United Lincolnshire Hospitals NHS Trust

Report of the Care Quality Commission

May 2017

1. Purpose

1.1 The purpose of this report is to formally confirm the findings of the Care Quality Commission (CQC) following its inspection in October 2016; and to update the Board on actions to respond to those findings.

2. Background

2.1 In October 2016 the CQC undertook a focussed inspection at Lincoln County Hospital, Pilgrim Hospital and Grantham Hospital (for A&E only); followed by an unannounced inspection in December 2016 at Pilgrim Hospital. Louth Hospital was not inspected.

2.2 Following their inspection in October 2016 the CQC raised some immediate patient safety concerns about major incident arrangements ligature risks, use of rapid tranquillisation, care of patients with tracheostomies and non-invasive ventilation, Sepsis management and GI bleed management. The Trust put in place an initial plan to respond to these concerns.

2.3 The CQC published their report on 18 April 2017 and NHS Improvement (NHSI) accepted a recommendation that the Trust be placed into Special Measures.

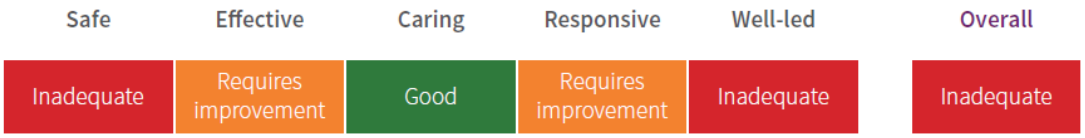
2.4 On 19th April 2017 a risk summit, co-chaired by the NHSI Medical Director and the Regional Chief Nurse for NHS England (Midlands and East). This meeting was attended by the CQC, NHSI, NHSE, CCGs, the Nursing and Midwifery Council, GMC, Health Education England and Public Health England. The meeting took on board perspectives from all bodies represented and reflected upon the Trust initial and planned response to CQC findings. It was agreed that progress had been made in some of the areas highlighted by the CQC and a number of further actions were agreed. A further meeting to review progress has been established for 5 June 2017.

3. CQC Findings

The detailed CQC reports can be access by using the following link

http://www.cqc.org.uk/provider/RWD/reports

3.2 Overall the Trust was rated as inadequate



3.3 This reflects the ratings of the individual sites as follows

	Safe	Effective	Caring	Responsive	Well Led	Overall
Lincoln County	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Pilgrim Hospital	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Grantham (ED only)	Requires Improvement	Good	Good	Good	Good	Good

3.4 The key concerns highlighted by the CQC related to:

- Governance, including serious incident management and learning from these;
- Medicines Management;
- Failure to meet national access standards for A&E, Cancer and Referral to treatment;
- Identifying vulnerable adults and responding to their care needs;
- Staff morale and managerial supervision;
- Board level oversight.

4. <u>Our immediate actions</u>

4.1 In response to the initial CQC concerns, significant progress has already been made:

Concern	**Progress**
Major Incident arrangements	All equipment in date and regularly checked Major incident plans up-to-date in A&E and training in place New CBRN storage facility
Self Harm	Ligature risk assessments carried out in all A&E departments and Paediatrics. Results acted upon with removal of hooks and ligature cutters now available on all ward areas Over 100 A&E staff completed training on the management of patients with regard to self harm Self harm and ligature risk audit demonstrated a good understanding of mental health issues and self-harm. All staff knew where ligature cutters were kept.

Mental Health	Mental Health Policy approved and training on-going. Currently piloting new Mental Health Triage Assessment form in A&E Lincoln
GI Bleed	Out of Hours policy in place and audit in progress. Additional Medical Director support from NHS I in place from May to support development of permanent Pilgrim GI Bleed rota
Rapid tranquilisation of patients	Management of BPSD and Delirium Policy relaunched Lorazepam audit undertaken Chemical restraint policy will be ratified by CESC in May
Tracheostomy and Non-Invasive Ventilation	100% of Registered Nurses trained on designated wards with evidence of appropriately trained staff on all shifts for designated wards available from ward rotas and e-roster (from April)
SEPSIS Compliance	Commencement of Sepsis Screening - INCREASED from 69% to 91% Admin of IV antibiotics within 1 hour - INCREASED from 39% to 72% Sepsis e-Bundle roll out (SQD audits 50% of patients once per month e-bundle will identify100% of patients with NEWS over 5 every day)

4.2 In addition to the above progress has also been made on the following:

Concern	Progress
Organisational Culture and Development	Launched Task and Finish Group with Staff Side Leadership Forum in place Leadership Charter Launched leadership programme Freedom to Speak Guardian relaunched and Voicing Concerns Policy refreshed Staff conversations in partnership with Staff Side and Non Execs Core Learning increased by 5% to 90% compliance
Board Oversight	Board Development Sessions External review for Well Led to be completed by November Fit and Proper persons requirements completed Fit and Proper persons policy approved

Access Targets	Trajectories in place Reduction in number of long waiters Increased diagnostic capacity for cancer pathways RCA process for 62 day cancer breaches in place Invested in level 1 beds to reduce cancellations
Urgent Care	Relocating Ambulatory Care Unit, co-located with short stay Rapid Assessment and Treatment area in place Expansion of minors capacity Trialled speciality led pathway model

5. Our future Quality and Safety priority areas

5.1 As reported and discussed at the Trust Board meeting in April 2017 our 2021 programme proposes five major priorities for improvement which will, in the medium term, make significant progress towards meeting our strategic ambitions.

5.2 At the centre of our improvement programme is the Quality and Safety Improvement programme. We have identified 17 priority areas which will

- Respond to the CQC concerns and recommendation ensuring that the 'must do' actions and requirement notices are addressed; and
- Deliver sustainable change in order to improve quality and safety and reduce variation and patient harm.

5.3 The 17 priorities are as follows, and they incorporate a continued focus on the immediate actions already implemented.

Project No	Project Name	Scope
QSIP01	Developing the safety culture	Culmination of a number of pieces of work including: learning lessons, freedom to speak up, customer care training
QSIP02	Clinical governance	External review to inform the development of an action plan to strengthen governance across the organisation. Clearing the backlog of existing SIs.
QSIP03	Sepsis	Immediate actions taken which will be developed and sustained across the trust

QSIP04	GI bleed service	Immediate actions taken to manage the risk. Further work to establish a sustainable 24/7 GI bleed rota across the trust
QSIP05	Airway management	Immediate actions taken to address concerns at PHB. These will be rolled out and embedded across the trust
QSIP06	Mental Health Assessment	Immediate actions taken to manage the risks. Further education, training and development in other clinical areas across the trust
QSIP07	Safeguarding	Delivering the plan developed following an external review. Including strategy development, policy review, compliance monitoring and education, training and development
QSIP08	Medicines management	Focus on omitted doses, medicines reconciliation , CD audits and quality of prescribing
QSIP09	Training and competencies	Clarity about core learning and core learning plus for categories of staff following a training needs analysis. ESR reporting on compliance and training rates.
QSIP10	Appraisal and supervision	Development of a positive performance management framework to enhance the appraisal process.
QSIP11	Outpatients	Utilisation of clinic space, clinical review/validation of patient referrals and follow ups, reducing backlogs, resolving environmental issues and finalising leadership and new ways of working
QSIP12	Control of Infection	Implement and embed the agreed IPC action plan and minimising lapses in care, reducing blood culture contamination rate and housekeeping review
QSIP13	Reducing variation in practice in clinical areas	This will contain a number of specific work areas including: DKA and diabetic care, pain assessment / management and hospital at night/deteriorating patient

QSIP14	Clinical staffing	Covers both nursing and medical staffing drawing in existing plans/groups
QSIP15	Medical engagement	Repeat of the Medical Engagement Scale and development of associated plan
QSIP16	Strengthening support for Pilgrim	This is wide-ranging and includes: Establishing a dedicated transformation team, providing support for matrons to embed new ways of working and establishing a ward accreditation framework
QSIP17	Estates and environment	Prioritised estates and environment programme of works

5.4 Detailed project plans, milestones and outcomes are being finalised for each of the 17 projects. These will form the basis from which the Trust Board can draw assurance through summary progress updates to the Trust Board; detailed oversight by the Quality Governance Committee and upward escalation of concerns to the Trust Board. The final improvement plan will need to be approved by NHS Improvement and will be submitted by the end of May.

6. Recommendation

6.1 The Trust Board is asked to formally note the CQC reports, actions taken to date and to approve the Quality and Safety Improvement programme.

Jan Sobieraj
Chief Executive