This report provides an overview of the progress against the action plan developed in response to the CQC inspection reports (the Quality Reports) published on 27th May 2016.

- As requested by the CQC, the trust submitted the CQC template detailing high-level actions taken/planned in response to regulation breaches identified in the Quality Reports. The template was submitted on 3rd July 2016 (Appendix One).
- A trust-wide action plan was subsequently developed, both corporately and by individual divisions to address the other areas of concern raised by the CQC.
- The trust-wide action plan is held centrally by the Compliance Manager with updates provided by either the Executive Leads or divisions.
- Divisions are presenting progress reports monthly to the Clinical Quality Assurance Committee and the Compliance Manager is presenting a monthly progress report to the Trust Executive Committee.

The following table summarises the progress:

<table>
<thead>
<tr>
<th>DIVISION/ ACTION PLAN</th>
<th>TOTAL</th>
<th>COMPLETE</th>
<th>IN PROGRESS</th>
<th>OVERDUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>23</td>
<td>3</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Regulation Breaches</td>
<td>14</td>
<td>3</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Urgent and Emergency Services</td>
<td>62</td>
<td>2</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Medical Care</td>
<td>26</td>
<td>11</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>26</td>
<td>7</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Critical Care</td>
<td>34</td>
<td>17</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Maternity and Gynaecology</td>
<td>100</td>
<td>18</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>Children and Young People</td>
<td>35</td>
<td>3</td>
<td>32</td>
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<tr>
<td>End of Life Care</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
### DIVISION/ ACTION PLAN

<table>
<thead>
<tr>
<th>DIVISION/ ACTION PLAN</th>
<th>TOTAL</th>
<th>COMPLETE</th>
<th>IN PROGRESS</th>
<th>OVERDUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients and Diagnostic Imaging</td>
<td>9</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>RENAL</td>
<td>22</td>
<td>8</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>SWLEOC</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>365</strong></td>
<td><strong>77</strong></td>
<td><strong>287</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

The progress reports submitted monthly to the Trust Executive Committee will be reviewed quarterly by the Clinical Quality Review Group, to support external scrutiny of progress.

### Report History

The CQC Action Plan was presented to the Trust Executive Committee for information and discussion on 24th August 2016.

### Link to Corporate Objectives/Board Assurance Framework

Delivering safe and effective care; creating a positive patient experience; providing responsive care.

### Risk

Failure to implement the actions identified by the CQC could lead to enforcement action. In addition, where regulation breaches have been identified, failure to comply with the fundamental standards (the Regulations) could lead to both enforcement action and prosecution.

### Board Action

For information.

### Appendices

Appendix One – CQC Report of Actions Template
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.**

<table>
<thead>
<tr>
<th>Account number</th>
<th>RVR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our reference</td>
<td>SPL1-2112238261</td>
</tr>
<tr>
<td>Location ID</td>
<td>RVR05</td>
</tr>
<tr>
<td></td>
<td>RVR50</td>
</tr>
<tr>
<td>Trust name</td>
<td>Epsom and St Helier University Hospitals NHS Trust</td>
</tr>
</tbody>
</table>

(For regulations requiring actions: Require one page per regulation)
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Procedures Treatment of disease, disorder or injury</td>
<td>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (c), (d), (e)</td>
</tr>
</tbody>
</table>

How the regulation was not being met:

Some premises and equipment was not properly used, properly maintained or suitable for the purpose for which they were being used because:

1. Emergency equipment was not always checked in line with the trust wide policy.

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

Quarterly arrest trolley audits are in place, undertaken by senior nurses using clinical time. Daily checking of the top trolley is in place, with the main body of the trolley checked weekly (if sealed) in all wards and departments. The Matrons and Ward Managers undertake weekly audits to support this. The audit results will be reported quarterly via the Nursing and Midwifery Committee.

Who is responsible for the action? Charlotte Hall, Chief Nurse and Director of Infection Prevention and Control (DIPC) (Senior nurses, ward matrons and ward managers.)

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

Matrons and ward managers will follow-up the weekly audits and the results will be monitored quarterly at the Nursing and Midwifery Committee and assurance regarding the completion of actions arising from the CQC Quality Report will be monitored by the Clinical Quality Assurance Committee (CQAC) quarterly.

Who is responsible? Charlotte Hall, Chief Nurse and DIPC

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

No additional resources are needed to implement this change; the processes will be undertaken by the existing senior nurses, matrons and ward managers.

Date actions will be completed: Audit results will be presented to CQAC in September 2016.

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

Without the on-going assurance that the correct and appropriate equipment is present on the trolleys at all times, there is a risk that this will not be available for a patient in an emergency situation.

Completed by: Charlotte Hall

Position(s): Chief Nurse and DIPC

Date: 27th June 2016
Regulated activity(ies)

Surgical Procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Regulation 15 (1) (c), (d), (e)

How the regulation was not being met:
Some premises and equipment was not properly used, properly maintained or suitable for the purpose for which they were being used because:
2. The existing estate in some areas was not fit for the purpose of delivering modern healthcare.

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

In June 2016, construction works started to replace water tanks, distribution pipework and associated equipment at St Helier under the trusts internal capital programme to address critical infrastructure. The immediate structural and water ingress works are planned for October 2016, subject to securing additional funding from NHSI.

We are developing an estate strategy (2016-2021), including plans to remove the Critical Infrastructure backlog maintenance challenge of £32m, with additional external capital support. We are developing a strategic outline case; the first stage (due for completion June 2016) will review options to address the estate challenges beyond 2021.
The NHS (South West London and Surrey Heartlands) are developing a 5 year plan (the Sustainability and Transformation Plan (STP)) in partnership with their local authorities. In order that our estates review complements the STP, any further engagement on our estate will wait until this process has been completed.

Who is responsible for the action? Trevor Fitzgerald, Director of Estates, Facilities and Capital Projects

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?

Delivery is monitored by the Capital Steering Group which reports to the Finance Committee. Capital requirement is an agenda item at the NHSI Integrated Delivery Meeting. The 2016–2021 estate strategy will be approved and monitored by the Board and several sub-committees. The programme board of all stakeholders (NHSI, NHSE, CCGs, ESTH) will review the progress and delivery and ensure it is aligned to the STP. All estate issues are being managed via the risk register and are regularly reviewed at Performance Assurance & Risk Committee and the Patient Safety & Quality Committee; both sub-committees of the board.

Who is responsible? Trevor Fitzgerald, Director of Estates, Facilities and Capital Projects

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

We will maximise the use of internally generated capital funds to manage risks associated with the estate. Additional external funding is required to manage the building risks in 2016/17 and to address the critical infrastructure backlog challenge over the next 5 years.

Date actions will be completed: March 2021 (subject to external funding), with interim milestones, as mentioned above.

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

Until remedial work is undertaken, patients will be treated within premises that in some areas are not fit for the purpose of delivering modern healthcare. All possible mitigations are currently in place. This could adversely affect the patient experience and put patients at increased risk of hospital acquired infections.

Completed by: (please print name(s) in full) Trevor Fitzgerald

Position(s): Director of Estates, Facilities and Capital Projects

Date: 27th June 2016
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Procedures</td>
<td>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</td>
</tr>
<tr>
<td>Treatment of disease,</td>
<td>Regulation 15 (1) (c), (d), (e)</td>
</tr>
<tr>
<td>disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Some premises and equipment was not properly used, properly maintained or suitable for the purpose for which they were being used because:</td>
</tr>
<tr>
<td></td>
<td>3. There were not robust processes in place for the maintenance of medical equipment.</td>
</tr>
</tbody>
</table>

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

Not all medical devices used are on one single asset register and work has started to identify all areas that manage their own equipment. All clinical divisions are reviewing their processes and ensuring that each service area has an equipment co-ordinator (DEC) and that they allocate time to regularly review their asset registers.

The Medical Devices Management Policy and the Medical Devices Management Group terms of reference have been reviewed. An associate medical director will join the group to support engagement of medical staff. We plan to improve medical device training for all nursing and medical staff and implement a future equipment replacement programme for all medical devices.

The trust plans to introduce central management of servicing and maintenance contracts for all medical devices, ensuring that all servicing due dates and records are maintained and reviewed so that no medical device is used past its servicing date unless a risk assessment is undertaken. In addition, we plan to develop the medical devices catalogue to ensure equipment is standardised and effectively utilised.

Who is responsible for the action? Trevor Fitzgerald, Director of Estates, Facilities and Capital Projects

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?

An action plan (which includes the development and implementation of new processes) has been developed. Progress against the action plan will be regularly reviewed at the Medical Devices Group and the Health, Safety and Risk Committee.

Who is responsible? Trevor Fitzgerald, Director of Estates, Facilities and Capital Projects

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

The trust has appointed a medical devices safety coordinator and amended the job description to reflect the requirements of the MHRA. An Associate Medical Director has been identified to sit on the Medical Devices Group.

Date actions will be completed: There are various dates for different actions, but all action will be completed by December 2016.

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

Failure to adequately maintain equipment could put patients at risk of unsafe or delayed treatment.

Completed by: Trevor Fitzgerald

Position(s): Director of Estates, Facilities and Capital Projects

Date: 27th June 2016
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 12 HSCA (RA) Safe care and treatment Regulation 12 (2) (h)</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
</tbody>
</table>

### How the regulation was not being met:

Care and treatment was not always provided in a safe way because:

1. Some staff did not consistently apply the trust wide infection control policy, including the timely isolation of patients at risk of acquiring, or diagnosed with infectious diseases and the restriction of wearing of theatre gear in general access areas.

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

The trust commissioned an external review of IPC practice and culture and is developing a 5 year IPC strategy, with robust ward to board assurance. We have refocused on the priorities of basic IPC standards, including hand hygiene and the reduction in MRSA line care associated bacteraemia. The primary objective in year 1 is to improve standards of basic IPC at local level and to develop a plan for managing biomedical devices. This will be monitored through divisional reports to the IPC Committee, which now includes NED representation. Action will be taken against all medical and nursing staff not adhering to IPC standards and restaurant staff have been reminded to not to serve any member of staff in scrubs.

The structure of the IPC Team has been reviewed with the aim of addressing cultural behaviour and practice and reflects the need to use improvement methodology to influence practice.

**Who is responsible for the action?** Charlotte Hall, Chief Nurse and DIPC

**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?**

Hand hygiene audits are now demonstrating improvement (from 24% in January 2016 to 85.5% in May 2016); the target is for all wards to achieve 85% or above compliance. We have set internal targets to reduce the rates of hospital acquired infections (achieving 5% below trajectory for C.Diff and 2 or less hospital acquired line-related bacteraemia) by March 2017. Targets will be achieved through a range of methods underpinned by learning from Root Cause Analysis of every bacteraemia and C.Diff acquisition.

**Who is responsible?** Charlotte Hall, Chief Nurse and DIPC

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

We are planning, if possible, to recruit an experienced Infection Prevention Manager with a proven track record of improvement. In addition, we are currently developing a project plan to achieve all the key milestones we have identified.

**Date actions will be completed:** March 2017

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

We will continue to put patients at further risk of contracting hospital acquired infections.

**Completed by:** Charlotte Hall

**Position(s):** Chief Nurse and Director of Infection Prevention and Control

**Date:** 27th June 2016
Regulated activity(ies) | Regulation
---|---
Diagnostic and screening procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (a)
Maternity and midwifery services | |
Surgical procedures | |
Treatment of disease, disorder or injury | |

How the regulation was not being met:
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 because [of]:
1. The quality and accuracy of performance data, and [the need to] increase its use in identifying poor performance and areas for improvement was not adequate.

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

A Governance review was undertaken to draw from best practice from Frimley Health, Salford, Northumbria and other trusts. As a result, the trust has developed a monthly integrated Performance Report including detailed information on performance across all CQC domains. The reports now show specific specialties, areas, sites or wards where underperformance has been identified, which might have been previously less visible from a trust-wide aggregate position. The report also includes key risks, and the first full report was shared at the Quality Summit on 1st June 2016. The report and KPIs will be refined further during 2016. In addition, we established a new board sub-committee in March 2016, Performance Assurance and Risk Committee, to provide detailed review of performance and risk before Board consideration, with the first output reviewed by the Board on 13 May 2016.

We have restructured the clinical leadership team, with 10% of our consultants now in leadership roles. New clinical directors have been appointed in obstetrics, paediatrics and surgery. The Trust Executive Committee is now the key leadership and decision making forum.

Who is responsible for the action? Peter Davies, Director of Strategy, Corporate Affairs and ICT

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?
Processes will be reviewed after 6 months to ensure that they are effective and are sustaining improvements.

Who is responsible? Peter Davies, Director of Strategy, Corporate Affairs and ICT

What resources (if any) are needed to implement the change(s) and are these resources available?
The trust has established a new committee; the Performance and Risk Committee to monitor performance and individual division/corporate risk registers, thereby identifying high risk areas for the trust and ensuring that the appropriate escalation/action takes place. Embedding these processes will require time commitment from divisional teams and from corporate areas.

Date actions will be completed: 30th September 2016

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a risk that underperforming areas will not be identified by the Board, thereby missing the opportunity to sustain improvements to the quality of our service and reduce risk to patients.

Completed by: Peter Davies

Position(s): Director of Strategy, Corporate Affairs and ICT

Date: 27th June 2016
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 (3)</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
</tbody>
</table>

**How the regulation was not being met:**

*Care and treatment of patients was not always provided with their consent and in accordance with the Mental Capacity Act, 2005 because:*

1. Not all patients who may have lacked capacity had a documented mental capacity assessment or if appropriate, a Deprivation of Liberty Safeguards (DoLS) assessment and application completed.

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

A specific mental health awareness training plan is now in place with our mental health providers to improve staff knowledge of mental health issues, Deprivation of Liberty Safeguards (DoLS) and best interest decisions and several staff are undertaking mental health modules through the local university. Training is delivered as part of the trust induction. Prior to the CQC inspection, an audit was undertaken to identify knowledge on the ward areas and additional short training sessions were instigated (bite-sized training delivered in 15 minute sessions delivered on the wards). Since the CQC inspection, mental capacity has been added to specialist sessions, including the learning disability, tissue viability and ITU/HDU training days. Safeguarding adults training sessions now have additional mental capacity and best interest information included. All future update training will be amended to reflect any changes in case law with regard to mental capacity and consent. A rolling programme of information will be published as required in the trust e-update. Targeted training for particular groups of staff involved in best interest meetings will be undertaken e.g. Discharge Coordinators. Staff in the Emergency Department and the assessment units will receive in-depth priority training in mental health and DoLS.

**Who is responsible for the action?**

Charlotte Hall, Chief Nurse and DIPC

**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?**

We will be undertaking 6 monthly audits at ward and department level, spot checks of staff knowledge and dip sampling of patient notes to ascertain staff knowledge levels and identify any continuing or emerging gaps.

**Who is responsible?**

Charlotte Hall, Chief Nurse and DIPC

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

The provision of safeguarding adult support is currently limited. A review of the deputy and Head of Education role is underway to identify funding to provide additional adult safeguarding support.

**Date actions will be completed:**

December 2016

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

Staff may not have a thorough knowledge of DoLS and it may be used inappropriately with patients, thus compromising their liberties.

**Completed by:**

(please print name(s) in full) Charlotte Hall

**Position(s):**

Chief Nurse and Director of Infection Prevention and Control

**Date:**

27th June 2016
Regulated activity(ies) | Regulation
---|---
Diagnostic and screening procedures | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Surgical procedures | Regulation 13 (1) (2) (3)
Treatment of disease, disorder or injury | 

**How the regulation was not being met:**
"Children were not being protected from abuse and improper treatment because child protection notifications were not always up to date, so staff were not always aware of children on the child protection register."

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

In May 2015 this was recognised and was monitored through the Safeguarding Committee and mitigating processes introduced. Staff were informed how to contact social care in and out of hours if they had concerns about a child. The Paediatric Liaison Health Visitor checked the ED cards of all children who attended against community systems (RIO), notifying the safeguarding team of those subject to child protection plans or known to children’s social care as a child in need. Administrative staff were assigned in September 2015 to upload and cleanse all data coming into the trust. This issue was resolved in early December 2015.

We plan to undertake a review of paediatric safeguarding information sharing processes between the Emergency Departments and the Paediatric wards on both sites as a priority (starting in August 2016). We have appointed (as a new role) a Head of Nursing specific for the Emergency Departments, who will be ensuring that the 2 paediatric sisters participate fully in paediatric safeguarding and that they are supported to fulfil their role in relation to this.

**Who is responsible for the action?**
Charlotte Hall, Chief Nurse and DIPC

**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?**

An independent assessor will be appointed to carry out a mapping of the current system of safety alerts. This will be reviewed at the Paediatric Safeguarding Committee and new systems and processes instated as necessary to address any identified gaps.

**Who is responsible?**
Charlotte Hall, Chief Nurse and DIPC

**What resources (if any) are needed to implement the change(s) and are these resources available?**
We have already funded an additional Head of Nursing staff within the ED.

**Date actions will be completed:**
December 2015

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**
Children will be placed at risk through the lack of and adequate safeguarding process.

---

**Completed by: (please print name(s) in full)**
Charlotte Hall

**Position(s):**
Chief Nurse and Director of Infection Prevention and Control

**Date:**
27th June 2016

<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 17 HSCA (RA) Good governance</td>
</tr>
<tr>
<td></td>
<td>Regulation 17 (2 (a), (b), (e))</td>
</tr>
</tbody>
</table>
Surgical procedures
Treatment of disease, disorder or injury

<table>
<thead>
<tr>
<th>How the regulation was not being met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 because:</td>
</tr>
<tr>
<td>1. There were not agreed guidelines specific to the critical care units.</td>
</tr>
<tr>
<td>2. The management, governance and culture in the critical care units did not support the delivery of high quality care.</td>
</tr>
<tr>
<td>3. Feedback from patients was not always obtained in the critical care units.</td>
</tr>
<tr>
<td>4. The ‘Five steps to safer surgery’ checklist was not always fully completed for each surgical patient.</td>
</tr>
</tbody>
</table>

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

We asked St George's Hospital to provide on-site leadership for our service and we established an Acute Response Team (ART), which includes a senior Nurse and an additional tier of middle grade doctor to ensure we identify deteriorating patients early and treat them effectively, including fast access and admission to ITU where required. The practice education team are utilising our simulation facility to strengthen learning in respect of the deteriorating patient (CRISIS) and we have appointed a senior nurse to manage and oversee the use of VitalPac. We have embedded mortality reviews for all in-hospital deaths.

A Critical Care Steering Group has been established, chaired by the Medical Director. Key priorities include the development of a faculty of Intensive Care with St George’s Hospital to share best practice, delivery of the national best practice guidance (GPICS) recommendations, updating of clinical policies/procedures, review of staffing to support the service, strengthening the governance structure, developing a behavioural code of practice, increased capacity of critical care beds and a closer working relationship with the Acute Medical Unit.

Who is responsible for the action? James Marsh, Joint 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?

The Critical Care Steering Group, attended by key leads, meets on a regular basis to review the governance and workforce development within the service. The development of a faculty approach with St George’s Critical Care has ensured that there is ongoing learning and development with regular exposure to best practice.

Who is responsible? James Marsh, Joint Medical Director

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

An experienced senior consultant is now based full time in our unit at St Helier and will become the Operational Clinical Lead. A Nurse Consultant in Intensive Care will also join the team.

Date actions will be completed: June 2016

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

The inability to monitor and improve the quality of the service could compromise patient safety.

Completed by: (please print name(s) in full) James Marsh

Position(s): Joint Medical Director

Date: 27th June 2016
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
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<td>Diagnostic and screening procedures</td>
<td>Regulation 17 HSCA (RA) Good governance</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Regulation 17 (2 (a), (b), (e)</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
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<tr>
<th>How the regulation was not being met:</th>
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</thead>
<tbody>
<tr>
<td>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 because:</td>
</tr>
<tr>
<td>5. All risks of harm to women in maternity services were not always identified, analysed and managed.</td>
</tr>
<tr>
<td>6. Identified risks in maternity services were not always reflected on the risk register and action to manage risks was not timely.</td>
</tr>
</tbody>
</table>

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

Currently, there is a weekly local risk meeting held on each site and a divisional Risk meeting is held monthly (with review of the risk register every 2 months). The newly appointed cross-site obstetric Clinical Director is present at the divisional Risk meetings in order to progress and report on clinician actions from this meeting. Overview of the maternity services is undertaken at the Maternity Board meeting. Maternity indicators are now part of the overall trust integrated performance report presented at the Trust Executive Committee and Trust Board on a monthly basis. There is an identified lead consultant for risk at each site. The Maternity service consultation is now underway which will include an overview of the current governance and risk processes. Daily review meetings commenced in January 2016 to ensure adequate deployment of staff to manage acuity and daily safety huddles have been introduced. Listening events have been introduced to respond to staff concerns.

The information sent to the CQC in PIR 2 (Sept 2015) included 2 risks (no. 581 and no. 81) relating to staffing.

| Who is responsible for the action? | Charlotte Hall, Chief Nurse and DIPC |

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?

There will be executive oversight at maternity Board, executive support to the divisional team on a weekly basis with quarterly review of KPIs at the performance meetings chaired by the Chief Executive.

| Who is responsible? | Charlotte Hall, Chief Nurse and DIPC |

<table>
<thead>
<tr>
<th>What resources (if any) are needed to implement the change(s) and are these resources available?</th>
</tr>
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<tbody>
<tr>
<td>An audit midwife has been in post since December 2015, to make more use of audit and action from audit to improve clinical care. There is now a dedicated Quality Manager for Women’s and Children’s Services who works closely with the Lead Midwife for Governance, and assists in all aspects of review of the risk register.</td>
</tr>
</tbody>
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| Date actions will be completed: | June 2016 |

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

Potential risks to women and their babies may not be identified and could compromise patient safety.

<table>
<thead>
<tr>
<th>Completed by:</th>
<th>Charlotte Hall</th>
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<td>(please print name(s) in full)</td>
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<th>Position(s):</th>
<th>Chief Nurse and Director of Infection Prevention and Control</th>
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<tr>
<th>Date:</th>
<th>27th June 2016</th>
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</table>
Regulated activity(ies)
Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation
Regulation 18 HSCA (RA) Staffing
Regulation 18 (2) (a)

How the regulation was not being met:
There were not sufficient numbers of suitable qualified, competent, skilled and experienced nursing [staff] and midwives in many areas, but in particular, surgery, children and young people and maternity services because:
1. Nurse staffing levels had a negative impact on patient care on one surgical ward and the children and young people services at St Helier Hospital.
2. There were risks to women due to the inadequate and poor deployment of midwives at St Helier Hospital.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
The use of agency nursing has reduced by 70% in 12 months and our vacancy rate has reduced from 15% to just over 7% (with 344 WTE more than last year). There is a targeted approach to areas with high vacancy rates, including attendance at recruitment events (UK and EU) and a series of events across the trust. Acuity dependency is undertaken twice a year and the nursing establishment reviewed in line with the results. The trust is undertaking a review of all nursing establishments, quality indicators, acuity, budget and WTE in post versus in budget. Daily review meetings (which commenced January 2016) ensure adequate movement of staff to manage acuity. The SafeCare tool will be implemented by August 2016, with all patients’ acuity scored daily. Further work streams include ward leadership review and review of models of nursing care at ward level. In relation to the surgical ward at St Helier mentioned above, we took a range of actions including appointing a new ward manager and have since seen improvements in the safety and quality of care on this ward.

Formalised rotation of midwives commenced at St Helier in November 2015 and Epsom in March 2016. Transformation of the midwifery workforce is underway to ensure maximum resources are available and includes rotating community and hospital-based staff across all units.

Who is responsible for the action? Charlotte Hall, Chief Nurse and DIPC

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?
Care hours per patient, per day will be benchmarked against the national average to ensure that we are performing favourably. Improvements will be visible in both the staff and patient FFT.

Who is responsible? Charlotte Hall, Chief Nurse and DIPC

What resources (if any) are needed to implement the change(s) and are these resources available?
We will appoint to a dedicated nursing post relating to workforce and transformation.

Date actions will be completed: July 2017

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Insufficient number of appropriate staff could compromise patient safety and adversely affect the patient experience.

Completed by: Charlotte Hall
Position(s): Chief Nurse and Director of Infection Prevention and Control
Date: 27th June 2016
<table>
<thead>
<tr>
<th>Regulated activity(ies)</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 9 HSCA (RA) Person-centred care</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Regulation 9 (3) (a), (b), (c), (d), (e), (f), (g)</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Care and treatment of patients was not always appropriate or met their needs because:</td>
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<td></td>
<td>1. The care and compassion shown to patients in the medicine, surgical and critical care areas was at times lacking.</td>
</tr>
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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

We are developing a dignity index to monitor care and compassion and all matrons are now expected to work clinically. Ward managers receive training in how to monitor compassionate, dignified care and we are considering the use of simulation training to improve staff communication skills. We aim to teach and use quality observational studies to observe and identify negative staff behaviours lacking care and compassion. The trust has commissioned a new provider (from May 2016) to support improvement in FFT response rates, reduce variation within and across sites and increase the accessibility of feedback to Wards (including targeted feedback) to support them to make improvements. In May 2016, we achieved the best ever response rates.

More wards are adopting the use of social mealtimes with food delivered to tables and chairs at which patients can sit. We are using ‘the perfect handover’, incorporating huddles, to discuss and agree care with patients 3 times a day. Further work is being progressed as part of the nursing transformation workstream to look at how nursing care is delivered to modernise and capture appropriate therapeutic interventions between nurses, midwives and patients. This includes a patient flow programme to ensure that patients are looked after in the most appropriate area. We are delivering personalised care in our dementia ward and are planning to roll this out trust-wide, using national campaigns (John’s Campaign) to change practice.

Who is responsible for the action? Charlotte Hall, Chief Nurse and DIPC

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?

Divisions will be asked to demonstrate how they assess the patient experience, other than routine monitoring of FFT and complaints, as part of their quarterly performance review. This will include the use of patient stories, individual feedback and ward manager clinics for relatives and carers. Improvement will be monitored by the use of observational quality audits.

Who is responsible? Charlotte Hall, Chief Nurse DIPC

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

We plan to recruit a 2nd Deputy Chief Nurse to implement modernisation and transformation of nursing care.

Date actions will be completed: August 2016

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

Failure to treat patients with compassion will have a negative impact on the patient experience.

Completed by: (please print name(s) in full) Charlotte Hall

Position(s): Chief Nurse and Director of Infection Prevention and Control

Date: 27th June 2016
<table>
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<th>Regulation</th>
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<td>Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury</td>
<td>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 9 (3) (a), (b), (c), (d), (e), (f), (g)</td>
</tr>
</tbody>
</table>

**How the regulation was not being met:**

Some premises and equipment was not properly used, properly maintained or suitable for the purpose for which they were being used because:

1. Emergency equipment was not always checked in line with the trust wide policy.
2. The existing estate in some areas was not fit for the purpose of delivering modern healthcare.
3. There were not robust processes in place for the maintenance of medical equipment.

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

Please note that this has been covered above under Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment.

Regulation 15 (1) (c), (d), (e).

**Who is responsible for the action?**

**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?**

Who is responsible?

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

Date actions will be completed:

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

Completed by:
(please print name(s) in full)

Position(s):

Date: