NHS
The Shrewsbury and Telford Hospital NHS Trust

Paper 15

Recommendation ☑ **NOTE**	The Trust Board is asked to note the Trust CQC 2018 Safest and Kindest Quality Improvement Plan update
Reporting to:	**Trust Board**
Date	30 August 2018
Paper Title	Trust CQC 2018 Safest and Kindest Quality Improvement Plan update
Brief Description	This appraisal identifies the progress made against the Trust's Quality and Safety Improvement Plan: Safest and Kindness since the last quarterly update in April 2018. It provides an overview of the themes across the Care Groups and categorises the frequency in terms of the prevalence of themes. CQC Insight is detailed in a separate paper. **Key points to note on Trust overarching CQC action plan:** Strengths: 1. **Mortuary** - Overall works in Mortuary area, including revised cleaning schedules, have improved environment significantly, including the reduction in the risk of infections. 2. **Incidents/Complaints** – Revised and strengthened governance and processes in place for reporting, reviewing and learning from incidents. 3. **EoLC –** Swan rooms, EoLC training now included at induction 4. **WHO checklist –** Revised and implemented into theatre documentation 5. **Appraisals –** Annual appraisal – improved compliance 6. **Quality boards –** Updated boards rolled out across all areas to include dashboard, RaTE and patient experience data. Exemplar programme demonstrates improved and sustained improvement in areas implemented. Weaknesses: 1. **MCA/DoL's –** The roll-out training programme is not due to be completed until August 2019 2. **Patient records –** Lockable notes trollies not in all areas, procurement underway 3. **Fluid balance –** Audit figures show low compliance, action plan in place 4. **Medicines management –** General audit compliance hasn't improved. Rolling audits, brilliant basics, and Exemplar in place 5. **Staffing –** Reliance on Tier 5 and agency use ceased, improved bank usage and utilisation of existing staff. Substantial nursing vacancies remain in some areas. Risks: 1. **Medical workforce –** Care groups have undergone significant planning and alignment with recruitment but workforce vacancies remain a risk in particular areas (i.e. ED), and usage of locums remains high. 2. **ED –** Delivery of DoH's target of discharging/admitted or transferring 95% of patients within 4 hours 3. **Stroke –** Achieving the requirement of receiving CT scans within 1 hour of arrival – access to scanner. Risk to delivery due to frequent CT scanner downtime at PRH. On risk register. 4. **Boarding/Patient Flow**
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Angela Hughes: Quality Assurance Lead Debra Holland: Information Analyst and Assurance Co-ordinator

Recommended / escalated by	To evaluate the effectiveness and the progression of the Quality Improvement Safety Plan "Safest and Kindest Every Day Plan".
Previously considered by	This paper has been through the Quality and Safety Committee for ratification
Link to strategic objectives	**Strategic Objectives 2017/18** SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce
Link to Board Assurance Framework	**BAF Risks** If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561) If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951) If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134) If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204) If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185) If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186) If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668) If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment (RR 670) If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (RR1187) If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423) Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts

Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Trust CQC 2018 Safest and Kindest

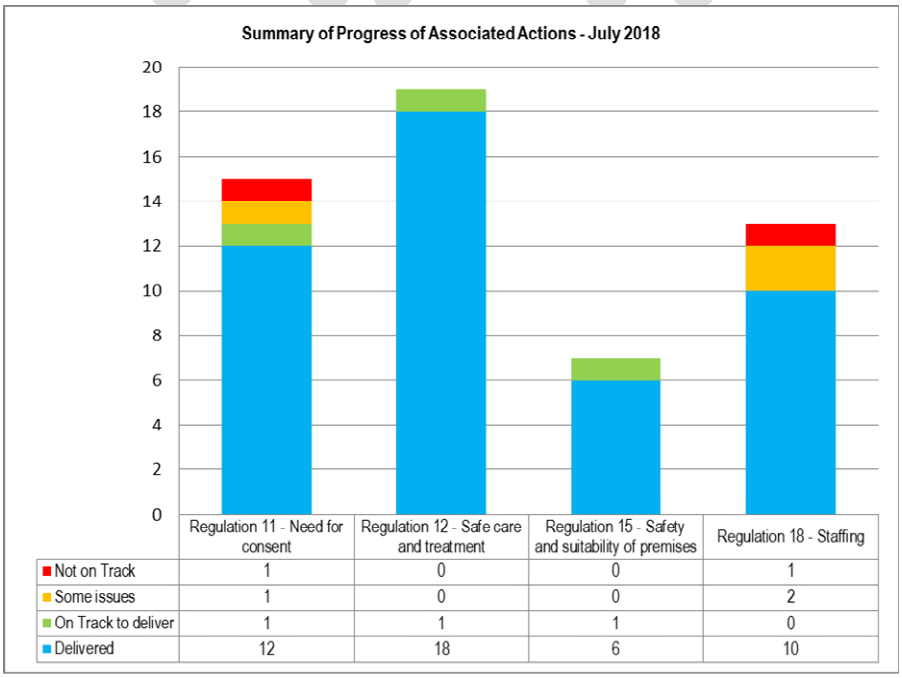
Quality Improvement Plan Update

Contents

Core Updates

'Safest and Kindest Quality Improvement Plan' brings together an update on fundamental action plans throughout all of the Trusts core services. This quarterly update provides information on its progression and the Trusts' collective assurance.

1.0 CQC Trust Regulations within overarching Action Plan



	Regulation 11 - Need for consent	Regulation 12 - Safe care and treatment	Regulation 15 - Safety and suitability of premises	Regulation 18 - Staffing
Not on Track	1	0	0	1
Some issues	1	0	0	2
On Track to deliver	1	1	1	0
Delivered	12	18	6	10

Summary Overview – July 2018
Regulation 11 – Need for consent (when a person who used services lacked capacity to make an informed decision, staff did not always act in accordance with the requirements of the Mental Capacity Act 2005)
Action: Documentation on defined ceiling of treatment decisions/nurses understanding inconsistent (audit results from DCT AND_Audit show little improvement) – update requested from Resus Team on Audit on action plan to address – outstanding and results remain poor. The action highlighted **Some Issues**, relates to EoLC/palliative care arranging Hospital @ Night team to design and implement an out of hours training pack (around consent/ceiling of care/management and options) – e-training package being implemented in July, once finalised for use (on Swan Scheme, and EoL and symptom management). One Minute Brief planned once Hospice out of hours contract details clarified, but planned for July. Action **Not on Track** concerning auditing of Mental Capacity act and audit/use in ward areas has not been consistent. Awaiting action plan to address this. (Audit results show inconsistent performance). Audit issues appear to be around completion of MCA forms. Copy of audit requested for assurance/evidence.
Regulation 12 – Safe care and treatment (staff did not always assess the risks of people in good time and in response to changing needs; learning from incidents was not always shared and promoted within and between service specialities and across the trust; medicines were not always managed safely)
Delivered
Regulation 15 – Safety & suitability of premises (people who use the services and others were not protected against the risk associated with unsafe or unsuitable premises because of inadequate maintenance)
Delivered
Regulation 18 – Staffing (there was not always sufficient numbers of suitable staff deployed to meet the care and treatment needs of patients)
Delivered 5/7 **Action with Some Issues:** Cease reliance on off framework agency nurses and strengthen bank and substantive utilisation: **Update:** 1st July was cut-off to cease using HCA agency staff. HJ to share contingency plans. **Not on Track: Reduction of locum use for medics –** workshops commenced to agree timescales for recruitment plans. Awaiting confirmation of action plans. Overall spending on medical locums has increased with a projection that this will reduce with the new intake in August with the junior doctor being better filled.

1.1 Trust Overarching Action Plan Progress

Fig 1 March vs May comparison 2018 – overall comparison on Trust Action Plan – status against action type (detail provided regarding actions which have exceeded deadline)

Trust overarching CQC action plan		
Action Type	**Delivered in March 2018**	**Status in June 2018**
Total	**10**	**19**
Immediate Action	3	3
Must Do Action	5	12
Should Do Action	2	4
Action Type	**On Track to deliver in March 2018**	**Status in June 2018**
Total	**22**	**18**
Immediate Action	0	0
Must Do Action	10	6
Should Do Action	12	12

Action Type	Some Issues update in March 2018	Status in June 2018
Total	**10**	**6**
Immediate Action	1	0
Must Do Action	6	5
Should Do Action	3	1
Action type	**Exceeded deadline March 2018**	**Status in June 2018**
Total	**4**	**3**
Immediate Action	0	1
Must Do Action	4	2
Should Do Action	0	0

Previous red actions in March – now compliant

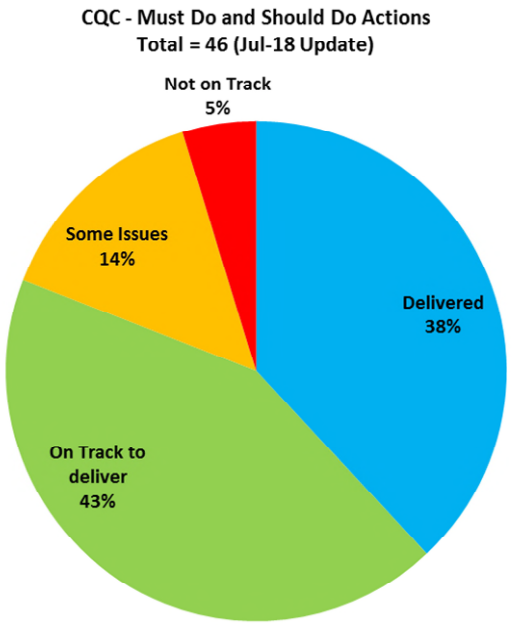
- Accurate monitoring of the maternity escalation policy
- Purchase of a washer disinfector – HSE guidance although not yet functional, installation is scheduled once the supporting utilities are upgraded (timescale has been requested but not supplied at time of writing)

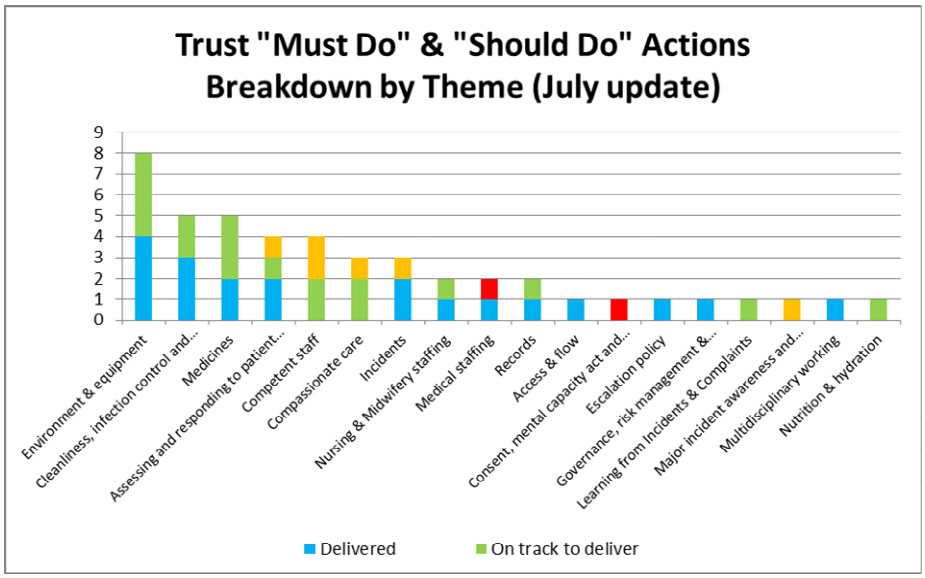
Trust Action Plan – Not on Track Action – Exceeded Target

- IA001R Reduction of medical locums – update provided in regulation section
- MD005 Mental Capacity Act – training – update provided in regulation section

No.	Actions	Deadline	Update	Moved?
MD020	Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment	Apr-18	Business Case in development to improve access to CT scanning in line with RCP/SSNAP 1 hour (from arrival) guidelines	no

Must Do and Should Do Actions – by Status %





Trust Must Do and Should Do Actions – Broken down by CQC Themes

2.0 Core Service Updates - Additional CQC actions and additional improvement actions from external reviews

Source of action plan	Total Actions	Delivered in March 2018	Status in June 2018	On Track to Deliver March 2018	Status June 2018	Some Issues update in June 2018	Status in June 2018	Exceeded deadline March 2018	Status in June 2018
	Total								
Emergency CQC	**36**	10	8	14	13	8	9	4	6
Medicine CQC	**14**	6	6	7	8	1	0	0	0
Stroke	**73**	30	33	21	18	19	22	3	0
Surgery CQC	**51**	27	38	10	2	14	11	0	0
WMQR	**37**	32	32	2	2	3	3	0	0
Critical Care CQC & critical care standards**	**37**	5	8	10	8	15	14	7	7
EoLC CQC	**22**	12	16	8	5	1	2	1	1
Paediatrics CQC and CIIC*	**120**	81	84	36	33	3	3	0	0
Maternity Sign Up to Safety*	**119**	108	111	5	5	6	3	0	0
Maternity & Gynae CQC	**71**	35	50	26	0	10	11	0	10

2.1 Details of Core Services Updates: Not on Track or Areas of concern, Actions Delivered

Emergency Department

4 hr target - Proportion of patients waiting longer than 4 hrs from DTA.
There are rolling admitted and non-admitted action plans in place with weekly Exec led Urgent Care meetings.

Consultant/management relationships (Care Group Action Plan)
Department meetings were not inclusive as some consultants objected to operations managers attending, whilst others believe it would improve relationships and understanding. Review of current process to take place at next meeting in July to see if things have improved with new COO and departure of personnel resistant to change.

Workforce: Consultant : junior doctor ratios
A number of initiatives are ongoing to try and address recruitment issues;

Escalation plans:
Internal ED escalation system had been under development (via ED board) – but has been removed from 2018/19 IT plan as part of IT prioritisation; It had been felt that frequent/daily escalation levels normalised actions and left ED under supported – new system was to highlight was actions should be happening depending on the escalation level of the department.

Mental Health (Wales)
Ongoing case conference calls in place for individual patients to ensure lessons learnt. Process and engagement underway to improve.

Actions Delivered:

- **Work has been completed on improving actions from audits in the department,**
- **Practice Development nurses has been in place on both sites with 8 newly quality starters commencing August onwards to deliver high quality, consistent care**
- **Quarterly ED patient experience audits carried out**
- **Fit2Sit process implemented, ambulance handover nurse and HALO role in place (at RSH)**

Medicine

- No "not on track" issues were raised through the Care Groups Action Plan, monthly meetings have been set-up between the care group and the Quality Assurance team to support the ongoing progress and maintenance of their action plans.

In progress:

- Resuscitation Trollies – improvements have been made in compliance against resus checklist/trolley audits. Ongoing monitoring to ensure embedded.

Actions Delivered:

- Improved visibility of Heads of Nursing and other senior leads at ward level
- Work on nasogastric tube (length and positioning) with training, engagement and audits completed.
- Oxygen prescribing – a SOP has been produced and supported by awareness training led by the clinicians and CNS team.

Stroke

Not on track:

Stroke Improvement Plan is out of date (a number of actions that are showing as "on track" or "amber" were in need of updating to reflect their current status or escalate if no update).

Surgery

On track

WMQR (Surgery)

On track

Critical Care

Engagement in identifying progress against their action plan has been difficult at times, and a number of issues (particularly associated wit therapy provision) are "not on track"

Not on Track:

Rehab needs of patients within 24hrs:

- This has been raised/escalated through the Carter Review meeting. A business case is needed for 7 day working (therapies), a staffing gap analysis required, an agreed SLA to meet Carter groups recommendations;

Discharge from ITU to general ward within 4hrs:

- More accurate recording required to monitor; in progress to amend Datix recording so can more accurately track/record.

ITU Care facilities should comply with national standards:

- Not likely to be compliant until Future Fit;

Some Issues

Availability of Intensive Care Consultant (in medicine) 24/7

- Consultant Recruitment: advert out for 2 x posts for cross site working.

Delivered

- Designated Clinical Director/leads have been appointed

EoLC

Not on Track

- End of Life care performance measurements were not part of the trusts dashboards – transformation team to develop dashboard - Rajinder Uppal assisting in escalating to progress forward.

Delivered

- Infection prevention training now part of mandatory training for Mortuary staff.
- Department now compliant with cleaning and IPC audits and level of cleanliness has improved significantly.
- Removed delays in obtaining out of hours death certificates/verification.
- EoL training now part of induction training
- Additional Swan rooms provided and a SOP in place to ensure appropriate use.

Paediatrics

On track

Maternity Sign up to Safety

The numbers are based on their improvement plan, which does not have target dates or status specifically attributed to each recommendation/improvement and therefore is difficult to RAG rate – action to broaden governance of plan.

Maternity:

Not on Track:

Training Elements:

- Mental capacity training figures - To be escalated at Maternity Governance
- Increase audit compliance – Bridgnorth Infection Prevention and Control Rate June 2018: 79% Delivery Suite 66% - To be escalated at Maternity Governance and with Bridgnorth Ward Manager - June 2018
- Mandatory Training figures are currently low – this includes: Gynae Adult Life Support training - June 2018: and Conflict Resolution
- Learning disability training - To be raised at Maternity Governance 2018 - for further action/implementation

Audit 5

- Telephone SOP Audit
- NEWS Audit to monitor compliance – commenced June 2018

In Progress

- Continuity of care during a womens pregnancy (named midwife) – increased numbers of midwives will improve one to one care ratio, and monitored through maternity dashboard.

Delivered

- Metric added to Dashboard and regular audits of Datix' raised of women arriving without notes
- Documentation improved to record all medicines administered during labour and all patients' observations.

3.0 CQC Quarterly Engagement Meetings

Details of the latest CQC Engagement Visit May / June 2018		
ED 16th May 2018		
ED Presentation 16th May	Assistant Chief Operating Officer Head of Nursing USCG Emergency Centre Manager	
Focus Groups 30th May	Cancelled due to site pressures	
7th June 2018		
Maternity Presentation and focus group 7th June 2018	Care Group Director HOM Quality Improvement & Governance Manager Clinical Director Assurance Co-ordinator Audit and Monitoring Officer Senior- HR Link Matron MLU and Community Matron Consultant Unit	
Pending CQC engagement visit		
Critical Care Services TBC	End of July 2018	New CQC Relationship Manager to confirm availability
Paediatrics services TBC	Early August 2018	New CQC Relationship Manager to confirm availability

4.0 Update on submission of the CQC PIR

Received CQC PIR 25th May 2018 with a submission date: Monday 18 June 2018. Trust met this deadline

CQC PIR update – 88 data requests and 49 document requests equating to 145 individual documents

CQC Insight - now in separate document for the Quality and Safety Committee.