Agenda Item No 7

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC) & ONWARD TO THE GOVERNORS' COUNCIL

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
	Decision		High	Med	Low
Emma Hardwick Chief Nurse	Discussion	✓	✓		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
	Strategic		1	2	3
	Operational	✓	4	5	
	Governance	✓	**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	All				

Meeting Date: **26 September 2017 & 03 October 2017**

Report Title: **CQC Inspection Preparedness**

PURPOSE:

To provide an update to the Trust Board/Governors' Council on the preparation to date for the next Care Quality Commission (CQC) inspection.

SUMMARY:

The Trust is undertaking a programme of work, which will:

- Drive Quality Improvement in the Trust
- Assess the Trust's services against the CQC's Fundamental Standards of Care and Key Lines of Enquiry
- Identify and evidence standards' compliance and good practice
- Identify areas of non-compliance and make rigorous plans for improvement to the required standard
- Provide insight and assurance to the Board concerning the Trust's compliance with quality standards
- Prepare the Trust for its next CQC inspection

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
✓	✓	✓	✓	✓	✓

RECOMMENDATION/S:

The Board/Governors' Council is invited to note the Trust's CQC Inspection Preparedness plans and to endorse the direction of travel.

1. BACKGROUND

1.1 The last CQC inspection visit to the Queen Elizabeth Hospital Kings Lynn (QEHKL) took place in July 2015. At this time the trust moved from a rating of 'inadequate' to 'requires improvement' (**Appendix A**). During the last months the executive team have been working with the clinical divisional teams to evidence the Trust's progress in addressing the 'Must' and 'Should' do recommendations, made following the last inspection. This progress has been reported to the Board regularly.

1.2 The CQC inspection regime has changed and the organisation will be inspected under this revised format. This will include an unannounced onsite inspection, a review by NHS Improvement for the 'Management of Resources' and an announced on site visit for inspection against the criteria of the 'Well led' domain. Intelligence is informing us that there will continue to be a significant request for information in the lead up and after the data request and the onsite visits.

1.3 It is anticipated that our next inspection could occur from the end of Quarter 3 onwards, and while formal notification of the format has not been received, discussion with the lead inspector (**see Appendix B**) has outlined the new format and the likely expectation that it will involve a re-inspection of the core services rated as 'requires improvement' (**see Appendix A**) and will involve between 2 and 4 Core service areas.

1.4 It should be noted that there remains a possibility of the CQC returning at any time; they have access to local intelligence - information and performance reports, and issues raised by the Coroner and the media or public enquiry. A number of activities have now commenced to enable the Trust to prepare for a re-inspection. This is being overseen by the Quality Improvement Group.

1.5 A significant change is expected to the 'well-led' domain moving from 5 key lines of enquiry to 8 - linking together the CQC's current assessment methodology and Monitor's 'Well-led framework'.

WELL-LED By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.	
W1	Is there the leadership capacity and capability to deliver high-quality, sustainable care?
W2	Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?
W3	Is there a culture of high-quality, sustainable care?
W4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?
W5	Are there clear and effective processes for managing risks, issues and performance?
W6	Is appropriate and accurate information being effectively processed, challenged and acted on?
W7	Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?
W8	Are there robust systems and processes for learning, continuous improvement and innovation?

2. ORGANISATIONAL PREPARATION

2.1 The oversight and delivery of the programme of work to prepare for the inspection will be through the established Quality Improvement Group. For the duration of the preparation period, the meeting timetable and membership have been revised and aligned. An oversight team and inspection planning group is also in place with executive leadership from the Chief Nurse. It is recognised that this preparation takes considerable organisation and resources and where additional capacity requirements have been identified these have been secured.

2.2 In order to gain a better appreciation of how the new inspection regime works, a 'go see' visit to Ipswich Hospital NHS Trust has taken place, and a follow up sharing of experience and peer review will be taking place with IHT colleagues after the 'Well Led' on site visit takes place in October 2017.

2.3 The following details some of the initial actions that are in place but this is not exhaustive:

- 'Go see' exercises are being undertaken and are known to work well as these helps staff to understand what to expect and provide valuable connecting experiences for staff
- Core services and teams are undertaking self-assessments, which will be presented to the QIG to facilitate oversight of potential issues. These assessments are based on the CQC revised prompts with the overlay of the known CQC Key Lines of Enquiry for all core services
- At ward level initial assessments have been undertaken and local actions are in place and will feed into the core service due diligence
- Opportunities to be created for teams to reflect on key CQC questions, through initial programme launch and briefing on October 11th 2017 and subsequent workshops
- We have begun a review of all key meeting minutes and terms of reference as previous experience informs us that minutes submitted as evidence are not always of a good quality and sometimes indicate areas for improvement in respect of governance i.e.

    - need to have clear conclusions and actions re agenda items
    - ensure items aren't frequently deferred
    - ensure that meetings don't fail to reach the end of the agenda
    - that action logs are managed well and progressed in a timely way

- Risk registers are now more up to date; however, the risk narrative requires reviewing to ensure it is timely and describes 'current' mitigations and actions and also reflects compliance risks
- Staff need to be prepared to discuss areas of good practice and innovation, not just areas of concern
- There is a need for attention to detail and ownership of any data submission, the process for submission, the factual accuracy and the gatekeeping to 'sign-off- before submission externally
- It is likely that some core services won't be part of the inspection – these services will be asked to support those that are
- Complete mock inspections for all core services, prioritising those rated 'requires improvement'. This will be undertaken alongside the Ward Accreditation Programme that commences this month
- Confirm evidence regarding any historic concerns and horizon scan for current hot areas

- Undertake a table top exercise with 'Requires Improvement' core services - complement the information from the mock inspections by reviewing incidents, complaints, risk registers, compliance register, meeting minutes
- The core service lines will be divided between the Executive Directors with the assigned executive working through core service self-assessment response with the triumvirate management team
- Hold focus groups with teams – what are the current concerns?
- Generate a comprehensive list of good practice, innovations
- Share key information with staff, key messages and improvements since the last inspection – infographics style – easy-read Trust wide
- Undertake a self-assessment against the 'Well-Led' criteria, at Board level (last undertaken in February 2017)
- Early review of the environment – 'Dump the junk'; Refresh the Trust communication boards around the Trust
- Develop an 'I need to know file'
- Recognise service user involvement
- Need particular support for middle managers recognising the changes in the Divisional teams

3. NEXT STEPS

3.1 Appoint Programme Lead

3.2 Agree 'branding' for CQC preparedness programme – 'Quality Matters' is proposed

3.3 Plan Launch event – 11 October 2017. NEDs will be invited to this event and NED roles in the programme will be developed

3.4 Identify 'Quality Matters Champions' at all levels of the organisation

3.5 Timetable engagement internally and externally

3.6 Develop and implement Communications Plan

3.7 Plan Peer Review exercises

2015 – CQC Ratings

Our ratings for The Queen Elizabeth Hospital King's Lynn

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

Please note that as the critical care service was not inspected on this occasion there are no changes to previous ratings which were good across the service.

CQC – Guidance (call with Trust's Relationship Holder)

Differences since previous regime

- Split core services (Gynae and Maternity / Diagnostics and Outpatients) – more accurate inspections and clearer assessment
- New inspection methodology – 5 elements:
    1. Ongoing Monitoring (patient voice – but no listening events, engagement with stakeholders e.g. RCN/GMC
    2. Pre-inspection phase
    3. Inspection of core services
    4. Inspection of well-led
    5. Post inspection
- Monitoring:
    - Focus group for staff throughout the year
    - Meeting key individuals
    - Attending Board meetings
    - Minimum of 1 phone call per month
    - Face-to-face meetings quarterly
    - Pro-forma template for collection of key information
    - Bi-annual communications with Healthwatch, HOSC, Governors, voluntary and community groups
- Pre-Inspection:
    - PIR (Provider Information Request) less burdensome (due to improved continuous monitoring)
    - Regulatory Planning meeting:
        - Inspection Team identified
        - Inspection Plan agreed (local Team presents plan to be signed-off – focus on troublesome areas)
        - Date for well-led inspection agreed for after the core services inspection (well-led inspections are announced)
        - Analysts will contribute where issues have been identified
        - Trusts will have 3 weeks to complete the PIR
        - Analysts will transfer data to an 'evidence appendix', which will form part of the final report suite
- Inspection:
    - Up to 12 weeks to undertake the inspection
    - Risk and evidence – based
    - Regionally, the CQC has decided that it won't spread the inspection of services, rather, the team will inspect selected core services at the same time
- Inspection:
    - Most inspections will be unannounced – max of 4 areas being inspected at any one time
- Inspection of well-led:
    - Core services inspection informs well-led review
- Post Inspection:
    - 12 weeks from well-led element of inspection

- ≈ 30 page outturn report + evidence appendix
- Quality Summit not usually required

Example Timetable:

Day	Week	Date	Milestone
1	1	12/06	PIR sent to Trust
15	4	03/07	Deadline for return of PIR information to CQC
45	10	14/08	Regulatory Planning Meeting
55	12	Around 28/08	Core Service Inspection (unannounced)
65	14	11/09	Well-led Review
80	17	02/10	Ratings Review meeting
84	17	06/10	Draft Report sent to Trust for factual accuracy check
95	20	23/10	Deadline for factual accuracy comments back to CQC
105	22	06/11	Final report published

Next Steps:

- Developing range of approaches e.g. celebration events
- Changes reviewed by Independent Assessor – within CQC
- New Toolkit 'Insight' – intelligence system
  - Facts, figures and ratings
  - Trust and Core Service analysis
  - Featured data sources
  - Glossary / definitions
- 66 page doc. on 4 tabs:
  1. Trust Tab
  2. Location
  3. Core Services
  4. Ratings Tab
- Insight will be available to Trusts soon

QUALITY IMPROVEMENT HIGH LEVEL REPORT

WELL LED

Q10 Divisional structure Review With a new Executive Team Roles and responsibilities to be reviewed; restructures agreed and proceeding to recruit; The Trust commenced an engagement process in reducing the Divisional splits from 4 to a more manageable level. On the 26th July 2017, to date there has been a good response from the organisation Comms strategy in place. The engagement process completes at the end of August with a view to have an agreed structure launched 4th September 2017 followed by a 28 day consultation process for those whose roles will be impacted upon. The agreed new Divisions will then be put in place. In light of a CQC visit prudence would suggest this commences in April 2018.	April 2018

EFFECTIVE

Q9a.Incraese Focus on management of delirium in patients Training update received following report – part of the recommendation and action plan - presented to the MH Governance committee	On- going
Q9b The Mental Capacity Act Update on training provided Audit conducted NICE compliance . Actions in place for audit of MCA & delirium screening questions	

CARING

Q12 Complaints EOL Complaints are easily identifiable as new Korner Codes (KO41) have been written and have an entire subject area dedicated to EOL. PALs concerns and compliments include in the narrative 'EOL' which also allows them to be easily identified. Over the last 18 months 7 formal complaints have been received and 5 were responded to within the 30 day deadline. EOL lead nurse and EOL steering group to evidence key actions of oversight , track themes and disseminate shared learning October 2018	On-going

RESPONSIVE

Q5 C Outpatients Risk stratification of patients on referral pathways undertaken at speciality level. Plans underway to reduce waiting times. Operational grip work on-going with plans in place to address back log.	Ongoing
Q6a Review clinical pathways for #NOF between Ed & orthopaedic service Flow chart provided showing pathway between ED & Ortho Current NOF performance data provided Main issue still remains around ring fence beds and patients sitting in SAU with Fractured NOF	On - Going
Q6b maternity pathways developed Business Case to be drafted to recruit Nurse Sonographer - completion - Oct 2017	On - Going
Q7 New workforce model for obstetrics to include consultant OOH & increased midwifery care Senior Midwife structure report and Ext Obstetrics report provide along with Midwife pathway Obs & Gynae Steering group (DoN/ MD & COO) - update	Partially completed
Q 11 Children's services Due to changes to RCPCH Guidelines the Business case for extended hours is under review . On-going	On -going

	Major Actions Outstanding
	Actions Outstanding
	Actions Completed but compliance monitoring on-going OR awaiting Closure Report & Evidence
	Business As Usual (BAU)

QUALITY IMPROVEMENT HIGH LEVEL REPORT

SAFE	
Q1a Medicines storage, security & handling Closure report received July 2017 Continue to monitor for next two months (end of Oct) regarding FP10's Re-Audit	Closure expected End of Oct following monitoring
Q1b Improved Storage of IV Fluids in ED & ITU Still areas of concern regarding consistency of storage of medicines On-going audits Ward Action report to be developed Update 21.09.17	On-Going
Q2 Equipment Rucksack & Trolley Audit data provided (Jan – May) Training data provided (including off site areas - NCH / Littleport / Fakenham that staff are ILS trained. Monitor for 6 month – need to be confident that process has been embedded Equipment maintenance data regularly presented at Divisional board. Resuscitation equipment checks continues to be monitored via Nursing Metrics.	Closure expected End of year following Monitoring
Q3 Accurate Recording of Patient Care Order comms • Project Board planned 23rd Aug to establish prioritisation of TWOC Programme of works – dates cannot be provided at this stage – not due until Q4 – early Q1 17/18 Documentation • Weekly Ward Audit Documentation evidence provided – this captures whether documents have been completed correctly / dated /signed and in the right order • Main areas of concern is regarding Signatures being identifiable and Drug errors. General comment • Action be picked up by MD CNO for clinical oversight	On -Going

SAFE	
Q4a Nursing Recruitment & Retention High Risk – Vacancies – as of June FYTD – Registered Nursing Staff Turnover = 14.57% R&R plan in place Bi Annual Skill mix – Sept 2017	
Q4b – Endoscopy/ staffing – JAG Accreditation received - Closed	
Q4c Midwifery Recruitment Closure report received July 2017 Evidence provided (Skill mix / MLB papers)	Presentation of evidence – next QIG 200917
Q4d Nursing Closure Report received July 2017 - Additional evidence provided – Neonatal Network Skill mix compliance	
Q4e – Nursing – Day Surgery Pending Closure Report and evidence Business Case for Theatre staffing / DSU Rotas /Action plan for Paeds - Received	Actions complete – awaiting evidence
Q5a Decontamination of flexible cystoscopies Closure Report reviewed and approved Aug 2017	
Q5b Clinical Outcome data in Maternity Closure Report and evidence received and approved	
Q 8 IPAC Closure Report and evidence received (July) – Evidence to be reviewed prior to signing off report (EH) – due to be reviewed and closed at QIG - 090817 Trust to ensure infection control practice are adhered to at all times in the ED and throughout the Trust.	