Agenda Item No.16

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

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

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

Meeting Date: 30 January 2018

Report Title: Quality Matters / preparing for CQC inspection

PURPOSE:

The purpose of this report is to:

- provide assurance to the Board in respect of the Trust's compliance with the CQC's Fundamental Standards
- identification of risks and mitigation and improvement actions
- update the Board in respect of the Trust's preparation for inspection of:
  - Core services assessment
  - Well-Led assessment

SUMMARY:

The Quality Matters Team (QMT) continues to meet with teams as part of its review against the CQCs Fundamental Standards. Since our last update new areas of assurance and risk have been identified and these are detailed within this paper with actions for mitigation where required. Work is on-going to assess the Trust's self-assessment rating against the CQC KLOE and this will be shared in February 2018 once it has been quality assured by the Core Service Leads.

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

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

RECOMMENDATION/S:

The Board is invited to:

- note the Quality Matters / preparing for CQC inspection progress update
- commission additional work to provide further assurance as required

Quality Matters / preparing for CQC inspection

Key Assurances:	Source of assurance (audits, evidence etc.):
Review of the Musts & Shoulds from 2015 CQC Report. **5 Musts – Subdivided in 12 actions.** 10 of the 12 subsection actions completed and moved to BAU. Outstanding Musts: • Checking of the resuscitation trolley. Current lack of assurance evidence which has been raised as a risk. • Improving documentation. The wording of this Must action is very general and over-arching. Currently obtaining audit evidence to demonstrate improvement and to move ongoing improvement arrangements to BAU. **7 Shoulds – Subdivided into 8 actions.** 2 of the 8 actions completed. 5 of the 6 outstanding actions work in progress to move these to BAU with evidence.	Varying sources of evidence reviewed for each Must including audits, Board and Committee papers, Matron Assurance Audits, staffing risk assessment tools.
1 Outstanding Shoulds which remain incomplete & a significant risk • Clinical leadership within maternity services.	Quality Risk Summit with NHSI and CQC attendance. planned for 31/01/18
Medical devices maintenance programme in place with compliance of 85% – Peer review with Colchester Hospital carried out and provided further assurance regarding the Trust wide maintenance of medical devices	Peer review feedback received.
Robust governance arrangements in place in relation to the reviewing and monitoring of investigations and actions of incidents graded as moderate and above.	Attendance at Incident Review Panel meeting. Review of meeting arrangements and management of the reporting and incident investigation process. Action focused meeting with appropriate representation.
Quality assurance process established for the completion of Serious Incident Action Plans to ensure evidence is robust in line with the recommendations outlined as part of learning and improvements.	First meeting established for January 2018. ToR reviewed. To monitor the launch of this new governance process. Process in place to prioritise the review of outstanding SIs which go back 12 months.
Emergency Planning arrangements have been reviewed and are robust with relevant policies and continuity plans in date and accessible. Appropriate training of key staff has taken place with a further training for on-call teams planned for end of January to April 2018. Current Business Continuity Plans (BCPs) fit for purpose, but plans in place to improve and standardise current BCPs.	Meeting with the EPO and review of policies and BCPs. Inspection of the Major Incident storage facility and quality checking of equipment process. Documentation of equipment checking confirmed.
Mandatory training below Trust target of 95%, Focused work required to identify compliance in key areas of mandatory training.	Director of HR leading a newly formed Mandatory Training Group to agree and monitor improvement actions in relation to mandatory/statutory training compliance.

C4C Cleaning Audits had not been carried out consistently in all ward department areas with inconsistent Matron involvement and cleaning programme requires review to ensure it is realistic and risk assessed in line with national guidance. Urgent meeting held with IPAC & Head of Hotel Services in December to agree actions	Cleaning Programme review completed in line with National Guidance and audit process altered accordingly. Improved audit results for December with confirmation that all areas will have been cleaned for January in line with the new cleaning programme. Policy for cleaning and disinfection of the hospital environment is in the process of being updated to reflect changes. Policy for ratification at the February HICC. New cleaning schedules to be displayed in all clinical area.	
Ongoing improvements in reducing the number of outstanding Trust policies. In March 2015, 98% of Trust policies were out of date. December 2017, only 9% policies out of date	Clear ongoing process in place QIA completed for the current outstanding policies and to inform the prioritisation of these policies to be completed. Review carried out and duplicate and outstanding copies removed from intranet.	
Key Risks	**Mitigating actions**	**Timeframe**
Identified risks as part of current review: Significant concerns regarding the safe delivery of care on Leverington escalation ward. The opening of an escalation ward policy and SOP remains outstanding. Risks related to the safe staffing and allocation of patients to this area are not being effectively mitigated against. Currently no quality metrics routinely captured and reviewed as part of the governance arrangements.	Full risk assessment of the ward carried out and on the risk register with actions to mitigate risk currently. Operational policy being re-drafted by COO. Triumvirate meeting planned to agree policy. ACN for Medicine requested by Incident Review Panel to carry out a review of Leverington escalation ward and associated risks with the support of ACN – CQC Implementation Lead and to make recommendations regarding risk mitigation	**Outstanding** **31/01/18**
Lack of assurance that the Trust has evidence that staff have been trained in the safe use of medical devices.	Staff training in the use of equipment is in place across the Trust but unable to evidence this training. Risk assessed as a High Level = 16 Options paper and business case presented to the Executive Team in January for funding of a software solution as adopted by other acute trusts.	**Decision regarding option by 31/01/18**
Theme identified from mock CQC inspections with staff - Changes to the operational organisational structure is impacting on the 'well-led' domain, as many staff unclear of reporting lines, divisional structures and who's who on the trust Board of Directors. Staff unclear of Trust vision and values.	Ward / Dept pictorial organograms printed for each area for staff and distributed. Divisional organograms in production. Nursing / Midwifery Leadership Team boards are in production for ward/dept. Currently exploring option of utilising 'Well-Led Board's for ward/dept to display Trust vision, key risks and improvements. Quality Matters – Guide to our inspection printed and will be sent	

	out to all staff in January 2018 with payslips.	
There remains ongoing significant concerns relating aspects of Resuscitation due to ongoing workforce issues within the team impacting on required improvements not being progressed at pace.	Work in progress to source both internal and external workforce expertise to manage both the immediate and longer-term risks relating to resuscitation and to progress the improvement actions required within the resuscitation portfolio.	
Risk of patients being able to access chemicals stored within Ward/Dept Sluice which could result in patient harm.	Review and risk assessment of current locking mechanism carried out (Risk level 12) a proposal to alter the locking mechanism on a number of the sluice room door with costings has been approved by the Executive Team for implementation.	
Operational pressure during December and January impacting on quality improvement work due staff managing operational risk, with a number of meetings cancelled for these respective months such as Clinical Governance and Risk Committees.	Need to balance operational pressures with BAU to support the leads to continue their work to provide evidence for KLOE and address gaps and to avoid delays on delivery of improvement work.	

COMMENTARY
CQC PIR Information Request Following distribution of the CQC PIR information requests on 24th November 2017 as part of our CQC preparation arrangements , a review of the information submitted and outstanding is to be carried out and risks identified regarding information gaps. Update to be included in the February Quality Matters Board paper. CQC Communication Cascade CQC Cascade process agreed and has been printed which includes pictures of the Trust Chair and Executive Directors. Will be distributed to all areas by 26th January 2018. Peer Reviews/ CQC Mock Inspections A peer review timetable is being drafted from January to April 2018 for all ward/depts to be inspected using a quality review template. This will build on already established reviews such as the 15 steps used by Non-Executive Directors and the Matron Checklist and will focus on areas of concern and risk identified as part of hard and soft intelligence gathering and includes speaking with a number of patients and staff. Clinical and non-clinical staff are involved including members of the Non-Executive team, Governors and support staff. Telling our Story Recognising that we have many areas of excellent practice and innovation here at the Trust we have created a log of these to ensure that we can share these with staff and the CQC. The Quality Matters team have created a risk log of issues or concerns that we have identified to ensure that we know where our gaps are and our plans to address with identified leads. CQC Insight A paper is being written by the Director of Strategy and IT for presentation to TEC in February to agree what information is shared and how this will be used to assist with intelligence gathering that the CQC will already have sight of.