Kathryn Rowles - Director of Public Health

From: Kathryn Rowles - Director of Public Health
Sent: 12 September 2002 14:39
To: Ian Piper - Chief Executive F&G; Tony Horne - Chief Executive EHPCT; Fiona Cameron - Operational Director; Ian Reid; 'Watling Jeff (RHU) Portsmouth Hospitals'; 'Stubbs Neil (RN4) Portsmouth Healthcare'; 'Humphrey Lesley (RHU) Portsmouth Hospitals'; Paula Turvey - Operational Director; Sue Damarell-Kewell - Head of Service Quality; 'Goodall Judith (RN4) Portsmouth Healthcare'; 'Peach Janet (RN4) Portsmouth Healthcare'
Cc: 'Tanner Simon (Q17) HIOWHA'; 'Julie Miller'
Subject: Draft CHI Action Plan

Importance: High

Dear all
We attach, a little later than intended, a further draft version of the CHI Action Plan following our meeting the other week.
We have also produced a front page introduction, which sets the context for the Plan and the arrangements for monitoring and implementation.

Please can you **scrutinise** the Action Plan carefully for each recommendation and identify any amendments/additions required. We are very mindful that there are still a number of gaps evident in the Plan, particularly under the outcome, monitoring and reference headings of the framework. This needs the detailed local knowledge that you'll have.
We have agreed with Julie Miller from CHI that we will submit the final version of the Action Plan at the end of this month.
To enable us to make the final amendments, please respond ***by Thursday 23rd September at the very latest*** (you can enter on the Plan in italics any changes/additions needed).


Action plan intro.doc


Draft CHI ActionPlan.doc

Also please note that the first meeting of the CHI Action Plan Implementation Group will be Friday 8th November 2.30 - 4pm at Fareham Reach.
Thanks

Kathryn Rowles and Noreen Kickham
Director of Public Health
Telephone - Code A

ACTION PLAN IN RESPONSE TO THE REPORT OF THE INVESTIGATION INTO PORTSMOUTH HEALTHCARE NHS TRUST AT GOSPORT WAR MEMORIAL HOSPITAL JULY 2002

Background

The Action Plan attached details Fareham and Gosport and East Hampshire Primary Care Trusts (PCTs) response to the 22 recommendations contained in the investigation report produced by the Commission for Health Improvement (CHI). The report is structured in line with the template prescribed by CHI.

The process adopted to create the action plan adhered to the guidance produced by CHI to assist organisations to develop a robust and comprehensive response to recommendations. A one-day workshop was held on the 1st August 2002 involving 45 staff from across the two PCTs, but also included colleagues from Social Services and the voluntary sector. The relatives of patients involved in this investigation were made aware of the workshop process by the Chair and Chief Executive of Fareham and Gosport PCT. The workshop provided the opportunity to action plan against each of the recommendations. Subsequent refinement of the actions identified has resulted in the Plan outlined below.

Scope of Action Plan

The Plan details the action required by Fareham & Gosport PCT, as well as those actions requiring a joint response with East Hampshire PCT, to address the recommendations outlined by CHI.

For each of the actions identified a timescale for implementation has been stated. It is implicit that there is a commitment in each PCT to achieving the implementation of these actions within the timescales agreed.

Monitoring arrangements

It has been agreed that a pan PCT (Fareham & Gosport and East Hampshire) Implementation Group will be responsible for overseeing and reviewing implementation of the Action Plan. The Group will comprise the accountable officers identified in the Action Plan and the Medical Director/Director of Public Health of the Hampshire and Isle of Wight Strategic Health Authority.

The purpose of the Implementation Group is to ensure that:

- the Action Plan is implemented to the agreed timescale
- a system is in place to audit delivery
- appropriate remedial action is taken where necessary.

The Group will be accountable to the Boards of Fareham and Gosport and East Hampshire PCTs and regular progress reports will be submitted. The Implementation Group will also report to the Strategic Health Authority (via the Medical Director/Public Health Director).

East Hampshire NHS
Primary Care Trust

Draft 1 CHI Action Plan

Recommendation	Objective	**Action required & timescales**	**Constraints &/or impact of not taking the action**	**Accountability**	**Intended outcome**	**Monitoring**	**Reference**
1. Build on leadership of PHCT to develop provision of care for older people at GWM. Appropriate monitoring tool to ensure shortfalls in quality of care and performance are addressed swiftly	Develop clear vision and leadership for the care of older people. Develop effective performance management mechanisms to ensure high quality care and services	• Appointment of Operational Director for Secondary Care **-in post** • Develop a Service level agreement for Older Peoples Services by jointly agreed key performance criteria– **by Dec 2002**	Lack of direction for the service managed across 2 PCTs Lack of formal agreement and monitoring processes for PCTs to evaluate	Chief Executive Operational Director		Divisional Review Bi-annual hosted service review Board Performance Reports	

3. Joint review of all local prescribing guidelines - appropriateness for current dependency levels	To ensure prescribing guidelines are appropriate for current dependency levels	• Establish Medicines Management Guidelines Group to oversee review and guidelines development process – to include consultant and GP representation **by Nov 2002** • Carry out 6 guidelines reviews based on agreed local priorities **by March 2003** • Ensure training requirements are linked to PCT training programmes following the development of new guidelines – **date?** • Develop a Guidelines Communication/ Dissemination Plan to ensure easy access and understanding by all key staff **by March 2003** • Identify IT opportunities as part of the prescribing guidelines review to enhance access **–date?**	Workforce capacity issues to support implementation of guidelines – dependent on approval of business case for expanded service Capacity to deliver course Adequacy of IT capacity	Pharmacy Service Manager (Portsmouth Hospitals NHS Trust) **Pharmacy Service Manager & HR leads** **Medicines Management Guideline Group** **ICT Service**	System in place to ensure the ongoing review of local prescribing guidelines for older people in community settings Comprehensive training programme Increased staff awareness and application of new prescribing guidelines Electronic guidelines dissemination included in ICT implementation strategy	Group established with clearly defined terms of reference 3 monthly reports submitted to the Area Prescribing Committee Training courses attended Course feedback IPR Staff survey	

6. All relevant staff including GPs are trained in the prescription, administration, review and recording of medicines for older people	To improve legibility of prescription sheets in patients notes	• Ensure "legibility" is addressed as a key issue in discussions between medical staff/GPs **- ongoing** • Ensure use of risk event forms to highlight problem of legibility – **date?** • Review planned implementation of electronic prescribing and patient notes and feedback to ICT strategy group **–date?** • Establish short life group to review make recommendations for action regarding training and development **group established by Sept 2002, plan developed by March 2003** • Ensure training requirements are incorporated into PCT training delivery plans **- date**		Pharmacy Service Manager (PHT)	Legible prescribing notes Improved delivery of care through reduced risk for patients All appropriate staff trained to prescribe, administer, review and record appropriately and adequately	Audit of quality of Prescribing notes Action plan developed for all risk events recorded Report produced and submitted to ICT Strategy group Training and development plans Number of staff trained by professional group Biannual Course programme	

7. All complaints should be used to improve care. Mechanisms should be put in place to ensure shared learning is disseminated amongst all staff caring for older people	To ensure effective mechanisms are in place to monitor and share learning from complaints	• Action and learning points from complaints to be included in PCT Quality Newsletter SEQUAL (Trust wide) **–from Oct 2002** • All complaints and lessons learned to be fed through Service Clinical Governance Groups **- in place** • Representatives from Service Clinical Governance Groups are responsible to share lessons at team meetings **date?**	Time /capacity	PCT Quality Leads	Staff have a clear understanding of quality issues from patient feedback and how they are acted upon Clear and open 2 –way communicatio n processes for sharing complaints issues and action	Newsletter contents Complaints Action plans and reviews Minutes of clinical governance meetings and appropriate team meetings	Quality Strategy Annual Service Plans Business Plan
11. Continue staff communication developments made by PHCT	To ensure that staff are kept informed of national and local issues and feel involved with PCT business	• Implement PCT Communications Plan **from Sept 2002** • Support Communications Champions already identified in role development **–1st meeting Sept 2002** • **Finalise internal communications improvements –newsletter (PCT) (SEQUAL bi-monthly attachment) –information exchange/briefings – fast news service/ electronic media** -joint PCT staff/patient newsletter **- by Dec 2002**		PCT Communication s Leads/ Comms Media shared service	All staff are kept up to date about NHS and PCT Issues, Accessible Communicatio ns Champions in all services Staff and patient/ public access to information in a range of mediums	Board Reports Staff opinion surveys Feedback from Communicati ons Cahmpions	Patient & Public Involvement Strategy HR Strategy
13?							

14. Ensure appropriate patients are being admitted to GWM with appropriate levels of support	To review and improve the appropriateness of admissions to GWM	• Undertake audit of patients admitted to Daedalus, Dryad and Sultan Wards to determine the appropriateness of admission against existing policies **Sultan Ward Sept 2002, Daedalus & Dryad Dec/Jan 2003** • Review exisitng policies/ guidelines and develop explicit admission criteria incorporating clear accountability for review **from Oct 2002**			Audit report produced that identifies current patterns of admission against policies and indicates rates of appropriate/ inappropriate admissions Clear and explicit admission criteria to ensure appropriate levels of clinical support to patients		

17. Ensure that learning and monitoring of action arising from complaints undertaken through divisional review is maintained	To ensure that there is a robust and effective mechanism for monitoring complaint throughout the PCT	• Continue Quarterly Divisional review process and bi-annual hosted services review –**in place** • Complaints trends and actions shared through Clinical Governance Committees and Quarterly Quality report – **in place** • Set up PCT Complaints Panel – **1st meeting in Oct 2002**		PCT Quality Leads PCT complaints Panel	Lessons are learnt and shared within and across the PCT and action plans are implemented.	Quarterly Quality Reports Board Performance Indicators Quarterly Divisional Reviews Clinical Governance Committee minutes Service Clinical Governance Group Minutes Complaints Panel Minutes	Quality Strategy Performance Management Plan Complaints Policy and Procedures

18. Staff at GWM should attend customer care and complaints training events. New training should be developed with patients, relatives and staff	To ensure staff have the knowledge and skills to provide high quality customer service and complaints support	• Identify all staff who have not received training **by Oct 2002** • Develop pack of procedures and guidance to support revised Complaints policy – **Oct 2002** • Run awareness roadshows and training for revised Complaints policy and procedures- **Nov/Dec 2002** • Develop comprehensive complaints training programme for staff that is linked to the PALS training programme – **March 2003** • Engage patients and relatives in designing new training – **from Jan 2003** • Identify staff requirements for bereavement training - **Oct 2002** • Review current training course in bereavement –**by Dec 2002** • Make improvements to bereavement training following consultation with patients, relatives and staff • Run courses - **from April 2003** • Review the "Living with Bereavement" booklet used at GWM –**date ?**	Capacity for ward cover and staff training	Operational Directors PCT Quality Leads Training and Development Manager	All staff provide care to patients and their families that is sensitive to their needs and the needs of those bereaved. Staff understand and provide clear information and support to patients/ relatives with concerns or complaints	Audit of current provision and uptake Complaints Policy and Support Pack Roadshow / awareness training attendance and feedback Programmes for Complaints and Bereavement training completed Divisional Reviews Board Reports	PALS strategy and training programme

19. PCTs must embrace the clinical governance developments made and direction set by PHCT	Implement the PCT Quality Strategy . Ensure robust mechanisms for monitoring action and review Develop an open and positive approach to improving the quality of care and services through training and development, learning from mistakes, the development of partnerships with patients and relatives.	• Implement Quality Strategy and annual action plans throughout the PCT. – **ongoing** • Audit current reporting mechanisms to test robustness –**by March 2003** • Develop and implement Quality Training programme – Risk management in place complaints, clinical governance and PPI developed by March 2003	Resources • Time • Staffing • finances	PCT Quality Lead Risk and Governance Manager	PCT culture of continuous improvement Clear action planning process Robust monitoring mechanisms and audit trail Training programme linked to strategy and individual/ service needs	Strategy Annual Action Plan PCT & Service Quarterly Quality Reports Quality Training programme Audit of training delivered Patient Feedback services Patients involved in service developments	PPI Strategy Business Plan Service Development Plans HR Strategy
20. All staff must be made aware that the completion of risk and incident reports is a requirement. Training to reinforce rigorous risk management must be put in place	To ensure that there is robust and effective risk management at all levels	• All staff trained in the completion of risk management forms and basic risk management & awareness – **ongoing** • Risk management training for junior doctors and new medical staff on induction - **ongoing from .....** • Agree process for cross organisational reporting and sharing lessons/ learning – **by .....**		Medical Director Head of Service Quality Risk & Governance Manager			

21. Clinical governance systems must be put in place to identify and monitor trends revealed by risk reports and ensure appropriate action is taken	Evaluate current risk identification and monitoring processes	• Develop an audit trail to identify any gaps in the current system – **by Dec 2002** • Implement recommendations as a result of audit – **by March 2003**	Certain staff groups under/ over reporting (linked to 20)	Quality Leads Risk and Governance Manager	Improved patient care and safety through effective risk reduction/ management	Risk Audits Quarterly Quality Reports Divisional Review Risk Management Committee Risk and Governance Leads Group	Quality Strategy Business Plan Service Plans
22. Revise the whistleblowing policy	Joint review of policy	• Work with Joint representative committee to review policy • Revise and approve **by March 2003**		PCT Heads of Human Resources	New Policy launched All staff aware	 Staff Opinion Survey	HR Strategy Poorly Performing Doctors Procedures