Agenda Item 10

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	17 January 2017
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Reference:	8038
Report From:	Director of Transformation & Governance

Contact name: Katie Benton, Scrutiny Officer

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1. Summary and Purpose

1.1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

1.2. Where appropriate comments have been included and copies of briefings or other information attached.

1.3. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

1.4. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

1.5. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission's re-inspection enforcement notice of PHT's Urgent Care *(Monitoring item)*	Portsmouth Hospitals NHS Trust Care Quality Commission	PHT have provided an update letter from the CQC (Appendix One, page 6), an enforcement notice action plan (Appendix Two, page 11) and the November 2016 performance update (Appendix Three, page 30).	The HASC considered this item in June 2016, where the Trust set out their 100 day plan to improve care and waiting times at the QA Hospital emergency department.
Recommendations: That Members: 1. Note the progress by Portsmouth Hospital Trust against the actions of the Care Quality Commission's re-inspection report on the Accident and Emergency Department. 2. Request a future update on performance in six months' time. 3. Request any additional information required.			
Topic/ inquiry	**Source**	**Action Taken**	**Comment**
Transforming Care Partnership: Delivery of a Community Forensic Learning Disabilities Service	Southampton Hampshire, IOW and Portsmouth Transforming Care P'ship	Report attached as Appendix Four (page 32).	New issue notified to Chairman in December 2016.

Topic	Relevant Bodies	Action Taken	Comment

Recommendations:

8.1 The HASC is asked to note:

- The closure of Cypress Ward and the re-investment of £615k in community Learning disability services
- The new model of care approach that replaces the Cypress Ward with an integrative working provision including:
  - the Forensic Community Learning Disability Team (FCLDT)
  - the NHSE capital investment of £935K for the procurement of Registered Social Landlord (RSL) supported accommodation for PWLD on the Forensic pathway
  - a 24 hours/ 7 days a week supported living provider for the RSL supported accommodation scheme

8.2 HASC is asked to advise:

- the Hampshire 5 CCGs board on how HASC would like to receive SHIP TCP overall work streams updates, for example -monthly, quarterly or annual reporting.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

0. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2 **Equalities Impact Assessment:** This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

2 Impact on Crime and Disorder:

2.1 This paper does not request decisions that impact on crime and disorder

3 Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No impacts have been identified.

CQC Representations
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Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
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For the attention of

BY EMAIL
Tim.Powell@porthosp.nhs.uk

Mr. Tim Powell
Interim Chief Executive
Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth
PO6 3LY

Date: 13 October 2016

Our reference: SPL1-2824807907.

Dear Tim,

Notice of Proposal to remove a condition on your registration for the regulated activity, treatment of disease, disorder or injury

The Commission's Proposal

Pursuant to Section 12(5)(a) of the Health and Social Care Act 2008 we propose to remove the following conditions from your registration:

1. The Registered Provider must ensure there is effective leadership of the emergency care pathway. There should be a clinical transformation lead that is appointed based on external advice and agreement. The lead should have the authority to make decisions, and ensure there is swift and appropriate action in relation to identified problems. There should be effective leadership, resource and support of the trust improvement plan to ensure changes are appropriately supported and implemented at pace. The trust improvement plan should be adhered to and any deviation must be based on external advice and agreement. Medical and nursing leadership, that is specific to the emergency department, should be clearly identified and supported, so that staff are empowered to make and act on decisions in the interest of patient care and safety.

2. The Registered Provider must operate an effective escalation

system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement April 2011 The trust should follow the escalation procedures identified to manage increases in demand and pressures on the emergency pathway. The escalation process should be defined based on external advice and agreement. The actions the trust should take should be responsive and should not be delayed.

3. The registered provider must ensure the large multi-occupancy ambulance known as the "Jumbulance" will not be permitted to be used on site at the Queen Alexandra Hospital. The exception to this will be if a major incident is declared. If the vehicle is then used, there should be appropriate action taken to ensure patients are kept safe at all times. The Registered Provider must ensure that ambulance waits do not exceed the recognised national target.

4. The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis.

 % of ambulance arrivals assessed within 15 minutes; indicate % >30 minutes and % > 60 minutes. Identify the longest waiting times (> 60 minutes), clinical details and reasons for long wait

 % of ambulance patients treated within 60 minutes; indicate % > 2 hours, % > 3 hours. Identify the longest waiting times (> 3 hours), clinical details and reasons for long wait

 % of patients (type 1) meeting the national emergency access 4 hour target

 % of patients waiting to be admitted 4 – 6 hours; > 6 hours; > 12 hours; >24 hours

 Number of 12 hour trolley breaches based on a decision to admit within four hours of admission (if the emergency access target is to be met)

 Number of ambulance delays > 30 minutes and > 60 minutes.

 Number of times 4 or more ambulances are waiting over 30 minutes outside the emergency department - frequency and duration. This should also be identified as an incident .

 Number of patients to ambulatory emergency care pathway

 Number of patients to the Urgent Care Centre.

 Number of medical outliers

 Number of escalation beds in use

 Number of patient bed moves for non-clinical reasons. Patient moving > 2, >3 or more times. Identify number of times vulnerable patients (e.g. frail elderly or end of life care patients) have been moved within these figures.

 Number of patient bed moves over night. Appropriately identify number of times vulnerable patients (e.g. frail elderly or end of life care patients) have been moved within these figures.

 Number of emergency medical patients whose length of stay is between 1 – 2 days. Number of patients delayed discharged who are medically fit: delays 24 hours; > 1 – 2 days; > 2 – 7 days; > 7 days. Reasons for delay.

• Number and details of incidents reported in ED and MAU - all near misses, low, moderate and severe harm.

 Assurance report on the quality of data and the level of incident reporting

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Registration history

On 1 April 2009 the Commission registered you to carry on the regulated activity treatment of disease, disorder or injury at Queen Alexandra Hospital Southwick Hill Road, Cosham, Portsmouth PO6 3LY

Reasons for the Commission's proposal

On 15 March 2016 we imposed the above condition on your registration following a responsive inspection of the Urgent and emergency core service and Medical services at the Queen Alexandra Hospital on 22 and 23 February and 3, 4 and 5 March 2016. We imposed the condition because you were failing to comply with the requirements of a number of regulations
We propose to remove this condition from your registration as the Commission no longer feels it is necessary.

Evidence relied upon

We carried out an inspection of Queen Alexandra Hospital on 29 and 30 September 2016. We found that you have made significant improvements with regards to compliance of Regulation 12(1) Safe Care and Treatment of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*

During our inspection, of the Urgent and Emergency Care service, we observed:

- A significant improvement in patient safety. However we had some concerns about resilience through the winter months.
- There were improved examples of caring from staff to patients in the department.
- The flow of patients into the emergency department had improved. The flow out of the department had improved although there were still some challenges within the medical service.
- Staff we spoke with were positive about the service. However there was lack of clarity with regards to communication across the department.

From the evidence observed during our inspection and submitted as part of your improvement plan, we have identified

- A clinical transformation lead had been appointed with external agreement and was in post from 18 July 2016.The medical and nursing leadership specific to the Emergency Department has been enhanced. The clinical director is confirmed in post and has support from the clinical transformation lead. There is now a head of nursing for the emergency department. Leadership and team building approaches are being supported within the department.
- Escalation policies and procedures have been written with the support of external advisors and stakeholders to mitigate risks to patient care. These work across the Portsmouth system.

- The Jumbulance had been removed and we were assured by staff that it had not returned to the hospital since our condition had been in place.
- The data has been submitted on a weekly basis. This data is being used across the Portsmouth system. We note, the trust has also developed and matured its monitoring arrangements from the provision of figures to identifying trends, and an understanding of where to direct action and interventions.

From the data submitted (June – September 2016), we have noted the following:

- This data has demonstrated that some improvements have been made within the service which has reduced the risk of harm to patients
- The emergency access 4 hour target is approximately 82%. This has improved from 69% in February 2016 but still does not meet the national target.
- The % of ambulance arrivals assessed within 15 minutes had met the target of 95% overall, although this has varied as times
- Patients seen by a doctor within 60 minutes is approximately 52% and does not meet the target of 95%. Medical sickness has impacted on this target and you have outlined the further actions the trust are taking to ensure effective medical cover within the Emergency Department.
- There has been a reduction in the amount of ambulances waiting over 30 minutes (from 12% of total ambulances to 7%). There is some disparity with the metrics supplied by the ambulance service which is being reviewed
- There have been no 12 hour breeches since June 2016.
- Escalation beds have been consistently used throughout our period of monitoring with a high level of medical outliers. Daily 'stranded patients' meetings are being held to improve the discharge process for patients.

From the evidence outlined above, the requirements of the s31 notice have been met and the conditions will be removed as patients are no longer at ' immediate risk of harm'. However, the trust is still not meeting national targets we therefore require you to continue to submit data on a monthly basis. This data will be used and discussed at your CQC engagement meetings. We have also served immediate requirement notices following our inspection where you need to take appropriate action. Our inspection findings will be set out in more detail in our inspection report which will be sent to you in draft form.

Conclusion

After assessing the evidence found during our inspection, CQC considers that this condition is no longer needed to encourage you to improve your care standards and comply with your legal requirements.

This notice is served under Section 26 of the Health and Social Care Act 2008.

The Act and its associated regulations are available on the Commission's website: www.cqc.org.uk

Your right to make representations

If you do not agree with any or all of these reasons or any other matter relating to this notice, you have the right to make written representations under Section 27 of the Health and Social Care Act 2008, to us within 28 days of the date this notice was served on you. To do this you should download and complete the relevant representations form on our website at: http://www.cqc.org.uk/reps and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations against our proposal, and make sure that you include the reference number SPL1-2824807907

CQC contact details

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote our reference number SPL1-2824807907 as it may cause delay if you are not able to give it to us.

Yours sincerely

Professor Edward Baker
Deputy Chief Inspector

Cc Joyce Frederick, Head of Hospital Inspection
Sir Ian Carruthers Chair of Trust
NHS Improvement
NHS England

Appendix Two

Part A: CQC Enforcement notice	
Improvement Action(s)	**Progress to date**
Condition 1: The Registered Provider must ensure there is effective leadership of the emergency care pathway	
Delivering an Urgent Care Transformation Plan (UCTP) and the eight associated workstreams to deadlines	• UCTP agreed and approved by Trust Board. • Amended Governance structures in place; reviewed by the Chief Executive Officer and Executive Director Emergency Care (EDEC) weekly and Trust Board monthly moving forward.
Chief of Service and Head of Nursing with sole responsibility for the Emergency Department	• Implementation from March 2016 onwards.
CSCs and Executive team to deliver change by facilitating engagement from all staff levels with executive support	• UCTP performance assessed and discussed at all CSC Executive performance reviews. CSC specific KPIs reviewed monthly. • Refreshed communications plan; currently being reviewed
Establishment of workstreams within ED for Triage, Minors/UCC, PITSTOP and Paediatrics	• Workstreams established and continuing • Pilot schemes (e.g. PITSTOP) have highlighted improvement opportunities. **August update:** • Minors 'navigator' role in place from 5th September. Reconfiguration works to support increase in Majors PITSTOP capacity and duration commencing 26th September. September update: • Minors process including Navigator role implemented on 5 September and now embedded. Staffing requirements identified and incorporated into business case. Staffing uplift to make this sustainable long-term and within budget. • PITSTOP reconfiguration works now underway. SOP for PITSTOP now complete and will be implemented on completion of reconfiguration works. • ED workforce business case will allow this area to function fully to demand as recruitment allows.
Staff engagement with improvement processes through workshops and feedback sessions	• Communications plan in development (as noted above). • Two ECIP facilitated Operational Board improvement events have taken place; next booked 16th October 2016 and quarterly following. September update: • Leading change and service improvement workshops facilitated by NHS Elect held in Sept and Oct with clinical and operational representation from across all CSCs. These workshops will in future be led by the PHT OD and UCTP Teams supported by ECIP with direction from NHSI.
Condition 2: The Registered Provider must operate an effective escalation system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement April 2011	

Establishment of escalation boards within ED.	• Installation will be completed following scheduled review of Escalation Policy. **August update:** • The final draft of the Escalation policy has been prepared and is due to be ratified at the Emergency Medicine CSC Management Board on 29th September. Following ratification will be implemented throughout thedepartment.

Part A: CQC Enforcement notice	
Improvement Action(s)	**Progress to date**
	September update: • ED Escalation plan and ED components of Capacity Escalation Plan updated and complete. • Changes currently with Ops Centre for ratification followed by incorporation into ED plans formally. • Escalation Boards will be placed in Majors 1 and 2.
ED to continuously monitor: • effectiveness of ambulance arrival triage processes • enhanced triage at times of high demand and when patients are held in ambulances	• Sustained improvement in 15 minute ambulance handovers. • Alignment of streaming and PITSTOP processes; implementation 5th September 2016. **August update:** • Minors 'navigator' role in place from 5th September. Reconfiguration works to support increase in Majors PITSTOP capacity and duration commencing 26th September supporting improvements in triage • Overall improvements in 30 and 60 minute ambulance handovers - within context of increased numbers of SCAS conveyances • Speed of escalation in PHT is improving from a SCAS perspective • Improvement in numbers of patients triaged within 15 minutes and first seen by clinician within 60 minutes • Refreshed Trust Escalation and Full Capacity policies, communicated with staff, implemented and currently under further review to optimise process • Regular dialogue, and information /data sharing with SCAS aligning activity profiles with ED staffing and whole Trust dischargedelivery September update: • Compliance with the 15 minute assessment and 60 minutes to be seen has increased to 71% and 55% respectively. Implementation of a Minors 'navigator' role has supported this. The PITSTOP reconfiguration works have commenced and in the long term, with an expansion of multi professional ED workforce bridging the staffing capacity gap to meet demand.
Provide an appropriate and modern Trust Escalation Policy which safely and consistently delivers: • appropriate SOP for immediate clinical review, management and escalation of patients being held in ambulances • immediate ambulance handover • the Trust Full Capacity Operational Process	• Refreshed Escalation and Full Capacity Policies now in place and currently being reviewed. **August update:** • Policy reviewed as part of whole system resilience table top exercise completed on 15th September – PHT plan validated; after minor changes, anticipated Trust Board sign off 5th October. **September update:** • Draft policy for managing patients in ambulances now complete and with Executive team for consideration as this has Trust-wide impact. • Action cards identify actions to be implemented to maintain 15 minute triage when an escalation in demand experienced.

Part A: CQC Enforcement notice	
Improvement Action(s)	**Progress to date**
Weekly submission of daily monitoring metrics as defined by the CQC	• In place. **August update:** • Weekly submissions, informed by multi-professional teams, demonstrating performance against the CQC improvement programme • RCAs undertaken on all 12-hour breaches (nil since May) • Executive escalation of incidents or concerns relating to internal professional standards across ED and AMU in place and acted upon. • Feedback via EDEC to individual specialty Chiefs whenever non adherence to internal professional standards adversely influences patient outcomes or staff experience September update: • Weekly submissions sustained - as above.
Condition 3: The registered provider must ensure the large multi-occupancy ambulance known as the "Jumbulance" will not be permitted to be used on site at the Queen Alexandra Hospital.	
Jumbulance' not to be used. If the vehicle is used, there should be appropriate action taken to ensure patients are kept safe at all times and ambulances waits do not exceed the recognised the national target	**August update:** • The Jumbulance has not been used since the Enforcement Notice. • Implementation of a refreshed, Emergency Department escalation process which escalates any safety concerns or risk of ambulance holds exceeding the national target • Improvement in ambulance hand over times. September update: • The Jumbulance has not been used since the Enforcement Notice. • Weekly ambulance handover delays reviewed and discussions on-going with SCAS.
Condition 4: The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis and based on the provided list of metrics	
Weekly (Thursday) submission of daily monitoring information to the CQC.	• In place and sustained. Completed weekly by multi professional teams with dedicated clinical input and signed off by Director of Nursing and Executive Director Emergency Care.
Improve incident reporting within the ED and AMU.	• Incident reporting via professional standards log introduced 1st April 2016 onwards (used to escalate ED Governance concerns). Expanded to AMU. • Root Cause Analysis undertaken on all 12-hour breaches. September update: • Incident reporting via professional standards log continues on ED and AMU. • Zero 12 hour breaches so no RCA undertaken. • Overall increase in number and variety of incidents. • Incident Trigger list developed and implemented in ED. AMU developing list.

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Process to establish an enhanced triage system at times of high demand and when patients are held in ambulances	**Complete - on-going monitoring through the Urgent Care Transformation Board and external A&E Delivery Board** • ED Escalation policy agreed by Chief Executive Officers of both the Trust and SCAS 14th June 2016; reviewed through SRG in September 2016. • ED escalation plan agreed: SOP for assessing ambulance held patients submitted to the Director of Nursing and Director of Operations - unscheduled care for comment. Update of all Trust escalation plans reflects new Majors layout and new PITSTOP (go-live 26th October 2016). • Draft policy for managing patients in ambulances now complete and with Executive team for consideration as has Trust-wide impact. • Action cards identify actions to be implemented to maintain 15 minute triage when an escalation in demand experienced.	• Ratified ED escalation policy with plan to review post PITSTOP reconfiguration works completed. • Action cards. • 15 minute assessment data.	Head of Nursing Emergency Medicine CSC
Weekly (Thursday) submission of daily monitoring metrics as defined by the CQC including the triage, assessment and treatment of patients. Weekly analysis of metrics to identify trends and learning	**Complete - moving to monthly monitoring by CQC** • On-going improvements being noted in metrics.	• Weekly e-mails submitted to the CQC with all metrics and associated narrative demonstrating analysis of information, trends and learning.	Associate Director of Quality and Governance
Ownership of data, ensuring analysis and learning is disseminated across the Emergency Department	**Complete - on-going monitoring through the Urgent Care Transformation Board and external A&E Delivery Board** • Analysis and learning from the weekly metrics are fed back to staff, including publication of the metrics on the staff noticeboard. In addition, key learning is included in the CSC Newsletter. • Following implementation of incident trigger list in ED w/c 27th June an increase in reported incidents is noted for that reporting period. • Incident reporting still being monitored although improved 15 minute assessments seem to be minimising the risk of events: on-going monitoring	• CSC newsletter. • Trust Board story. • Incident themes and trends	Chief of Service Emergency Medicine CSC

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Ownership of data, ensuring analysis and learning is disseminated across the organisation	**Complete and on-going** • Data used at the Operations meeting to manage flow. • Data reviewed at the Urgent Care Transformation Programme Board. • SAFER flow bundle reported at CSC Performance reviews.	• Weekly submission of metrics to CQC and partners, with associated narrative demonstrating analysis of information, trends and learning; contextualised with operational position of the hospital. • Unscheduled Care dashboard available on the intranet.	Deputy COO
Trust full capacity and escalation policies to be implemented fully and in a timely manner as the ED approaches full capacity	**Complete and on-going** • Escalation implementation still not robust with variation across Trust with Trust on red while ambulances being held: ED review and production of escalation boards in ED may help mitigate this: Ops Centre need to be more robust in this.	• No 12 hour DTA breaches since May 2016; despite high level of attendances. • Weekly submission of metrics with associated narrative demonstrating improvement in ambulance holding compliance and sustained 15 minute assessment.	Deputy COO
April 2016			
No actions			
May 2016			
Using the Trust's performance review policy, all staff will be monitored against the delivery of their objectives with an appropriate personal development plan identified where required	**Commenced and on-going to be monitored via appraisal compliance and yearly audits of the quality of appraisals, objectives set and delivery.** • Training available for all managers of staff to ensure they can effectively set objectives and appraise staff on delivery against them • Further guidance has been developed to support managers to set SMART objectives and hold a coaching conversation as part of their regular 1-1s with direct reports	• Diarised performance reviews at CSC level. • Formal performance review letters following reviews to CSCs. • An audit of the quality of appraisals undertaken during October by the Organisational Development Team; findings will be reported back to management teams along with any recommendations. • 2016 National Staff Survey results will demonstrate whether staff feel their appraisal has helped them to do their job more effectively	All line managers across the pathway
All new or reviewed processes and procedures will be developed with staff and communicated effectively with an opportunity for evaluating their effectiveness	**Complete – monitoring through local Pulse and National Staff Survey results.** • The CSC Management Teams and Senior leaders are aware of the need to engage staff. A variety of engagement methods are being utilised within individual CSCs.	• The local Pulse and National Staff Survey results. • Outcomes of Listening into Action (LiA) events).	Chief of Service for each CSC

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	• Specific Urgent Care service changes will be monitored through the workstream updates at the Urgent Care Transformation Board and communicated through a monthly Team Brief slide.		
Chief of Service and Head of Nursing with sole responsibility for the Emergency Department.	**Complete**	• Noted in the May 2016 Board CQC Enforcement Notice Exception Report	Chief Operating Officer
CSC senior management team (SMT) to deliver change by facilitating engagement from all staff levels with executive support.	**Complete – monitoring through local Pulse and National Staff Survey results.** • The CSC Management Teams and Senior leaders are aware of the need to engage staff. A variety of engagement methods are being utilised within individual CSCs.	• The local Pulse and National Staff Survey results. • Outcomes of Listening into Action (LiA) events).	Chief of Service for each CSC
Establishment of workstreams within ED for Triage, Minors/ UCC, Pitstop and Paediatrics	**Complete – monitoring through Urgent Care Transformation Board.** • Pilots for Minors and PITSTOP completed in June and July. • New minors process commencing 5th September. **August update:** • Minors pilot complete and new process fully implemented 5th September 2016. Now undergoing weekly review and PDSA to ensure maximal benefit. Challenges remain over role of GP in UCC and there are on-going discussions with Commissioners around this. • Majors pilot complete and process identified. Requires building works to be completed and these commence 26th September 2016 with completion date end of October	• Pilots demonstrated 100% achievement of 15 minute to triage in both Minors and Majors supporting move to new processes in both areas of ED, as well as funding for PITSTOP reconfiguration works.	Chief of Service Emergency Medicine CSC
Staff engagement with improvement processes through workshops and feedback sessions	**Complete** • Two workshops completed. • Project groups have subsequently been established, involving all levels of staff to take forward the ED urgent care workstream	• The local Pulse and National Staff Survey results.	Chief of Service Emergency Medicine CSC
June 2016			
Emergency Department continues to monitor the effectiveness of	**Complete** • Emergency Department Escalation Policy agreed by	• Sustained performance demonstrated through CQC weekly metrics.	Chief of Service Emergency

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
ambulance arrival triage processes, utilising competent ED nurses	Chief Executive Officers of both the Trust and SCAS 14th June 2016; to be reviewed through SRG in September 2016. • Weekly data submitted to the CQC demonstrating a marked and sustained improvement in compliance with 15 minute assessment and ambulance holding.		Medicine CSC
Implementation of the Trust Full Capacity Policy and Capacity Escalation Policy Earlier robust activation and management by Operations Centre when triggers are reached	**Complete** • Commenced measuring unplaced speciality patients in ED at 0800 as a KPI.	• No 12 hour DTA breaches since May; despite high level of attendances. **August update – action complete** • Reduction in number of unplaced speciality patients in ED at 0800 and in time pulled from ED into speciality bed.	Deputy COO
Audit the effectiveness of the 12 hour DTA breach SOP to ensure timely escalation and reporting of breaches	**Complete and on-going**	• No 12 hour DTA breaches reported since May; this will be audited should any patients be at risk of spending 12 hours from DTA.	Deputy COO
University of Southampton to be invited into the Trust to meet mentors and discuss how they are enabled to support students to ensure the learning environment provides the requisite experiences, mentorship and support to enable pre-registration students to progress to competent and capable registrants	**Complete**	• Final report from the University of Southampton received. The Faculty were entirely satisfied that the learning environment within the Trust is of high quality, fit for purpose and meets the Nursing and Midwifery Council requirements.	Head of Nursing and Midwifery Education
Duty Matron daily review of compliance with single sex requirements in escalation areas	• Process implemented, CQC review demonstrated gaps in process. A reminder has been sent to staff. The Lead Nurse for Single Sex will raise with Heads of Nursing as a standing agenda item at monthly meetings.	• Daily staffing reports demonstrating compliance.	Head of Nursing CHAT
Re-enforce professional accountability for senior nurses relating to safe storage of medicines; with engagement from pharmacy	**Complete**	• Minutes of meeting held on 29th June 2016 confirming discussions.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
AMU audit of current processes and environment - outcome of audit	**Audits completed weekly.** **CQC highlighted practice was not sustained. Further actions will inform the new CQC action plan.** • Safe storage of medications audit undertaken by AMU Matron on 21st June 2016 • Pharmacy action plan regarding safe storage of medicines developed. • Alert signs developed and used in each ward.	• E-mails to Director of Nursing demonstrating audit compliance.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
Re-enforce professional accountability relating to infection control practices	**CQC highlighted practice was not sustained. Further actions will inform the new CQC action plan.** • Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.	• Minutes of meeting held on 29th June 2016 confirming discussions.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
July 2016			
Identify champions to promote and adopt the Listening into Action methodology for engaging staff to be involved in and empowered to make decisions and changes that affect them.	**Complete**	Across the pathway: • 7 members of staff across the pathway are formally engagement/innovation champions. • 11 staff in addition have attended a training module for 'engaging for success'. • Further training sessions to actively promote staff led change. • AMU and Emergency Department Team brief Slide and internal newsletter.	General Manager, Emergency Medicine, Medicine and MOPRs CSCs
Display in staff areas learning from incidents taking best practice from Critical Care's approach and share with wider organisation	**Complete** • The CSCs use Safety Learning Posters as a way of sharing learning and best practice. • Trust-wide 'Spotlight on Safety' newsletter. • Various methods of shared learning currently exist across the pathway including written displays in staff areas and shared learning at department meetings.	• Safety Learning Posters. • Trust-wide 'Spotlight on Safety' newsletter. • CSC newsletters.	Governance Leads Emergency Medicine, Medicine and MOPRs CSCs
Staff are clear on who to escalate to	**Complete**	• Spot checks with staff.	Chief of Service

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
and how to access members of the senior leadership team	• Various initiatives have been introduced within CSCs, e.g. Emergency Medicine have introduced a professional standards mailbox which allows staff to report/escalate issues to senior members of the team. A discussion/feedback follows and any themes identified are discussed within the department and escalated to the executive team where appropriate. Surgery and Cancer have introduced 'cake with Matron', 'tea with the Head of Nursing' and 'Take a Break with Management'.		for each CSC
Establishment of escalation boards within ED. These to be used in conjunction with new role and responsibility cards for consultant and nurse in charge	**August update:** • Escalation plans are being updated across Trust; due to be completed by the end of October 2016 once all plans updated. This has also been limited by other demands on the Senior Management Team time to deliver on other workstreams. **September update:** • ED Escalation plan and ED components of Capacity Escalation Plan updated and complete. • Changes sitting with Ops Centre for ratification followed by incorporation into ED plans formally. • Escalation Boards will be placed in Majors 1 and 2.	• Escalation Policies	Chief of Service Emergency Medicine CSC
Trust Escalation Policy to recognise patients being held within ambulances and to agree the appropriate level of escalation	• Trust Escalation policy is currently being rewritten with a view to sign off in September 2016. This detail is currently in the ED escalation policy. **September update:** • Draft policy for managing patients in ambulances now complete and with Executive team for consideration as has Trust-wide impact. **October update:** • PHT Resilience Plan agreed by Trust Board 5th October.	**September update:** • Further revision of the Trust Escalation Policy underway. • Whole system resilience table top exercise completed on 15th September	Deputy COO
Implementation of the ED escalation Policy to allow immediate ambulance handover into a clinical care space	**Complete** • Emergency Department Escalation Policy agreed by Chief Executive Officers of both the Trust and SCAS 14th June 2016; to be reviewed through SRG in September 2016.	• Marked reduction in ambulance holds: not at level where numbers allow correlation between CQC metrics and SCAS data on delayed handovers: assessment commenced w/c 1 August	Chief of Service Emergency Medicine CSC

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
		2016.	
Development of a Standard Operating Procedure to deliver a clinical review of patients held within ambulances when the Trust Escalation Policies have failed to provide capacity to allow immediate transfer of patients from ambulances	• Initial draft complete with limited feedback to date; out of hours ED consultant and SpR will need support from other teams to manage referred patients in ED. AMU/Medicine do not have capacity in the current model to deliver this **August update:** • Currently being formulated; to sit alongside escalation plans. **September update:** • Draft policy for managing patients in ambulances now complete and with Executive team for consideration as has Trust-wide impact.		Chief of Service Emergency Medicine CSC
Clear roles and responsibilities for ED staff as stated in the ED Escalation Plan	**Complete** • Roles and responsibilities detailed in escalation plan in last version: will be further reviewed as part of escalation plan review w/c 1 August 2016. **August update:** • Part of on-going update of escalation plan. **September update:** • Completed and in escalation plans and individual cards being produced.	• Escalation Policies. • Action cards.	Chief of Service and Head of Nursing Emergency Medicine CSC
Ensure ED staff awareness of when and how to raise a Safeguarding Adult alert	**Complete**	• Staff in the Emergency Department have received additional safeguarding training.	Head of Nursing Emergency Medicine CSC
Revise incident reporting trigger list to include non adherence to the AKI and sepsis pathways in ED, with staff re-education and publication of trigger list in all staff areas	**Complete** • Trigger list complete. • Sepsis audit and meeting to support adherence to new CQUIN being arranged.	• Incident trigger list.	Chief of Service Emergency Medicine CSC
Development of a Duty Matron checklist to include escalation areas and single sex compliance	**Complete** • Additional checks to the Duty Matron report added on 15th June 2016 as soon as the CQC report was received.	• Daily staffing reports demonstrating compliance	Deputy Director of Nursing
Review escalation areas to include CCG and Governor validation	**Internal actions complete** • All escalation areas reviewed internally by either Deputy Director of Nursing and/or Head of Nursing for	• Director of Nursing is part of the National Mixed Sex Accommodation Taskforce.	Head of Nursing CHAT

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	CHAT. Staff in these areas given guidance about DSSA policy and use of Kwik screens to ensure compliance. Process for escalating concerns has been reinforced. Deputy Director of Nursing has met with Duty Managers to provide guidance on DSSA. Director of Nursing liaising with CCGs and Governors to validate areas. • Additional checks to the Duty Matron report added on 15th June 2016 as soon as the CQC report was received.	• Awaiting external assurance. **August update:** • Visit by CCG to validate areas scheduled to take place on the 31st August was postponed by the CCG. This will be discussed with the CCG Chief Quality Office and Trust Director of Nursing. **September update:** • CQC highlighted practice was not sustained. Further actions will inform the new CQC action plan.	
Programme of education for senior ward leaders	**Complete** • Discussed the importance of single sex compliance with Heads of Nursing and Matrons. And an e-mail has also been sent detailing expectations on Duty Matron to ensure single sex in place, particularly in escalation areas has been sent to Heads of Nursing, Matrons and Hospital at Night. • The Deputy Director of Nursing has met with lead for the Duty Hospital Managers to clarify expectations and will attend a team meeting in August to talk through scenarios with the team. Single sex requirements will be discussed at the Duty Director training. • Further discussions to take place with ward managers and Matrons in August and ad-hoc if single sex breaches occur to ensure learning is implemented. • Reminder of single sex requirements included in the June 2016 Team Brief.	• To be discussed at the Nursing and Midwifery Advisory Committee 24th August 2016. **August update – Complete** • On-going monitoring in place; will be highlighted if feedback suggests non-compliance. • Night inspection undertaken on 5th September to check single sex compliance in place.	Deputy Director of Nursing
AMU audit of current processes and environment - Action plan following audit	**Complete** • No further action required. • To ensure that practice is maintained and evidenced through weekly Matron checks. • POD lockers delivered in mid-October.		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
Review current documentation audit	**Complete**	**August update – action complete**	Head of Nursing

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
tool to determine appropriateness for the Acute Medical Unit	• Current documentation tool does not give level of assurance required. • New documentation audit designed by Matron/ Practice Educator. **August update:** • The audit has been completed and reviewed. Areas of concerns have been noted with actions in place to provide education and training. The audit will be re-completed in 3-6 months.	• Audit review and associated actions.	Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Increase the use of VitalPac for the recording of risk assessments in AMU (audit)	**Complete** • Audits commenced on time; led by Band 6 nursing team. **August update:** • The audit has been completed and reviewed. Areas of concerns have been noted with actions in place to provide education and training. The audit will be re-completed in 4-6 months.	• Weekly reporting of compliance to the Director of Nursing. **August update – action complete** • Audit review and associated actions.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Improved completion and quality of nursing assessment documentation, to include Falls and Braden risk assessments, and appropriate individualised care planning in AMU (audit)	**Complete** • Audits commenced on time; led by Band 6 nursing team.	• On-going audit programme. **August update – action complete** • Audit results demonstrate areas of key areas for improvement. Action plan in place to address; including staff education. • Re-audit 4-6 months.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Focussed education from Infection Prevention Control team concentrating on 'Back to Basics'	**CQC highlighted practice was not sustained. Further actions will inform the new CQC action plan.** • Initial education undertaken; further education required. • In-depth Infection Control plan for AMU. **August update:** • Weekly infection prevention performance is sent to the Director of Nursing.	• Week commencing 28th August over 75% of all nursing staff have had a refresh of infection control training. **August update – action complete** • Weekly infection prevention performance is sent to the Director of Nursing.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Weekly internal hand hygiene audits to commence 18th July 2016	**Complete** • Weekly internal hand hygiene audits have commenced. **August update:**	• Feedback to wards with increased evidence of compliance. **August update – action complete** • Weekly infection prevention	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	• Weekly infection prevention performance is sent to the Director of Nursing.	performance is sent to the Director of Nursing.	Older People, Rehabilitation and Stroke
Monthly peer review audits (hand hygiene, environmental and NPSA)	**Complete** • Monthly peer review audits continue. **August update:** • Weekly infection prevention performance is sent to the Director of Nursing.	• Monthly peer review. • Weekly infection prevention performance is sent to the Director of Nursing.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Re-launch Health Records Management Policy	**Complete** • Partially complete – links to staff briefing at team brief about importance of record management and confidentiality. **August update:** • Trust-wide e-mail to be sent to remind staff of the importance of safe handling and storage of patient records; to include a link to the Trust policy.	• All staff e-mail sent 23rd September.	General Manager and Head of Professions Clinical Support Services
Staff briefing in Team Brief	**Complete** • Outcome of April Quality Care Review relating to the identification of poor care of patient records in the May and July 2016 Team Briefs. Team Brief also included a verbal discussion regarding patient records and the duty to maintain patient confidentiality.	• May and July 2016 Team Brief.	General Manager and Head of Professions Clinical Support Services
Quality Care Review focussed on records management	**Complete**	• Records management now include in reviews. Evidenced through reports from the reviews.	General Manager and Head of Professions Clinical Support Services
Front line peer review focussed on records management	**Complete** • Frontline peer review undertaken on Friday 10th June 2016. Results indicate a mixed picture of compliance with some areas demonstrating good compliance, whilst other areas medical notes found accessible whilst in use and not put back in trolleys. Feedback has been provided to clinical areas.	• This will be an on-going theme of front line peer and quality care reviews.	General Manager and Head of Professions Clinical Support Services

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	August update: • New Standard Operating Procedure for Duty Matrons has been developed; due to be operational by the end of September, this will support the current processes regarding safe storage of records.		
Development of a Duty Matron checklist to include records management	**Complete** • The Deputy Director of Nursing to discuss with the General Manager and Head of Professions Clinical Support Services the possibility of amending the Duty Matron SoP to include records management, single sex etc rather than a specific checklist to be completed each day; to include the requirement to escalate any concerns immediately. Information from the shift is already contained in a three times a day report. **August update:** • Form and function of Site Operations Team commenced with the appointment of a dedicated General Manager for Site Ops; recommendations due at the end of September 2016. • Implementation plan developed. **September update:** • Checklist revised and agreed by Heads of Nursing.	• Mixed Sex Accommodation compliance reporting included. • Duty Matron checklist.	General Manager and Head of Professions Clinical Support Services
Sub-committee of the Board to review progress against the implementation of the Urgent Care Transformation Programme	**Complete** • Agreement made at Trust Board workshop 28th July 2016. The Director of corporate affairs is supporting development of the Terms of Reference and scheduling.	• Terms of Reference available for Chief Executive Officer weekly meeting. • Board Terms of Reference awaiting ratification. • Board Terms of Reference ratified	Executive Director Emergency Care
Review Terms of Reference of the Urgent Care Transformation Board	**Complete** • Confirmed at Urgent Care Transformation Programme (UCTP) Board on 28th July 2016. Terms of Reference and reporting structures currently being reviewed by the Executive Director Emergency Care • New governance arrangement in place from w/c 25th July 2016 an Urgent Care Transformation Programme (UCTIP) Meeting and UTCP Board. New terms of reference to be drawn up following the review of each	• UCTP Board Terms of Reference (previously UCIP Delivery Group) ratified. • UCTP Governance Structure updated within UCTP PID and workbooks.	Executive Director Emergency Care

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	group.		
August 2016			
All staff have access to and an understanding of the incident reporting system to promote reporting of incidents.	**Complete** • Roll-out of upgraded DATIX Web reporting system has been completed. • All staff have a log-in to report any Patient Safety Learning Event. • Since the introduction of the upgrade with a simplified reporting form a 45% increase in reporting has been sustained to date.	• Monthly Integrated Performance Report to Trust Board.	Acting Head of Risk Management
Priorities identified and appropriate actions taken from themes arising from the quarterly Staff Friends and Family Test (FFT)	**Complete** • The CSCs have developed local actions to take forward feedback from FFT. • FFT performance is discussed with the Chief of Service at monthly Performance reviews.	• Minutes of staff meetings. • Survey results. • 'A day in the life' results are presented in the monthly UCTP programme report. • Clinical Support: action complete.	Chief of Service for each CSC supported by Head of Organisational Development
Clear intervention in place to reduce overall staff sickness rate and support staff health and well-being	**Complete** • Resilience training being provided. • Dedicated HR support available for managers to effectively and appropriate manage absence cases. • Delivery of the Health and Wellbeing CQUIN plan on-going. • Discussion at monthly Performance Reviews.	• Training taken place. • Resilience and well-being training being provided across the pathway with good update. • Health and Wellbeing 'Staff story' presentation to October Trust Board.	Chief of Service for each CSC supported by the Head of Organisational Development
The Urgent Care Transformation Workstreams will deliver earlier assessment. On completion, business cases will be developed to support improved process and staffing establishment to reflect increased demand	• Draft business case is 90% complete: final options appraisal will be completed w/c 1st August 2016 following nursing workforce requirements being identified: initial submission to finance for sense check following this and for discussion at next CEO UCIP meeting 5th August. **August update:** • ED business case requires updating after input from the Executive Director, Emergency Care. Looking to focus on a consultant delivered service with less reliance on middle grades. **September update:**		CSC Senior Management Team as required

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	• Business Case submission delayed as case required additional detail. Due for submission to the next BCRG on 4th November 2016.		
Improve incident reporting within the ED and AMU	**Complete** • ED - Improved and use of professional standards mailbox is identifying other factors impacting on ED. **August update:** • AMU - Work underway to improve Datix reporting.	• Incident trigger lists implemented. • On-going action to increase reporting. • Reported and monitored as part of CQC metrics.	ED and AMU CSC Management Teams
Review outcomes of the use of VitalPac for the recording of risk assessments in AMU audit (audits commenced July)	**Complete** • The audit has been completed and reviewed. Areas of concerns have been noted with actions in place to provide education and training. The audit will be re-completed in 4-6 months.	• Audit review and associated actions.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Review outcome of audit into the completion and quality of nursing assessment documentation, to include Falls and Braden risk assessments, and appropriate individualised care planning in AMU	**Complete** • Audit completed.	• Audit results demonstrate areas of key areas for improvement. Action plan in place to address; including staff education. • Re-audit 4-6 months.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Focussed education of staff as part of audit programme in AMU	**Complete** • Audit completed.	• Audit results demonstrate areas of key areas for improvement. Action plan in place to address; including staff education. • Re-audit 4-6 months.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
September 2016			
All staff appraisals will be up to date and provide clarity of roles and responsibilities with underpinning objectives to enable the effective delivery of the emergency care pathway.	**Complete** • Performance monitored and discussed at the monthly performance reviews.	• Audit undertaken in October by Organisation Development Team. • Increasing appraisal compliance. • Managers trained. •	Chief of Service for each CSC
Stop using HALO as additional capacity with patients queuing in the corridor	• Corridor still being used on occasion but less frequently and flow is better: risk as winter approaches of this being utilised again as flow is still late in day and escalation is not early enough for ED		Deputy COO

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	to be decompressed quickly. **August update:** • HALO and corridor continue to be used on a regular basis. Although patients are being held in ambulances this is infrequent and the 15 minute assessment has been maintained. This is an increased risk from 26th September as PITSTOP work starts. **September update:** • HALO and corridor continue to be used if required to release ambulances, although the 15 minute assessment has been maintained.		
AMU rolling audit programme to ensure safe storage of medicines	**CQC highlighted practice was not sustained. Further actions will inform the new CQC action plan.**		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
Implementation of an Integrated Discharge Services and Discharge to Assess (Pathways 1, 2 and 3) jointly with external health and social care partners	**Complete- on-going service delivery monitoring via external A&E Delivery Board**	• IDS Standard Operating Procedure ratified by all Health and Social Care Partners. • IDS/Decision to Admit Pathway 1,2 and 3 Standard Operating Procedures ratified by all Health and Social Care Partners. • IDS launched on 26th September.	Deputy COO
Revision of the Board Assurance Framework	**September update** • The Board Assurance Framework is currently being update by those Executives who are responsible for the different Organisational Priorities. The Framework will be on the agenda for the Trust Board meeting on 3rd November.	• Agreed Board Assurance Framework.	Director of Corporate Affairs
October 2016			
Provide team leaders with the skills to lead change and deliver service improvements.	**Complete** • Leading change and Service Improvement workshops facilitated by NHS Elect. held in September and October with clinical and operational representation	• 22 team leaders attended the workshops. • Developing skills to lead change through adopting service improvement	Head of Organisational Development

Part B: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	from across all CSCs. These workshops will in future be led by the PHT OD and UCTP Teams supported by ECIP with direction from NHS I. • Discussions with Board are taking place regarding organisational approach to service improvement and adopting best practice. • Service Improvement 'link role' will be established in early 2017 to support staff led service improvement	techniques is now a part of the Trust staff development package. • 2016 National Staff Survey results will provide evidence of any improvements in how staff report on their ability to implement change	Urgent Care Transformation Programme Manager
November 2016			
Trust Escalation Policy to be reviewed post implementation in November 2016 in line with SRG agreement			Deputy COO
December 2016			
January 2017			
February 2017			
March 2017			
Delivery of the Urgent Care Improvement Plan and the eight associated workstreams to deadlines.			Executive Director Emergency Care
Delivery of the Urgent Care Improvement Plan workstream 'Ward discharges including Patient Flow Bundle – SAFER'			Medical Director and Director of Nursing

CQC Monthly Monitoring - Queen Alexandra Hospital

Main Dashboard

Reporting Period: Month of November 2016

No.	Metric	Week1 31/10/2016	Week 2 07/11/2016	Week 3 14/11/2016	Week 4 21/11/2016	Week 5 N/A	Monthly Total/ Average	Monthly Minimum - Maximum
0	Type 1 (QAH A&E) Departures	2129	2076	2203	2262		8670	2076 - 2262
1a	% ambulance arrivals assessed within 15 mins	88%	83%	79%	91%		85%	79% - 91%
2a	% of ambulance patients treated within 60 mins	53%	51%	43%	48%		48%	43% - 53%
3	% of patients (Type 1) meeting the national emergency access 4 hour target	72%	69%	68%	68%		69%	68% - 72%
5	Number of 12 hour trolley breaches based on a decision to admit within four hours of admission	0	0	0	0		0	0 - 0
6a	Number of ambulance delays 30-60 mins (validated data)	85	83	111	83		362	83 - 111
6b	Number of ambulance delays >60 mins (validated data)	26	50	79	57		212	26 - 79

12a	Number of patient bed moves for non-clinical reasons. Patient moving >2 times	0	0	0	0		0	0	0
14d	Number of patients delayed discharged who are medically fit. Delays within 1-2 days	344	266	360	336		1306	266	360
14f	Number of patients delayed discharged who are medically fit. Delays within 3-7 days	448	342	467	459		1716	342	467
14h	Number of patients delayed discharged who are medically fit. Delays within >7 days	877	608	807	801		3093	608	877




Appendix Four

Transforming Care Partnership
Delivery of a Community Forensic Learning Disabilities Service

1. Purpose

1.1 The Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Transforming Care Partnership (TCP) made a commitment to reduce reliance on specialised in-patient care for people with Learning Disabilities and/or Autism with behaviour that challenges.

1.2 As part of implementing this plan the Health and Adult Social Care Select Committee (HASC) are asked to approve the closure of the Cypress Ward and the reinvestment in a Community Rehabilitation Service. The service is for People with Learning disabilities (PWLD) who have been in specialist beds within the criminal justice system or at risk of admission to a specialist inpatient service. This service is otherwise known as a 'Forensic Learning Disability Care pathway'.

2. Transforming Care Partnership Commitments

National Context

2.1 The SHIP TCP plan is strategically aligned with the national drive (Building the Right Support, October 2015) for Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England Specialist Commissioning to work collaboratively to develop better local community services as an alternative to hospital care. The national directive is

- To close by March 2019 unnecessary in-patient beds and discharge these people to better alternatives in the community. The SHIP TCP target is an overall reduction of 10 specialist inpatient learning disability beds between 2016 – 2019, to meet the national target.

2.3 The learning disabilities agenda has been influenced by the Winterbourne View Joint Improvement programme aimed at avoiding the mistreatment of PWLD in hospital, who are a long way from home. This has led to a reduced reliance on institutional care to support PWLD/autism through the closure of asylums, campuses and long stay hospitals. For a minority of people however, there is still an over reliance on in-patient treatment for people who could, given the right support, be at home and close to their loved ones (NHS England, 2015).

2.4 The SHIP TCP places a responsibility on health and social care systems to ensure that people with a learning disability and/or autism can access specialist health and social care support in the community. In addition, when necessary, people should be able to get support to stay out of trouble – with reasonable adjustments made to universal

services aimed at reducing or preventing anti-social or 'offending' behaviour through liaison and diversion schemes in the criminal justice system, including a community

forensic health and care function to support people who may pose a risk to others in the community (NHS England, 2015).

2.5 Building the Right Support (NHH England, 2015) requires local systems to redesign care pathways for people with Learning Disabilities and/or Autism and behaviour that challenges to ensure community based services have the right resources in place to enable successful outcomes, including the need to break the cycle involving high rates of secure unit admissions and readmissions.

SHIP Context

2.6 The SHIP TCP is a collaborative consisting of the following stakeholders; one county council, three unitary authorities, 11 District and Borough Councils, eight Clinical Commissioning Groups, 235 GP practices and one NHS England Team.

2.7 GP practice registers report ~8,453 PWLD; where ~5219 are known to services; ~23 utilise non-specialist in-patient beds; ~41 utilise specialist in-patient beds.

2.8 A local consultation involving Hampshire people highlighted the future health priorities were children, young people and adults with a learning disability and / or autism and behaviour that challenges.

2.9 Similarly to the national picture, some PWLD hospital length of stay can be for many years when they could have been living a normal life within their communities as service users shared:

- They wanted to live in areas where '*they have things to do around them'*
- *'Be closer to home to see family even with good transport links'*
- *'To live in a town with facilities close by such as shops, GP, dentist, a pub'*
- *'Good footpath and cycle path'*

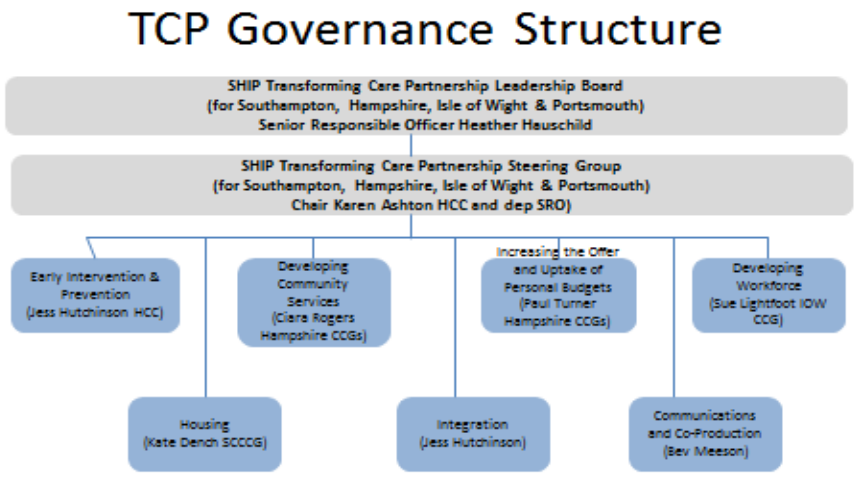
2.11 The implementation process started in March 2016 and considerable progress has been made. Overall activities have centred on:

- Gathering the views of service users through workshops
- Multi-agency, multi- professional service review and planning groups
- All ideas and plans are being tested through local partnership boards, clinical networks, health and well-being boards and patient-led advocacy local Implementation groups (LIGs)

2.12 The TCP governance structure has been established shown in Figure 2 below where a programme board that includes all key stakeholders along with PWLD advocacy representation, where service user and their families are involved in communication and

engagement co- planning focus groups. There is overall monitoring of progress across all work streams by the Leadership Board, undergoing change management, mainly in the

areas of housing, community services and workforce. The programme reporting is scheduled through monthly, quarterly and annual progress reports



2.13 The development of a community forensic LD service is a key element of the SHIP TCP plan.

3. Reason for service change proposed: Cypress Ward Closure at Woodhaven Hospital

3.1 Cypress Ward at Woodhaven hospital is a low secure six bedded inpatient rehabilitation facility. The Hampshire 5 CCGs commissioned 3 beds.

3.2 The client cohort description for Cypress Ward is:

- Satisfied the criteria for intellectual disability
- Have committed an offence or show a pattern of behaviour which has not resulted in a conviction, but ordinarily be regarded as offending behaviour
- Could be previously known to Community Learning Disabilities teams due to challenging behaviours that offers the opportunity for integrated working to support subsequent discharge from the low secure unit.
- Clients may have court restrictions in place

3.3 The original aim of the inpatient service within Cypress Ward was to promote patients' independence and support people to learn or develop their life skills to prepare them to live independently in the community. However, Cypress Ward proved '*not fit for purpose'* for the following reasons:

- It is based in a remote location with a minimal bus route that limited service user options to access the community.
- The '*ward'* environment was not conducive with the development of independent life skills and undermined their motivation to achieve personal life goals.

3.4 Southampton City CCG (SCCCG) disinvested from Cypress Ward with effect from 1 October 2016 and reinvested the funding in developing a community learning disability forensic team. This resulted in the service being financially unsustainable for Southern Health NHS Foundation Trust (SHFT). SHFT approached Hampshire CCGs to discuss disinvestment in the inpatient rehabilitation unit and the development of a Community Learning Disability Forensic Team.

3.5 The Hampshire 5 CCGs have served notice on Cypress and the service will close on 31 March 2017. This will release £615k for Hampshire CCGs to reinvest in developing the community learning disability forensic pathway as committed to in the SHIP Transforming Care plan.

Service User Involvement

3.6 There has been considerable engagement with service users and their families in the development of the TCP plan. The redesign of the Forensic Community Learning Disability Team has been an integral part of those discussions. SHFT has been working closely with commissioners as they develop the new Forensic LD Community service model.

3.7 SHFT has started a full programme of engagement with LD staff, both at Cypress Ward and the wider community LD Teams of Southern Health staff. This is to ensure the wide ranging skill sets of SHFT teams are retained. SHFT will also ensure the HASC is kept updated on developments, along with other local stakeholders such as Healthwatch, local MPs and patient interest groups.

Description of population affected:

3.8 The service will be accessible by individuals with a diagnosable learning or intellectual disability who have committed an offence or show a pattern of behaviour which, although not resulting in a conviction would ordinarily be regarded as offending behaviour. This population group are known to be on a 'forensic learning disability care pathway'.

3.9 There are currently 10 people with a learning disability in forensic low and medium secure services (specialist beds) that will be the responsibility of Hampshire CCGs on discharge. It is anticipated that some of these people will require '*step down bed'* rehabilitation before moving on to longer term supported accommodation. All of these people will be eligible for aftercare funding under S117 or the Mental Health Act.

3.10 Services users who continue to require treatment in a secure setting under court order or because of their mental health needs will remain in a secure setting. The community rehabilitation service will only be for those people who have been assessed as no longer requiring a secure setting.

4. Forensic Learning Disability Community Rehabilitation - The New Model of Care

4.1 The disinvestment from the inpatient model in Cypress Ward releases £615K to commission a community rehabilitation service that is person centred and designed for PWLD who no longer require hospital care or to prevent a referral to a secure unit. All of the £615k will be reinvested in services for people with learning disabilities. The key service components where impact assessments are planned to be completed include:

- A forensic community learning disability team (FCLDT) that will provide support in the community and encourage collaborative team working with other health and social providers shown in Figure 3 below.
- NHSE capital grant (£935K) to fund Registered Social Landlord (RSL) supported accommodation – 5 flats across two locations across SHIP. Procurement for an RSL has started. The locations of the flats will not be determined until the RSL has been procured and they then work with the TCP board to identify suitable properties and locations. The Step up/ down service will provide long term (12 -18 months) intensive rehabilitation units with 24-hour staffed support from a supported living provider across Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP 8 CCGs)

4.2 Once the properties have been purchased a supported living provider will then be procured through the CCG Learning Disability Framework to provide 24 hour support in the RSL properties based on the PWLD individual needs. Those needs cover (to name a few):

- Behaviour support plan
- Breathing (respiratory care)
- Choking prevention and response
- Cognitive behaviour plan
- Medication
- Mobility
- Nutrition – food and drink
- Pain management / Physiotherapy




- Communication skills development
- Elimination/continence management
- End of Life care
- Social care plan
- Skin / tissue viability
- Washing / Dressing

Market engagement is planned from January 2017 with local providers who are specialist in learning disability forensic support. The number of people to support will be small but the packages of care will be intense. Having clinical support from a Specialist Forensic

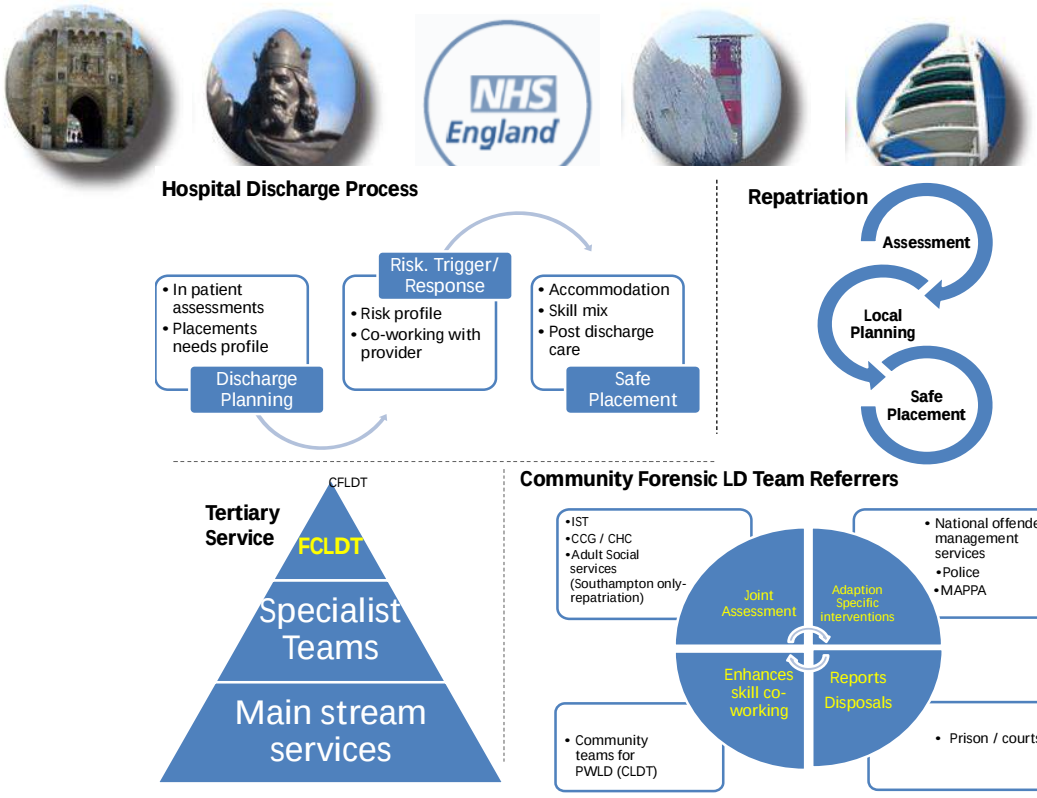
Community Learning Disability Team makes the service more sustainable and attractive to the provider market.

4.3 A specialist Forensic Community Learning Disability Team (FCLDT) will be in place from 01 April 2017 to

- Work with partners (e.g. police, probation, MAPPA, mental health services) to address needs of offenders with specific needs
- Develop skills through advice, co-working and supervision of mainstream services (e.g. Community Learning Disabilities Teams (CLDT) social services, domiciliary care provider)
- Support the development of Health and Social care supported living service to carry out the following service deliverables:
  - Client risk assessment/ management
  - Client/ families targeted therapeutic intervention through one to one and group approaches covering positive behaviour support, periodic service review, sex offender programmes, anger management, fire setting
  - Collaborative working
  - Staff skills development (across community based Health and Social care)
  - Support for closure of Cypress ward (client care transition to alternative accommodation)
  - Support in the repatriation of patients in 'out of area' placements to reduce number of PWLD in out of area placements. This will be a focus in year 2 of the service. Year 1 will focus on safe discharges and community support for people ready to move on from a secure setting.

- The FCLDT will be integrative multi agency, multi professional membership from psychiatry, psychology, CBT therapist, Social worker, Speech and Language therapist, occupational therapy, Nursing, administration and the CLDT Intensive Support Team (IST).

- Figure 4 describes the FCLDT processes for Cypress Ward discharge, and repatriation, the services key referrers and tertiary position across the community care landscape of providers.



5. New model of Care Benefit Realisation

5.1 The new model of care represents a risk avoidance strategy for the client cohort for the wider LD community in the following way:

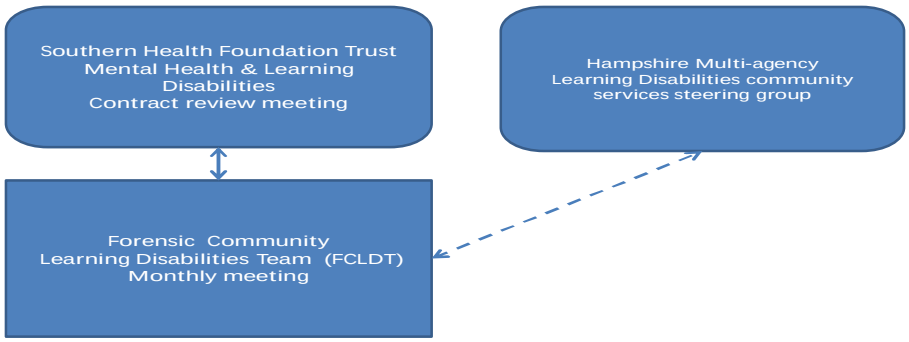
- Ensure robust holistic assessments are undertaken which achieve the right outcome and provide the necessary '*My Shared pathway' outcome focused* rehabilitation package and support in the community
- Offer the opportunity for PWLD to take part in meaningful and therapeutic activities, to reach their recovery goals including employment and appropriate housing
- Improve rehabilitation outcomes and reduce costs of long term packages of care
- Reduce delays in discharge from secure units and encourage early supported discharge
- Reduce admissions and re-admissions to secure units
- Reduce health inequalities
- Promote collaboration and integrative processes between RSL, Community Forensic LD teams, domiciliary care teams and criminal justice system (e.g. MAPPA, NOM, Police, probation services)
- The RSL procurement will deliver economies of scale as the flats would be grouped together in two locations where clients will have their own tenancy, own front door with better opportunities with support to integrate safely into the community without the '*institutionalised'* stigma
- The collective delivery of several national agendas to name a couple of key publications the NHS Transformation plans under SHIP TCP; '*Building the right support'* paper (NHSE, 2015) for learning disabilities; and the Joint Commissioning Panel for mental health guidance for forensic mental health services (2013).

6. Delivering the New model of care

6.1 The draft overall implementation plan is shown in Figure 5 below:

- April 2017: Cypress ward closes and FCLDT commences
- October 2017: RSL procurement completed, Supported Living Provider recruitment begins
- April 2018: Full service mobilised

6.2 The governance of the FCLDT implementation plan is shown in Figure 6 below:



6.3 The Hampshire Community LD Service steering group has membership of both clinical and non-clinical senior management representation from all providers and Hampshire 5 CCGs. It is a point of escalation for collaborative discussion of any system wide service risks and issues. The Contract Review Meeting (CRM) function will be performed by members of the Hampshire 5 CCG Vulnerable Adults Team, through a regular monthly meeting.

6.4 A memorandum of understanding that covers December 2016 to March 2018 activity for the new FCLDT (Dr Kevin O'Shea, Clinical Director, and Nicki Brown Associate Director Specialised Services (Mental Health) has been agreed with the Hampshire 5 CCGs (Beverley Meeson, Deputy Director of Service Development; Ciara Rogers, Head of Vulnerable Adults for the 5 Hampshire CCG's). The CRM process for the first year, will include baseline monitoring through a performance dashboard (that will be consistent as far as possible with the Southampton dataset for comparative analysis); with a subsequent Service Development Improvement Plan (SDIP) jointly agreed by the end of the year.

7. Risks

7.1 When Cypress ward closes on 1 April 2017 and the step / step down flats are not yet in place there may be an increase in spot purchase of inpatient rehabilitation services in

independent providers. However, funding will be available from disinvestment in Cypress to cover costs and there are independent providers in the area.

7.2 If NHSE do not allocate the £935K capital funding in 2017/18 the CCGs will need to find alternative ways to deliver community based rehabilitation using the funding released from the Cypress disinvestment. A contingency plan to work with existing supported living providers is being worked up with partners.

7.3 SHFT may not mobilise the Forensic Community LD Team as quickly as agreed with commissioners. This risk is mitigated by having regular mobilisation meetings and ensuring a high quality service specification and key performance indicators are in place.

8. Recommendations:

8.1 The HASC is asked to note:

- The closure of Cypress Ward and the re-investment of £615K in community Learning disability services
- The new model of care approach that replaces the Cypress Ward with an integrative working provision including:
  - the Forensic Community Learning Disability Team (FCLDT)
  - the NHSE capital investment of £935K for the procurement of Registered Social Landlord (RSL) supported accommodation for PWLD on the Forensic pathway
  - a 24 hours/ 7 days a week supported living provider for the RSL supported accommodation scheme

8.3 HASC is asked to advise:

- the Hampshire 5 CCGs board on how HASC would like to receive SHIP TCP overall work streams updates, for example -monthly, quarterly or annual reporting.