CQC Progress Report including Actions from the Quality Summit

1. Purpose

1.1. Give a brief update on the recent unannounced CQC visit on the 10th January 19
1.2. Provide an update on completion of the MUST DO Action Plan
1.3. Share an overview of the developed of Composite Improvement Plan
1.4. Give a progress update on the Actions from the Quality Summit
1.5. Outline a proposal of the CQC preparation plan

2. Background

2.1. The CQC inspected the Trust in June and July 2018 and rated it as 'Requires Improvement' overall.

2.2. During the inspection, the CQC issued 5 warning notices, 1 of which was later withdrawn following provision of satisfactory evidence by the Trust. Immediate swift action was taken to address the issues raised by the warning notices.

2.3. The final report was published in August 2018 and outlined 39 MUST DO actions and 74 SHOULD DO required Actions to improve overall quality. Comprehensive Divisional Action Plans were developed by the Trust with ongoing monitoring and seeking of assurance by the Executive Team as we embark on an Improvement Journey

2.4. The CQC made an **unannounced visit to the Trust on the 10th January 2019** to test out implementation of the action plans from the warning notices. They visited Maternity, Switchboard and Critical care at NWP, A&E and Medical wards in Ealing.

2.5. Interviews were held at NWP site with the Head of Estates, Interim Chief Nurse, Estates team, Natasha Beech, Security staff, head of unified communication and the Divisional General Manager and Head of Midwifery for Maternity.

2.6. A range of from line staff were interviewed at Ealing Hospital including ward managers, clinical leads for A&E, supported by the Operational Manager for Ealing and the Deputy Chief Nurse based at Ealing.

2.7. Preliminary feedback has been positive and a few further information requests are being processed with ongoing submissions. An example being nurse staff ratios on the

medical wards at Ealing Hospital. The CQC is currently formulating their findings into a report which the Trust expects to receive shortly.

2.8. **Comprehensive Divisional Action Plans** were developed by the Trust with ongoing monitoring and seeking of assurance by the Executive Team as we embark on an Improvement Journey

2.9. A Trust wide CQC Composite Action Plan (see Appendix 1) has now been developed supported by the NHSI Improvement Director Sheila Adam and shared with key stakeholders including CCG and CQC. Monitoring and Assurance is sought at the dedicated ETM for Quality Improvement and Transformation Programme. Following the 16th January 19 meeting, both Composite Action Plans for Must Do and Should Do are being refreshed to incorporate progress, areas of challenge alongside the submitted evidence.

2.10. The table below provides an overview of the progress made on completion of both the MUST and SHOULD DO actions as of 16th January 19;

Must Do	November 18	December 18	January 19
Green	21 (54%)	22 (56%)	23 (59%)
Amber	18 (46%)	15 (39%)	14 (36%)
	0 (0%)	2 (5%)	2 (5%)
Total Actions	**39**	**39**	**39**

Based on advice from the NHSI Director of Improvement, the two red must Do's remain on red because they have gone beyond the initially set delivery date. However, there is sufficient evidence of progress that suggest these could be moved to amber status. This would require a change in the expected date of delivery; therefore following a discussion with SA NHS Director and the Interim Chief Nurse, the proposal is to be taken to the executive for consideration on 23rd January 19 and then reported to relevant committees including Trust Board in January 19. The red Must do's are;

a. Must do **3.01 The Bleep systems in Maternity-** the SMT does not have the assurance that the escalation process is robust enough. Exec. Team notified. Further audits required.
b. Must do **11.01 Mental Health Needs for Inpatients in the Community (Willesden) including security risk-** Clinical Model is under review and Security team is leading on improvements initiatives including collaboration with the police.

It is proposed that this process be also undertaken against a number of the should do's, examples being: **4.02 Staff Mandatory Training, 5.02 Fluid balance and Nutrition assessment, 12.05 Alert systems for community midwives** etc.

Should Do	November 18	December 18	January 19
Green	28 (38%)	30 (41%)	30 (41%)
Amber	45 (45%)	33 (45%)	30 (41%)
Red	1 (1%)	11 (14%)	14 (18%)
Total Actions	**74**	**74**	**74**

2.11. The Trust Risk Register has been thoroughly reviewed and updated with cross referencing of the CQC Composite Plan. Accordingly, new entries of identified risks which emanate from the CQC report have been made onto the risk register and await approval; this enables further monitoring and strengthens assurance. New Risk Register entries include Paediatric Anaesthetic cover at Ealing and Junior Doctors' compliance with mandatory training (Risks 909 and 910 respectively).

2.12. Actions from the **Quality Summit held on the 6th November 18** are steadily progressing and updates were given at the 16th Jan 19 ETM (see Appendix 2). The Quality Summit Themes were:

- Leadership, Culture, Patient Experience and Staff Engagement
- Maternity
- Ealing Hospital
- Continuous Quality improvement and Transformation
- Patient flow

2.13. Ahead of the upcoming CQC re-inspection anticipated during the 1st to 3rd Quarter of 2019/20, a Trust CQC preparation plan and calendar of activities is being developed for the Executive Team discussion and recommendations which will be shared with the Trust Board.

3. 2019/20 Trust wide CQC re-visit Preparation proposal

3.1. It is proposed that each Executive Team Member will adopt a site and lead oversight of CQC preparation with periodic updates at ETM and also take part in:

- Monthly Executive Led Staff open sessions on CQC – a draft generic presentation has been developed for adaptation by Divisions and will be sent out for comment
- Executive Walkabouts schedule has been drafted
- Mock CQC Inspections will be undertaken on an ongoing basis supported by key stakeholders

3.2. The proposed Executive area and site allocation will be confirmed at the Executive Team Meeting.

3.3. A Walkabout guide has been prepared so that teams are aware of what to look for including a template for providing feedback. The Staff handbook for a successful CQC inspection is under review and will be launched by March 2019 and printed copies disseminated to frontline staff; the handbook is a resource to support staff with expectations during inspection and how to manage them.

3.4. Currently all clinical areas are being reviewed using the Excellence Assessment Tool (EAT) via the Perfect Ward App. A review of the questions aligned with the updated CQC key lines of enquiries (KLOE) is ongoing and will be incorporated into the five CQC domains. Actions from findings, once developed by the unit/ward manager and matron will be approved and monitored by the Divisional Heads of Nursing (DHON/HON) whilst support and challenge meeting will be conducted by the Interim Chief Nurse, Deputy Chief Nurses and CQC Lead. The reviewers will not be operational in the area they assess to ensure an objective and impartial assessment.

3.5. Pre CQC Mock inspections will be carried out in collaboration and supported by NHSI and CCG colleagues. Every Division will be asked to nominate a CQC lead and CQC champion for each department and/or specialties.

3.6. Divisions will be required to review their PIR submissions for the 2018 CQC Inspection and guidance will be provided by the CQC engagement meetings led by the Chief Nurse, supported by the NHSI Improvement Director.

3.7. It is envisaged that this process of monitoring will continue for a further 6 weeks after the scheduled CQC visits in anticipation of unannounced inspections that will follow.

3.8. Monthly updates / reports will be provided to the Quality and Safety Committee and Integrated Governance Committee.

4. Improvement Plan

4.1. The CQC Action plan completion is progressing well with ongoing review at the dedicated CQC Executive Team Meeting (ETM) as part of the overall CQC Improvement and Transformation Programme. The process commenced in November 18 and enables the Executive Team to receive progress updates with exceptions, challenges and assurance.

4.2. The Quality Summit Actions are being progressed by the respective Executive Team Leads in collaboration with relevant stakeholders.

4.3. A deep dive is due to be undertaken in Maternity and presented at the Quality and Safety Committee. Current Maternity specific activity is as follows;

- NHSI Maternity Safety Support offer led by Barbara Kuypers NHSI Midwifery lead - she has just completed the maternity diagnostic phase which has been agreed by the Trusts CEO and is now moving to the next stage of the process.

- NHSI/NHSE Maternity Review and Support plan which includes Sheila Adams our NHSI Improvement Director looking at; assurance around Serious incidents and is due to complete this by end of January 19, review of safer staffing that is in its final stages, the Maternity CQC Improvement plan must and should do's, as well as Compliance with the Warning Notices.

- The Trust internal review of midwifery services which have been agreed with staff side and are just commencing (first open meeting with staff took place on 8th January 19)

- A Maternity Monthly Improvement Journey Newsletter is now produced and shared with the service and across the Trust.

4.4. There is a full report going to the Trusts' Quality and Safety committee in February and Trust Board in March 19 which will also cover assurance on progress against national, regional and local maternity policy such as Safer Births etc.

4.5. The CQC team is scheduled to visit Sherwood Forest on the 4th and 18th February 19, a Trust that moved from Requires Improvement to Outstanding from whom we hosted a visit to share their practice at the end of 2018, to identify transferable learning from their Improvement Journey.

5. Recommendations

5.1. The Committee is asked to consider and note the actions taken in response to the CQC Report.

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