BOARD OF DIRECTORS MEETING (Open)

Date: 12 December 2018 **Item Ref:** 07

TITLE OF PAPER	**Care Quality Commission – Well-led Inspection 2018 Progress Update**
TO BE PRESENTED BY	Mike Hunter, Executive Medical Director
ACTION REQUIRED	Receive this report
OUTCOME	To inform the Board of Directors of the progress to date following the well-led inspection in May to July 2018 and associated actions the Trust will take.
TIMETABLE FOR DECISION	Discussed at the Board of Directors in October, Quality Assurance Committee in November 2018 and Board of Directors in December 2018.
LINKS TO OTHER KEY REPORTS / DECISIONS	Reports to the Executive Director Group (EDG) and Quality Assurance Committee (QAC)
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	Quality & Safety 1.1 Effective quality assurance and improvement will underpin all we do. A101i Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance). Health and Social Care Act 2008 (Regulated Activities) Care Quality Commission's Fundamental Standards Care Quality Commission's Enforcement Policy Mental Health Act 1983
IMPLICATIONS FOR SERVICE DELIVERY AND FINANCIAL IMPACT	Deficits in Care Standards impact upon the quality and experience of care for service users. Failure to comply with CQC Regulatory Standards could affect the Trust's registration, negatively affect care delivery and require additional funding to address.
CONSIDERATION OF LEGAL ISSUES	Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) could leave the Trust at risk of enforcement action by the CQC, with a potential financial and reputational impact.

Author of Report	Tania Baxter / Julie Walton / Anita Winter
Designation	Head of Clinical Governance / Head of Care Standards / Associate Director of Patient Safety
Date of Report	27 November 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: 12 December 2018

Subject: Care Quality Commission – Well-led Inspection 2018 Progress Update

Presented by: Mike Hunter, Executive Medical Director

Author: Tania Baxter, Head of Clinical Governance
Julie Walton, Head of Care Standards
Anita Winter, Associate Director of Patient Safety

1 Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
		✓			

2 Summary

This report is provided to the Board of Directors, following the detailed discussion at the Quality Assurance Committee in November 2018 and seeks to provide necessary assurances regarding its oversight of the Trust's response to the CQC inspection.

The Trust received the final reports following the CQC's well-led inspection on 30th September, with these being published by the CQC on 5th October 2018. The new style reporting process comprises of one inspection report, with summaries of the overall findings at Trust and service level with an accompanying evidence table. The report findings have previously been discussed at the Board of Directors, Quality Assurance Committee and Council of Governors meetings.

This report aims to summarise the findings and define the 'themes' around the areas identified as requiring actions to be taken to improve practice.

Requirement Notices

The Trust received 20 requirements (must do's) relating to four Requirement Notices for breaches in Regulation 12 (Safe Care and Treatment), Regulation 15 (Premises and equipment), Regulation 17 (Good Governance) and Regulation 18 (Staffing).

The requirements (must do's) were given as overleaf:

Core Service	No. of Requirements
Trust-wide	3
Acute Wards of Working Age & Psychiatric Intensive Care Unit	6
Long-stay Rehabilitation Wards	1
Forensic (Low Secure) Services	3
Acute Wards for Older Adults with Mental Health Problems	2
Wards for People with Learning Disabilities and Autism	3
Mental Health Crisis Services and Health Based Place of Safe	2

In addition to the 'must do's' 39 'should do's' were also highlighted as part of this inspection. The 'should do' action plans are for internal approval, overseen by the Quality Assurance Committee. The Committee will receive the 'should do' action plans at their December 2018 meeting.

Each of the 'must do' requirements and the 'should do' recommendations have an associated action plan that has been formulated by the staff delivering the services and those responsible from a corporate perspective. The plans went through a quality assurance process, which was a coordinated approach and undertaken in partnership across operational and corporate services. This comprised:

- Service level formulation of plans, ensuring these were SMART, checked and approved at local level
- A quality assurance check and approval by senior clinical operations directors/managers
- A quality assurance check by the task and finish group
- Subject to scrutiny and approval by the Executive Directors Group

The actions to address both the 'must dos' and the 'should dos' are being monitored through a 'master action plan', creating a central contemporaneous record of progress.

Themes

In the tables below are the 'themes' identified through the requirements and areas for improvement recommended by the CQC within this inspection.

Trust Level Actions:

	'Must do'
1	The Trust must ensure that effective systems and processes are in place to monitor and manage staff access to clinical supervision.
2	The Trust must ensure that its telephone systems are fit for purpose and ensure there is a system in place to monitor the volume of calls to the single point of access.
3	The trust must ensure that policies are reviewed and updated to reflect current national guidance and best practice.
	'Should do'
4	The trust should continue to monitor and review the impact of the reconfiguration of community services, including the waiting times for patients accessing the single point of access.
5	The trust should continue to consider and monitor the impact of the implementation of the digital integrated mental health care programme on operational staff to prevent future risks to the organisation.
6	The trust should ensure that that learning from incidents is shared with staff across all services.
7	The trust should ensure that the accessible information standard is fully implemented.

Service Level Action Themes:

	Themed 'Must do'	
1	Staffing:	- Staffing levels – including physical intervention trained - Induction - Supervision - Mandatory training - Staff sickness
2	Environment :	- Risk assessments to include blind spots - Nurse call alarms - Seclusion (Forest Lodge) - Telephone system
3	Physical Health:	- Health monitoring related to prescribed medication - Medical reviews (MHA) during seclusion - Health monitoring following administration of rapid tranquillisation
4	Medication	- Medicine management and storage
5	Emergency equipment	- Access and checking
6	Policies	- Dissemination, review and timely implementation
7	Incidents	- Lessons learnt
8	Mental Health Act Assessments	

	Themed 'Should do'	
1	Environment	- 'Green room' function - Nurse call alarm - Access to spiritual/prayer facilities - Safety of a garden path
2	Smoke free environment	
3	Care plans and risk assessment	- Accuracy, involvement/collaboration and review
4	Communication with carers, including how to complain	
5	Clinical supervision	
6	Governance processes	- Use of data, monitoring staff assaults, cancelled leave, staff shortages, recording and monitoring waiting lists

The Quality Assurance Committee received a presentation at their November 2018 meeting which summarised the areas above and provided an update on progress up to the end of October 2018. Within the 20 requirements (must do) 81 actions were identified, of which 23 (28%) had been completed as at 31 October 2018. Some examples of these are given below:

- Installation of dashboard for telephony monitoring at SPA and substance misuse services
- Development of Insight care records to capture the date and time of MHA referrals, assessments and outcomes
- Reference to visits by children policy included within safeguarding training
- Weekly audits of the physical health monitoring form (Forest Close)
- Backlog of incidents awaiting review at ATS now cleared

The remaining actions are in progress, expected to meet their timescales and are being monitored through the governance processes.

The Committee received a summary of the key priority areas which were outlined as acuity levels, staffing, policies and procedures, environment/infrastructure and acute and community crisis care, ensuring patient safety was at the forefront. An update on the work undertaken within SPA was highlighted, as this was the area rated as inadequate in the inspection. Work has been undertaken, both with the service itself and the senior operational managers, working with the Executive Directors. This has shown a real willingness to engage at all levels and regular follow-up sessions with staff and the leadership team are planned.

The Committee also received assurance that following inspection, the Trust is in the process of reviewing a number of key documents to ensure that priorities remain aligned with the findings from the inspection.

These are:

- Business Plan, including annual plan refresh
- Quality Improvement and Assurance Strategy
- Quality Objectives
- Board Assurance Framework
- Corporate Risk Register

CQC Monitoring of SHSC

The CQC is varying the way it engages with providers with an emphasis on regularly updating intelligence on each organisation to monitor potential changes to quality and support regulatory decision making. In order to achieve this, the CQC has introduced an intelligence tool called 'Insight', which they will use to decide what, where and when to inspect. CQC Insight brings together quantitative information, data and analysis of inpatient and community services, as well as Trust wide data. The data is captured using a number of national data sources that Trusts already routinely provide, along with other information submitted to or collected by the CQC. In addition to providing data profiles of the Trust, the tool allows for comparisons with peers and illustrates changes over time. The tool is produced every 2 months and contains information on:

- Contextual information
- Ratings
- Comparative risk based analysis for services (captures changes in performance)
- Analysis over time

The Insight tool is intended to assist Trusts to strengthen governance through sharing a range of data submitted to national data sources in one report. It should be noted that the CQC's 'Insight' tool is different to the Trust's patient information system - Insight.

The intelligence gained from the Insight tool will be used as one of sources to inform the discussion topics for the regular engagement meetings that are held with the CQC. The first engagement meeting to discuss the Trust's latest Insight report is 20 December 2018.

As this is a useful source of information for the Trust and will be a valuable addition to the Trust's governance and assurance processes; work is taking place on what would be the most useful form of reporting to the Executive Directors Group (EDG), Quality Assurance Committee (QAC) and the Board of Directors (the Board), for example through regular summary reports or exception reporting.

In addition to the regular formal and informal engagement meetings with the Trust, the CQC will also be increasing its contact with the Trust with more regular observations of meetings and holding focus groups with staff throughout the year.

3 Next Steps

Within the presentation to the Quality Assurance Committee, a process for providing regular assurance was shared, covering Clinical Operations Governance meetings, Senior Clinical Operations, Performance and Governance meetings, the Executive Directors Group and the Quality Assurance Committee.

4 Required Actions

The Board of Directors is asked to:

- Receive this report;
- Discuss the suggested assurance route for the oversight of CQC action plans, through the Quality Assurance Committee;
- Discuss the inclusion and use of the intelligence data with the CQC's Insight tool within these reports.

5 Monitoring Arrangements

The action plans will be monitored through:

- Clinical Operations Governance meetings
- Senior Clinical Operations, Performance and Governance meetings
- Executive Directors Group
- Quality Assurance Committee

6 Contact Details

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