December to mid-January and doing a greater proportion of day case surgery. This gives medicine up to a further five bays of beds to use.
5.	**Quality Governance**	The Trust and CCGs are to review metrics, risk trigger thresholds related to A&E performance and patient safety, monitoring and escalation arrangements to ensure they are appropriate and fit for purpose.	The Trust Executive and CCGs	Next Risk Summit	Revised quality metrics in place and monitored daily
6.	**Workforce**	The Trust is to review, update and report on planned staffing levels and provide assurance that they have safe staffing levels in place for all areas of responsibility and appropriate arrangements in place to increase appropriate workforce areas during periods of increased demand.	The Trust Executive	Next Risk Summit	Workforce monitoring of nursing and medical staffing skill mix and numbers in place on a shift by shift basis. Nursing workforce review of roles and skill mix underway and medical planned
7.	**Sepsis in A&E**	The Trust is to ensure all CQC Section 31 Notice sepsis-related actions are implemented as a priority, and provide an update report at the next risk summit on progress towards delivering the standard.	The Trust Executive	Next Risk Summit	Daily audits in ED of use of revised sepsis pathways are taking place. Based on these audits, further targeted work is being undertaken to ensure compliance of all sepsis 6 interventions.
8.	**Paediatric Care**	The Trust is to ensure an appropriate Paediatric service is in delivered meeting national standards,	The Trust Executive	Next Risk Summit	These processes are already in place. The East Midlands

		and that staff involved in the treatment and care of paediatrics understand the processes and procedures for ensuring timely access to transport and transfer of patients. Where delays occur, the Trust must ensure appropriate arrangements are in place to prevent unnecessary impact on the patient. An update on steps taken is to be provided at the next risk summit.			does not have a regional paediatric transport team.

The next risk summit is scheduled for Monday 1st February 2016. Progress is monitored in the interim by the TDA and NHS England via the Clinical Quality and Safety Oversight Group which held its second meeting on Thursday 31st December 2015.

5.0 Risk Assessment as detailed on the Trust risk register

Datix Risk ID	Risk Title	Review Date	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2762	Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	21/01/2016	**Causes:** Failure to consistently undertake and record initial assessment by appropriately trained clinical staff within 15 minutes of presentation and document in real time. Failure to consistently ensure that all patients receive adequate care and treatment in accordance with Trust sepsis clinical pathway. Lack of ability to demonstrate we	Quality	CEO and executive leadership with clear responsibility and oversight in place. Programme management arrangements in place supported by trio of nursing, medical and operational leads with allocated time and objectives. This is supported by four oversight meetings per week. Internal reporting in relation to quality metrics (sepsis compliance, staffing, initial assessment within 15 mins) Weekly reporting to CQC on required metrics in place **Sepsis** Implementation of trust-wide single adult sepsis pathway supported by a programme of daily audit in ED. Supporting action plan in place including rollout of single paediatric pathway.	Extreme	Almost certain	25	Overarching action plan to address all 3 of the CQC areas of non-compliance - complete Governance and PMO arrangements to be agreed - paper to Quality Assurance Committee - complete On-going assurance monitoring that controls and completed actions are	15	JSMI

			have an appropriate staffing skill mix in place on a shift by shift basis. Lack of recording of induction for temporary staff. **Consequences:** Significant risk of patient harm Conditions placed on licence to practice Risk of CQC placing the Trust in Special Measures Risk of CQC imposing unlimited financial penalties Adverse media attention affecting reputation of the Trust Breaches in Statutory duty with subsequent criminal prosecution		**Initial Assessment** Standard Operating Procedure (Initial Assessment and Dynamic Priority Scoring - version 3 December 2015) revised and implemented to ensure ED patients are prioritised appropriately. Consistent real-time recording. Review of patient harm associated with delayed initial assessment (>15mins) at patient level. **Staffing/ skill mix** Shift by shift real-time reporting template looking at overall staffing numbers (e.g. nurse in charge, number of agency staff utilised) monitored by 'gold' command four times daily. '' Safe staffing overview by 'gold' command four times daily. **All temporary staff induction** Trust-wide induction policy for temporary staff Adherence to policy checked on a daily basis by Matron and monitored via quality metric within ED Communication to staff in relation to the importance of appropriate induction via local communications and via CEO face to face and written briefing.				effective - Reviewed weekly via CQC steering group		

6.0 Conclusion and next steps

The Trust has responded to the conditions as set out by the Care Quality Commission. There are robust governance arrangements for the monitoring and implementation of the required actions internally and externally. Reporting is being carried out as per the requirements of the conditions and improvements are being seen in performance. These improvements were supported by a quality visit undertaken by the Clinical Commissioning Groups and the Trust Development Authority on Thursday 17th December 2015 and was reported to the Risk summit on 18th December 2015.

The safety of patients and staff remain the primary focus and are being monitored closely. The revised ED quality dashboard is being further developed to include all elements of the weekly reporting alongside the quality indicators to provide an entire view of ED quality performance.

The action plan is being refreshed daily to ensure all elements are closed monitored and progressed as sufficient pace.