East London NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
28 NOVEMBER 2019

Title	Care Quality Commission compliance update
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Purpose of the Report:

PART ONE provides the Board with assurance in relation to the implementation of the action plan generated in response to the Trust's inspections during March/April 2018.
PART TWO provides a brief overview of the Trusts proposed changes to strengthen the processes by which the Trust understands and promotes regulatory compliance and inspection readiness.

Summary of Key Issues:

The report sets out the method by which assurance of implementation of actions was sought. It sets out those actions that have not been fully implemented to date, the reasons for arriving at that conclusion, and the action plan going forward.
The report goes on to set out priorities for action to improve inspection readiness, and awareness of key regulatory and quality issues.

Strategic priorities this paper supports

Improved population health outcomes	☒	
Improved experience of care	☒	The 'CQC action plan' supports the strategic priorities regarding service user satisfaction and staff satisfaction by providing detailed information on metrics used to understand, assure against and improve Quality across the Trust.
Improved staff experience	☒	
Improved value	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
13.10.2019	Quality committee part 1 – the priorities and readiness process

Implications:

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards
Service User/Carer/Staff	The Quality report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers and staff throughout the Trust.
Financial	None
Quality	The information and data presented in this report and accompanying dashboard help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care.

Supporting Documents and Research material

N/A

PART ONE

1.0 Introduction

1.1 The Trust underwent its comprehensive inspection by the Care Quality Commission in June 2016.

1.2 The Trust received its outstanding rating and report in August 2016.

1.3 In the aftermath of the inspection and reporting process, the Trust was required to respond to the areas for improvement identified in the CQC's inspection report in the form of an action plan.

1.4 The report identified 5 'must do' actions that the Trust is required to undertake to ensure that it complies with the regulations set out in the Health and Social Care Act (2008).

1.5 The 2016 action plan was reviewed and presented back to the Trust Board in February 2018. It identified one must-do action that was yet to be fully implemented. This related to the ongoing challenge to meet waiting time targets in Memory Services in Bedfordshire, specifically Bedford. A local management plan was put in place and a QI project set up to seek to address this.

1.6 A further inspection took place in March/April 2018, when the Trust received a well- led review, along with clinical inspections of the following core services:

- Forensic Services
- In-patient Learning Disabilities Services
- Community Learning Disabilities Services

1.7 As a result of this inspection the Trust's overall rating remained 'Outstanding'.

1.8 The core service rating for Forensic Services moved from 'Good' to 'Outstanding'

1.9 The core service ratings for both in-patient and community Learning Disabilities services remained 'Good'.

1.10 The Trust received an inspection report (Appendix A) that set out no 'must do' actions (those essential for the meeting of regulations set out in the Health and Social Care Act 2008) and a number of should-do actions for the Trust as a whole arising from the well-led review, and for each core service.

1.11 In response, an action plan was generated to address the suggestions made, and executive leads allocated to oversee each area of action. The actions were on a broad spectrum from ensuring checks are made to clinical fridge temperature, to ensuring work continues on implementation of the new trust strategy.

1.12 Some themes recurred across core services, in particular compliance with mandatory training, and ensuring consistent standards of supervision for staff. The action plan is attached to this paper in Appendix B.

2.0 Review and scrutiny of the action plan

2.1 During the course of its implementation, progress has been monitored regularly by the Chief Nurse..

2.2 After two years, and in common with our approach to reviewing the 2016 action plan, it was decided to collate the evidence of implementation of those actions identified as complete, and to review those actions deemed to be not yet fully implemented to agree the way forward with them.

3.0 Method of assurance review

3.1 Graham Hinchcliffe, a bank inspector with the Care Quality Commission, who worked closely with the Trust in preparation for the 2016 inspection, was brought back to work with us again to step up preparation for further inspection..

3.2 His first task has been to conduct this assurance review of the action plan.

3.3 in collaboration with action leads and relevant clinical leads, Graham has reviewed in detail the evidence of implementation of all of the actions for improvement identified by the Care Quality Commission.

3.4 To do so he met (in person or by phone) with all action leads, along with other parties who had a responsibility to provide evidence around implementation of specific actions.

3.5 A range of evidence was reviewed, protocols and procedures, audit and spot checks, performance data etc. However alongside this ‘desktop exercise’, site visits were also undertaken to view physical changes, and review other evidence in its day to day context, where this was necessary.

3.6 Additional assurance was provided by the Directors of Nursing

4.0 Conclusions of the assurance review

4.1 The process has concluded that there is clear evidence that 8 of 18 actions are fully implemented. Further evidence is required to demonstrate that the remaining actions are fully implemented, but there is evidence that all are at least partially implemented.

5.0 Next Steps

5.1 The Chief Nurse will meet individually with each action lead for those actions still outstanding, to review, and where necessary refresh, each plan of action.

5.2 The 'focused action plan' addressing those issues not yet fully addressed will be monitored by Quality Assurance Committee going forward.

5.3 'Action plan progress summaries' will be circulated to clinical teams in a readily digestible format, setting out in a straight forward way what was asked of us by the CQC, and what we have done in response.

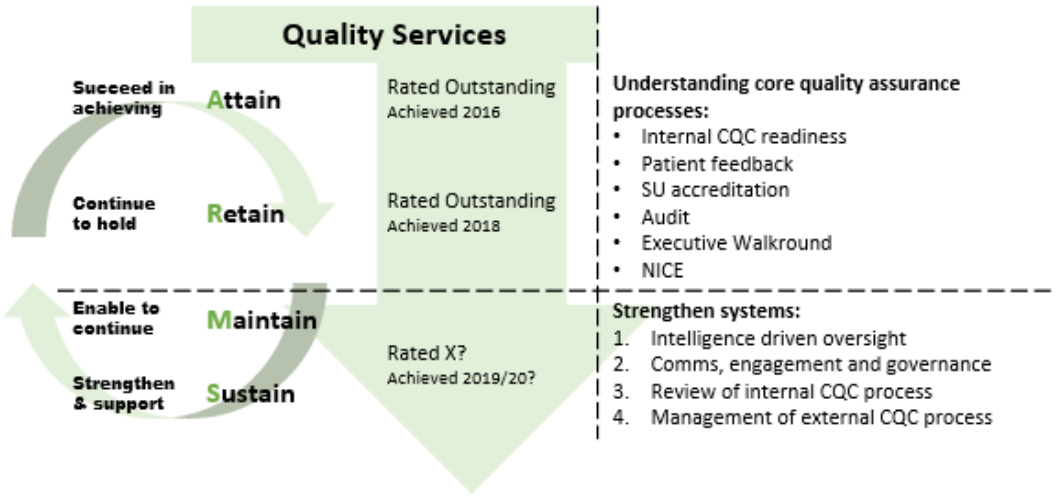
PART TWO

6.0 Background

6.1 The Trust underwent its first full inspection in September 2016 attaining an 'outstanding rating' and then again inspected June 2018, retaining its 'outstanding rating'. A further inspection is due to take place during 2019/20.

6.2 The central function of the Quality Assurance Team is to enable teams to **understand the quality of services they provide by understanding their core quality assurance functions** (CQC readiness, patient feedback, service user accreditation, audit, executive walkround and NICE).

6.3 In the spirit of continuous improvement, further focus and attention is required to review the trusts current CQC readiness position and ensure services continue to provide high quality care by meeting quality standards. The below image represents the steps required to ensure the trust 'maintains' and 'sustains' its 'outstanding' rating.



7.0 Proposals for action

7.1 In order to strengthen assurance in relation to regulatory compliance and inspection readiness, and support the quality and safety of services, it is proposed to focus on the following four areas.

1. Intelligence driven oversight
    a. Co-ordinate and support quarterly external CQC governance 'engagement meetings'
    b. Improve visibility, dissemination and utilisation of CQC 'Insight Report'
    c. Proactive regulatory horizon scanning, and systematic oversight of CQC and other relevant policy publications, and oversight of appropriate Trust response

2. Communication, engagement and governance
    a. Implementing a "Quality Standards" trust forum to share and communicate key messages, promote learning, and understand risks to quality
    b. Explore development of early warning system/triangulation of high value data/Power BI/ predictive models
    c. Promotion of clinical learning networks

3. Review and development of existing internal CQC readiness process *(reported in detail to the Quality Committee November 2019)*
    a. Strengthen local CQC readiness process by further supporting inspection readiness alongside compliance with standards/quality
    b. Integrate national CCQI accreditation, and other high value quality data, into reporting to improve understanding of quality at service level
    c. Oversee, and integrate into reporting, Directorate risk registers, and promote their use to identify and mitigate risks to regulatory compliance/quality

4. Management of external CQC process
    a. Develop and implement local management processes within the QA Team to support the external inspection process
    b. Support the Executive Lead to develop a Board support package (i.e. for Well Led inclusive of programs including buddy arrangement, NED and Governor sessions etc.)

8.0 Next steps

8.1 A workplan will be drawn up to deliver the proposals above setting out the work in more detail and establishing timelines for implementation. Progress will be reported to the Quality Committee as part of the regular CQC update.

9.0 Action being requested

9.1 The Trust Board is asked to **RECEIVE and APPROVE** the findings of the assurance review set out in the paper, and the resulting 'focused action plan'.

9.2 The Trust Board is asked to **RECEIVE and NOTE** the proposed actions to strengthen CQC readiness processes.

ELFT Trust wide CQC actions (well-led)

Update as 21/11/2019 - LS

#	Should do	Exec Lead	Key actions	Target date	Update Aug/Spet 2019	Status
S1	The trust should complete work on the trust strategy including reviewing supporting strategies where needed	Mason Fitzgerald	Strategy development - - paper to board - annual priorities agreed - Directorate plans	Feb-18	The Trust strategy has been developed and launched, after being to board in March 2019 with agreed priorities. Strategy/priorities for 20/21 currently being compiled.	Completed
			Supporting plans developed	Apr-18	Supporting plans have been included as part of the strategy	Completed
			Marketing, comms and engagement -DMT away days	Nov-18	Various comms were used launched to promote the Trust Strategy Launch	Completed
			Monitoring - - BAF refreshed - performance reports developed	March 2020	Review of DMT reporting underway	Amber
			Institute key priority workstreams - - Population health - Patient experience - Staff experience - Value for money	Nov-18	The four work streams were successfully launched as part of the Trust strategy.	Completed
S2	The trust should continue to take steps to further improve the results of the	Lorraine Sunduza	New Equality and Diversity strategy to be developed	Nov 18	Equality Diversity and Human Rights Strategy in place. Two equality and diversity plans have been developed, one for staff and one for service users, as part of the Trust Strategy. These went to board in Nov 18.	Completed
			Set of metrics to be developed to monitor implementation and impact of E&D strategy	Nov-18	Oversight of metrics in performance report monitored at board meetings and Service Delivery Board.	Completed (ongoing)

	workforce race equality survey. They should also continue to support the staff networks to ensure staff with protected characteristics have their equality diversity and human rights protected and promoted		Promote participation in annual staff survey	Oct-18	Procurement of an engagement system and increase of engagement to 4x per year (from once). National RES report 2019 shows improvement in engagement.	Completed (ongoing)
			Relaunch of staff led Staff Networks, with Executive sponsorship	Oct 18	Four networks have been relaunched: ELFT ability, Women's, LGBTQ+ BAME. An intergenerational group is being established. Each has an exec sponsor and at least one network lead.	Completed
S3	The trust should continue the work to ensure all mandatory training courses reach the targets for completion	Tanya Carter	A statutory and mandatory working party has been implemented. The Trust statutory and mandatory training target has been amended to 90%. The working party has rationalised the TNA matrix reducing the overall number of courses reported from 40 to 30 and employed a set of guiding principles and a structure for regular review. A mapping exercise will be undertaken late summer 2018 to update each staff member's competency matrix on OLM.	Sep-18	The competency matrix has been updated. A real time reporting system has been implemented in OLM. Team training compliance reports for managers increased from monthly to weekly for increased oversight.	Completed (ongoing)

			A new ILS/BLS provider is in the process of being procured and they have been commissioned to deliver ILS/BLS (including bank workers). A Resuscitation Officer will also be employed by the Trust to undertake audits, spot-checks and support teams across all localities.	March 2020	Provider has now been procured and commissioned, and are providing training. A resuscitation officer has now been employed within the trust who is proactively training staff and doing “mock arrests” onwards. ILS and BLS trainings are in place across the trust. As of 2019 B4s/B5s were mapped to BLS training increasing the numbers requiring this more complex training. The training department has booked places accordingly and we are on a good trajectory.	Amber
			The L&D team have received significant investment and an L&D Officer (System) will be assigned to each locality/Borough to support the services to increase compliance. The structure should be in place by November 2018 at the latest.	Nov-18	L&D officer assigned and in place in each locality as of Nov 18.	Completed
			DNA's are routinely reported to SDB and the follow ups with managers and Borough Directors.	Nov 18 (ongoing)	DNAs can be found in the performance report that goes to Service Delivery Board. There has also been an ongoing QI project around training DNAs put in place.	Completed (Ongoing)
S4	The trust should continue to work towards making the necessary financial savings with the active	Mohit Venkataram	Commercial Director Leading a PMO approach to CRES	N/A	PMO office established. Full-time PMO lead in place. Regular reporting to FBIC. Two steering groups were established which looked at fostering ownership and setting more relevant agenda items. Three project groups have been created as a result which are led by clinicians. CMO leading on QI around waste management. More awareness through intranet where staff can vote on how the trust makes savings.	Completed
			Clinical Lead in place to support process	N/A	A consultant has dedicated two PAs to supporting this process.	Completed

	participation of all members of the executive team		CRES discussed at Monday Exec meetings	N/A	Included as a quarterly agenda item as well as any financial and savings issues being raised ad hoc.	Completed
			Meetings between COO/CFO and directorate teams	N/A	Monthly meetings take place with COO, CFO and commercial director which reports to FBIC.	Completed
S5	The trust should continue to resolve any staff contractual issues in a timely manner	Mohit Venkataram	Any procurement relating to outsourcing should have a checklist that will include staff contractual resolution	Sep-18	Procurement and Sub-contracting policy updated with staff consultation see appendix two. Incorporates changes into the timetable where TUPE and staff transfers are involved. Applies to a Hard FM tender.	Completed
S6	The trust should continue to grow the numbers of peer support workers	Paul Calaminus	Review of target trajectory with directorates	Oct-18	PB and PC have met with each borough director in the last 6 months to discuss trajectory. Local targets not set. Trust target is 10% increase per month. Awarded community transformation money from NHS England. This will include an expansion of PSWs. Includes expansion of PSWs into Community Health Services. Training for PSWs is being accredited by the Royal College of Psychiatrists.	Completed
			Recruitment to new roles	Mar-19	Rolling advertisement through NHS Jobs. There are currently 56 PSWs. This is part of the workforce report.	Completed (Ongoing)
S7	The trust should continue to	Paul Gilluley	Trust mortality review meetings to be held monthly	Mar-18	In progress since July 2018	Completed

	ensure that the review of potentially avoidable deaths takes place in a timely manner		2 x Trust mortality reviewer to be employed to allow 50 % of cases paper reviewed.	Apr-18	2x Mortality Reviewers were appointed in July 2018 on a fixed term contract. A Mortality Reviewer has been substantively appointed as at July 2019. Provision has also been made for an Apprentice to provide administrative support to this role. Oct 19: Two reviewers were in post with an apprentice until July 2019 , there is currently one reviewer in a permanent role.	Completed
			Themes to be reviewed from the mortality reviews and consider actions that need to be taken.	Jun-18	Themes have been assessed on an ongoing basis since July 2018. We are now fully compliant with this action and have completed an annual report on deaths which is going to Board this September. 100% of all the expected deaths where care has been managed by ELFT are reviewed, these are reported monthly. 25% of all hospital or care home deaths, where ELFT was not managing care but was providing a service are reviewed, figures are reported monthly, quarterly and annually. . There have been a small number of deaths that have been taken to further investigation; these had been identified in the mortality review SJR process. All such deaths continue to be reported monthly and raised at the SI grading panel. Reviews are being carried out in a timely manner, all SJRs for any given month are reviewed and reported. Figures are reported two months after the death.	Completed
S8	The trust should ensure that	Amar Shah and Richard Fradgley	A broad-ranging review to be undertaken, starting with an analysis of data and a workshop with key stakeholders in	Mar 20	Richard and Amar have led a group which has been exploring supervision over the last few months. They have critically appraised the current	Amber

	staff on all wards receive regular supervision		September. Actions to be determined from there.		system and policy, looked at what the future might look like, and now have a few work streams in place. This includes a policy re-write with a new standard definition of supervision at ELFT, a new training offer for supervisors and supervisees, and a better way of recording and reporting supervision. There are no outputs as yet but there is a team in place that will be coordinating the work under the oversight of the leads. Supervision data is monitored locally and reported to SDB. Supervision structures are in place across the trust. These are audited during quality visits.	

Forensic Services

#	Should do	Key actions	Target date	Update Aug 2019	Status
S9	The trust should ensure that staff always sign to confirm that procedural security checks have been carried out in line with the trust's procedures	A new procedural security Guidance is being developed for the role of Security Nurse	Sep-18	Procedural security protocol completed and in use.	Completed
		Standardise all security checks across the service with new forms	Sep-18	New form in place. Audited on a monthly basis. Checks reduced to 2x per day. Results show improvements.	Completed
		Audits of security checks randomly by service	Sep 18	Checks have been taking place on an ongoing basis (at least monthly)	Completed
S10	The trust	Records are being	Sep 18	Standardised booklets are in place across the trust to monitor issues in treatment	Amber

	should ensure that a record is kept of clinic room and fridge temperatures including a note of the actions taken if temperatures are outside the safe range	kept and reviewed.		rooms. These have been launched through teaching on away days. Variation in some wards being addressed via supervision	
		All clinic rooms will have air conditioned systems installed	Sep-18	. Funding agreed. As a temporary measure there are mobile air con units. Datix being used to report when temperatures out of range. On the estates risk register.	Amber
		Audits of clinic room temperature books completed every quarter by the service	Oct 18	Monthly audit by the ward Clinical Nurse Manager implemented. Audit in October 2019 by lead nurses. Improvements noted with some gaps in one ward. A capital bid has been approved to fit aircon units in treatment rooms where temperatures are known to regularly exceed expected levels. A roll out programme is being developed by the Estates and Pharmacy department. Pending the full roll out plan mitigation plans are in place, and staff are made aware of their responsibilities in this regard. Clinic room are monitored via Director of Nursing and Chief Nurse team visits	Amber
		System of ward Matrons, CNM and Clinical practice leads checking the clinic room on an ongoing rota basis now in place	Oct 18	Monthly audits do not show how any required actions or gaps were escalated. There are trust wide agreed Matron and ward manager audits in place, that includes checking of treatment rooms. There is an external audit conducted quarterly around treatment room, feedback is given to local leads and is discussed at the borough lead nurse forum. A trust wide community teams treatment room audit was conducted in 2019 by the pharmacy departments, the results of which were feedback to locality leaders with arising issues discussed in the medicines committee.	Amber
S11	The trust should ensure that	All blood glucose machines monitored with the	Sep 18	. This forms part of the treatment room audit.	Amber

	blood glucose monitoring equipment is regularly calibrated and that calibration fluid is replaced every three months	clinic room checks on a monthly basis by the ward teams to include the Matron and Clinical nurse manager			
		All calibration fluids will be dated and diarised to ensure new fluid is ordered in a timely way	Sep 18	This forms part of the treatment room audit. Lead nurse audited October 2019 reviews completed. Entries missing in one ward. Addressing via supervision	Amber
S12	The trust should ensure that problems with the lifts in Wolfson House are addressed, to so that they are both kept in good working order	Lift is part of the estates risk register and reviewed monthly until service is satisfied with lift condition.		Remains on the directorate risk register until resolved. Any instances of break down are reported from security to Head of Nursing and also via datix.	Completed (ongoing)
		Spare parts have been ordered and stored on site for ease access if it breaks down	Completed	Spare parts are available at Wolfson house for lift engineers to use when the lift becomes faulty.	Completed
S13	The trust should continue to monitor the cancellation of planned patient leave and continue work to reduce such cancellations	Quality improvement project now in place with learning to be disseminated to all teams	Dec-18	Ongoing with projected spread in service by the end of the year	Completed (ongoing)
		Quarterly audits of cancelled leave continue with action plans for each ward		Ongoing review in Forensic Quality committee	Completed (ongoing)
S14	The trust	See s8.		The service monitors management supervision on a monthly basis.	Completed

	should ensure that staff receive monthly supervision				(ongoing)

Learning Disability Teams

#	Should do	Exec Lead	Key actions	Target date	Update Sep/Oct 19	Status
S8	The trust should ensure that staff receive monthly supervision	Amar Shah and Richard Fradgley	See S8 as above	See S8 as above	See S8 as above	See S8 as above
S15	The trust should ensure that all staff complete mandatory training	Paul Calaminus	See S3 as above	See S3 as above	See S3 as above	See S3 as above
S16	The trust should continue to work with commissioners to ensure that patients within adult autism services commence their	Paul Calaminus	Review of demand and capacity with commissioners	Dec-18	The review of the Adult Autism Service will likely be a redesign into a Neurodevelopmental Service. Currently scoping a model. There have been some very basic and early conversations with commissioners but this is moving forward in the next few months.	Amber
			Use of RiO for Learning Disability activity	Dec-18	The current wait in Bedfordshire and Luton for Adult Autism diagnosis is 9 months - the team has had 40% of their staff on long term leave for a year until recently, and we were unable to recruit to backfill. There service is currently reviewing the provision and identifying additional diagnostic capacity across the service to reduce the wait. The Service has also experienced an increase in referrals from an average of 18 per month in Jan 2018 to 28\30 within the last 3 months - a sustained	Amber

	diagnostic assessment within the agreed timescale.				increase. The referral and screening process has been reviewed resulting in screening out approx. 20% of referrals as inappropriate which is reducing the wait.	
S17 *	The trust should ensure that minimum and maximum fridge temperatures are recorded in line with pharmaceutical guidance to maintain the efficacy of medicines stored in fridges	Lorraine Sunduza	Standardise auditing process and documentation for clinical leads and modern matrons for all localities who utilise this equipment.	March 20	There are trust wide agreed Matron and ward manager audits in place, that includes checking of treatment rooms. There is an external audit conducted quarterly around treatment room, feedback is given to local leads and is discussed at the borough lead nurse forum. *At the Coppice there are currently no admissions and have not been any for over 7 months.	Amber
			Matrons to undertake regular review and periodic spot checks of fridge temperatures	March 20	The Clinical Nurse Manager undertakes a monthly check of the daily records. This forms part of the treatment room audits. There are trust wide agreed Modern Matron and ward manager audits in place that includes checking of treatment rooms. There is an external audit conducted quarterly around treatment room, feedback is given to local leads and is discussed at the borough lead nurse forum.	Amber
			Deviation of fridge temperatures to be reported as incident	July-20	There is increased monitoring across the Trust with specific wards showing a few gaps. The medical devices team have completed a trust wide review of treatment room fridges and concluded that many need replacing due to age and unreliability. A rolling programme of replacement will commence	Amber

					in 2020.	
S18 *	The trust should ensure that care plans are in accessible formats for patients	Lorraine Sunduza	Review of documentation formats to be undertaken	April 20	The care plan format has been reviewed and updated to an accessible format. A further accessible format for care planning (the Collaborative Safety Plan) is being developed in Forensic LD services - translating complex interventions into easy to understand concepts and steps. Once this process is complete and evaluated, training will be provided for CNMs.	Green
			Spot checks of care plans provided	April 20	The Clinical Nurse Manager provides ongoing guidance for completing the care plans on mainstream wards. This is part of Quality Reviews by directors of Nursing	Amber
			Consider use of PREM for feedback on accessibility of information provided	April 20	There is a folder on the Intranet for Accessible Information – There is folder on the network K Drive folder under Greenlight - this contains written resources, the accessible care plans and videos about how to communicate with a person who has a learning disability LD leadership team and communications have reviewed the IG Accessible Leaflet for service users The PREM form has been reviewed in an accessible format - this is now a Trust wide document	Amber

					Communications team, LD leadership team and Staff Network Elft Ability are creating a 'Quick How To' page on the intranet for everyone, not just people who have a Learning Disability	