# EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **29 JANUARY 2015**

SUBJECT: **CQC ACTION PLAN**

REPORT FROM: **CHAIR OF IMPROVEMENT PLAN DELIVERY BOARD**

PURPOSE: **Discussion**

## CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

- The Trust was put into special measures following a CQC inspection in March 2014.
- In response the Trust developed an action plan based on the 21 Key Findings and 26 Must Do areas that were identified in the CQC report.
- Detailed action plans were developed at Divisional level. These feed into the High Level Improvement Plan (HLIP) to give an overall picture of progress.
- The Improvement Plan Delivery Board (IPDB, monitors progress against the HLIP and associated action plans. The IPDB is chaired by David Hargroves, Consultant Physician (who commenced in December). It has met monthly since 29 Oct 2014. The terms of reference for the IPDB were approved by the Board on 30 October 2014.
- A Programme Management Office has been established to oversee delivery of the action plans.
- Sue Lewis has been appointed by Monitor as the Improvement Director.
- Progress towards achievement of the HLIP is recorded monthly in the Special Measures Action Plan. This is submitted to Monitor via Sue Lewis. It is then uploaded to the NHS Choices website and EKHUFT staff and public websites.

## SUMMARY:

Divisions are asked to provide a monthly update to the Programme Management Office. This update is used to record progress against the HLIP and to populate the monthly report to Monitor and the monthly NHS Choices Special Measure Action Plan.

The summarised RAG ratings which are used to populate the NHS Choices Plan are given below.

| **HLIP RAG RATING** | | | | | |
|---|---|---|---|---|---|
| | **Definition** | **Date of Monitor meeting** | | | |
| | | **5 Nov 2014** | **3 Dec 2014** | **7 Jan 2015*** | **4 Feb 2015** |
| Red | Not on track to deliver | 2 (4%) | 0 (0%) | 2 (4%) | 5(11%) |
| Amber | Some issues – narrative disclosure | 25 (53%) | 8 (17%) | 18 (38%) | 17 (36%) |
| Green | On track to deliver | 19 (41%) | 36 (77%) | 25 (53%) | 24 (51%) |
| Blue | Delivered | 1 (2%) | 3 (6%) | 2 (4%) | 1 (2%) |

* RAG ratings agreed with the Improvement Director following the meeting with Monitor.

**Achievements since the last report to the Board on 28 November 2014 include:**

- Appointment of a Medical Director to the Surgical Division
- Cultural change programme gathering pace
- Good progress made on National Clinical Audit Programme both in terms of participation and in ensuring validation of data
- Achievement of 100% WiFi coverage in all clinical areas
- Introduction of partial booking for booking outpatient appointments in ophthalmology

**Actions not on track to deliver**

The two actions reported to Monitor in January as not being on track to deliver were:

**M06** – *Ensure that paper and electronic policies, procedures and guidelines that staff refer to when providing care and treatment to patients are up to date and reflect current best practice*.

**KF14** – *There was a lack of evidence based policies and procedures relating to safety practices across the three sites and a number of out of date policies across the Trust.*

**Trust response** – Each Division has identified a lead or leads charged with reviewing and updating policies. Some departments, including renal, dermatology and cancer have completed the task but others, including maternity, paediatrics and obstetrics have a lot more work to do if they are to complete this by July 2015.

In addition to the two actions above, the following three actions will be reported as delayed to Monitor on 4 February 2015.

**M19 -** *Ensure safety is a priority in A&E.*

This action relates to the flow of patients through A&E and the role of the Integrated Discharge Team. The action has been RAG rated Red as:

- there have been concerns that the paediatric pathway through A&E is not clearly defined
- there are concerns that funding for the Integrated Discharge Team will not continue in the next financial year. This is now being considered as part of the business planning process.

**M23** - *Ensure staff are fulfilling their roles in accordance with current clinical guidance.*

This action relates in part to ensuring Trust policies are aligned with national clinical guidance, in part to ensuring all admitted patients have a risk assessment and to the management of pressure relieving equipment. The main issues that still need to be addressed are:

- a review of NICE guidelines. This is now being done by the Divisions
- a snapshot audit to ascertain whether all admitted patients have a risk assessment.

**KF20** - *The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high a number of complaints were referred to the Ombudsman, and there were 16 open cases as of December 2013.*

The Trust is taking action to reduce the time it takes to respond to complaints and, as previously reported to the Board, response times have significantly improved over the past couple of months. A revised complaints policy has been produced and this is going to the Quality Assurance Board in February for review and will then go out for consultation.

**Risks and mitigations**

Divisions are asked to produce monthly reports for the IPDB that identify:

- Actions completed in last month
- Focus area for the following month
- Risks and mitigations.

The key risks and associated mitigations are attached.

**RECOMMENDATIONS:**

The Board is invited to note the report and the progress to date.

**NEXT STEPS:**

The Improvement Plan Delivery Board meets monthly to oversee delivery of the plan. The next meeting will take place on 25 February 2015.

**IMPACT ON TRUST'S STRATEGIC OBJECTIVES:**

The actions included in the HLIP are aligned to the Trust's strategic objectives. Achievement of these is essential to enable the Trust to move out of Special Measures and to restore the confidence of all stakeholders including commissioners, staff and the general public.

**LINKS TO BOARD ASSURANCE FRAMEWORK:**

AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

**IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:**

The Trust's success in implementing the recommendations of the HLIP will be assessed by the Chief Inspector of Hospitals upon re-inspection of the Trust. The results of this inspection will have a significant impact on the future reputation of the Trust.

**FINANCIAL AND RESOURCE IMPLICATIONS:**

Improvement initiatives that are successfully delivered and embedded into daily operations support the more effective and efficient use of resources.

**LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:**

The Trust is currently in breach of its Licence with Monitor by virtue of being placed in Special Measures.

**PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES**

None

**ACTION REQUIRED:**

(a) To note

**CONSEQUENCES OF NOT TAKING ACTION:**

Failure of the Trust to respond in a timely fashion with appropriate information may affect the Trust rating with Monitor and the CQC.

| **RISKS AND MITIGATIONS – CQC IMPLEMENTATION PLAN, JANUARY 2015** | | | |
|---|---|---|---|
| | **RISK** | **ISSUE** | **MITIGATION** |
| 1. | Recruitment and retention of staff (A&E, paediatrics, general) | Local and national staff shortages | - Re-engineering the workforce<br>- Reducing turnover through development of<br>- a more strategic approach to succession planning<br>- Enticing new recruits by offering opportunity to contribute to exciting new service developments (A&E)<br>- Recruiting from overseas<br>- Auto-enrolling all new nursing staff on NHSP Bank<br>- Working with wider health economy across Kent to address challenges |
| 2. | Outpatient booking system | Reducing number of follow up appointments cancelled and seeing patients in a timely manner | - Significant increase in OP referrals has increased the pressure and delayed the improvements<br>- Developing more innovative ways of working including telephone clinics, one stop clinics, changes to map of medicine and identification of new clinical pathways<br>- Promoting Choose and Book until introduction of new national referral system<br>- Agreeing joint plan to reduce referrals with CCGs as part of contract negotiations<br>- Reviewing 18 week referral process and criteria |
| 3. | Mandatory Training | IT issues | - Review of IT interfaces<br>- Identification and then spread of good practice across all areas<br>- Temporary introduction of paper based monitoring while IT problems are addressed<br>- Working with Medical Director to improve clinician compliance levels |
| 4. | Number of incidents | Inconsistent approach to addressing risks | - Working with clinical teams to agree further triggers for reporting at specialty level<br>- Meeting clinicians to raise awareness of incident reporting and setting a good example for colleagues |
| 5. | Patient Flow | Capacity issues due to increased demand and continued delay in transfer of patient | - Internal and External escalation processes reviewed and improved<br>- Communication and engagement with sector<br>- “perfect week” with focus on discharges<br>- Introducing electronic bed monitoring giving real time information |
| 6. | Updating of policies | Poor functionality of systems | - Task group set up to oversee revision and updating of all policies<br>- Review of system by IT<br>- Review of governance at Specialty and Divisional level |

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# Must Do

| | | Oct | Nov | Dec |
|---|---|---|---|---|
| MD01 | Vacancy (%) - Consultants | 7* | 7* | 8* |
| | Vacancy (%) - Staff Grades | 23 | 22 | 17 |
| | Vacancy (%) - HCAs | 8 | 5 | 5 |
| | Vacancy (%) - RNs | 4 | 5 | 7 |
| | Vacancy (%) - Techicians | 9 | 6 | 7 |
| | Midwife:Birth Ratio (%) | 31 | 26 | 25 |
| | Avg. Time to Recruit (Wks) | 11 | 10 | 11 |
| MD02 | Vacancy - Paed. (%) - Cons. | 3 | 6 | 3 |
| | Vacancy - Paed. (%) - S. G... | -1 | -1 | -1 |
| | Vacancy - Paed. (%) - RCNs. | 4 | 4 | 4 |
| | Vacancy - Paed. (%) - HCAs. | 6 | 2 | 2 |
| | Vacancy - Paed. (%) - Techs. | 7 | 7 | 7 |
| MD03 | Board Rep. for C&YP | 3 | 3 | 3 |
| MD04 | Mandatory Training (%) | 81 | 80 | 78 |
| MD05 | Number of Incidents | 1,433 | 1,432 | 1,422 |
| MD06 | Policies in Date (%) | 55 | 55 | 55 |
| MD07 | Obs. On Time - Day (%) | 68 | 69 | 69 |
| | Obs. On Time - Night (%) | 65 | 64 | 64 |
| MD08 | Patient Exp. - Cleanliness (%) | 99 | 98 | 98 |
| MD09 | Equipment Incidents | 26* | 36* | 43* |
| MD10 | Cleanliness Audits (%) | 97* | 97* | 97* |
| MD11 | Paediatric Clinical Audit | 2 | 2 | 2 |

CQC Dashboard

| | | Oct | Nov | Dec |
|---|---|---|---|---|
| MD12 | Emergency Training (%) | 100 | 98 | 106 |
| MD13 | Survey: Aware of EoL Path. | 2 | 2 | 2 |
| MD14 | Do Not Resuscitate Audit (%) | 75 | 75 | 75 |
| MD15 | OP Clinic Delay Audits (%) | 77 | 80 | 76 |
| MD16 | OP Letters Sent - 10d (%) | 69 | 77 | 80 |
| MD17 | Full & Partial F-Up (%) | 72 | 71 | 71 |
| | OP Hospital Canx (%) | 21 | 19 | 19 |
| MD18 | Shifts Filled - Day (%) | 102 | 99 | 94 |
| | Shifts Filled - Night (%) | 96 | 102 | 101 |
| MD19 | Vacancy - A&E (%) - Cons. | -12 | -12 | 4 |
| | Vacancy - A&E (%) - S. Grades | 44 | 44 | 44 |
| | Vacancy - A&E (%) - RNs. | 12 | 9 | 8 |
| | Vacancy - A&E (%) - Techs. | 8* | 11* | 11* |
| MD20 | Pharmacy TTAs Dispensed (%) | 42 | 38 | 44 |
| | Reduction in DToC Level | 32 | 29 | 34 |
| MD21 | Avg. Ward Moves (per Day) | 29 | 27 | 29 |
| | Avg. Ward Moves (per Night) | 12 | 13 | 13 |
| MD22 | Survey: Aware of C&YP Lead | 2 | 2 | 2 |
| MD23 | Clinical Audit Review | 3 | 3 | 3 |
| MD24 | Pharm: Fridges Locked (%) | 39* | 39* | 39* |
| | Pharm: Fridge Temps (%) | 76* | 76* | 76* |
| | Pharm: Medicine Waste (%) | 87* | 87* | 87* |
| | Pharm: Cupboards Locked (%) | 92* | 92* | 92* |
| MD25 | CD: Wards No Discrepancy (%) | 96* | 96* | 96* |
| | CD: Ampoule Storage (%) | 97* | 97* | 98* |
| | CD: Stock Check - 24hr (%) | 70* | 70* | 71* |
| | CD: In Date Ward Stock (%) | 92* | 92* | 88* |
| | CD: High Strength Return(%) | 95* | 95* | 98* |
| MD26 | Review End of Life Care | 3 | 3 | 3 |

* Data collected from historic audit - see glossary for details

# Key Finding

| | | Oct | Nov | Dec |
|---|---|---|---|---|
| KF01 | Performance Review (%) | 76 | 77 | 76 |
| | Sickness (%) | 4 | 4 | 5 |
| | Staff Turnover (%) | 13 | 13 | 13 |
| | Appraisal Quality | 87 | 88 | 87 |
| KF02 | Data Verification Audit | 3 | 3 | 3 |
| KF03 | Performance Review (%) | 76 | 77 | 76 |
| | Sickness (%) | 4 | 4 | 5 |
| | Staff Turnover (%) | 13 | 13 | 13 |
| | Appraisal Quality | 87 | 88 | 87 |
| KF04 | Raising Concerns | | | 4 |
| KF05 | Staff FFT - Work (%) | 45* | 45* | 45* |
| | Staff FFT - Treatment (%) | 70* | 70* | 70* |
| KF06 | Patient Risk Audit | 2 | 2 | 2 |
| KF07 | Leadership Training (%) | 12 | 12 | 12 |
| KF08 | Shifts Filled Day (%) | 102 | 99 | 94 |
| | Shifts Filled Night (%) | 96 | 102 | 101 |
| KF09 | Survey: Training Needs | 2 | 2 | 2 |
| KF10 | A&E Waiting Time Audit | 3 | 3 | 3 |
| KF11 | Number of Incidents | 1,433 | 1,432 | 1,422 |
| KF12 | Paed. Process & Policy Audit | 3 | 3 | 3 |
| KF13 | Paed. Resus Trolley Audit | 3 | 3 | 3 |
| KF14 | Policies in Date (%) | 55 | 55 | 55 |
| KF15 | Clinical Audit Prog. Audit | 3 | 3 | 3 |
| KF16 | Audit of WHO Checklist | 99 | 99 | 99 |
| KF17 | Equipment Problems | 26 | 36 | 43 |
| KF18 | Full & Partial F-Up (%) | 72 | 71 | 71 |
| | OP F-Up Booking Audit | 2* | 2* | 2* |
| KF19 | Survey: Aware of EoL Path. | 2 | 2 | 2 |
| KF20 | Ombudsman Case (6M %) | 38 | 35 | 44 |
| KF21 | OP Clinic Delay Audits (%) | 77 | 80 | 76 |

East Kent Hospitals University NHS NHS Foundation Trust

Putting patients first