SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Council of Governors	Date of meeting 21st July 2015

Subject	CQC Action Plan
Prepared by	Emma Carter, Trust Governance Manager Ruth James, Director of Quality
Approved by	Ruth James, Director of Quality
Presented by	Ruth James, Director of Quality
Name of meeting considered/approved by	Board of Directors

Purpose: To provide the Council of Governors with the CQC action plan for information.		
	Decision	
	Approval	
	Information	●
	Assurance	

Executive Summary

The CQC action plan summarises the actions we intend to take in response to the Requirement Notices in the CQC report. The action plan was submitted to the CQC at the start of July.

Engagement meetings with the CQC to review the plan and agree timescales will commence in August

A detailed action plan covering all of the areas for action has been developed and was reviewed at the Quality Assurance Committee on the 8th of July 2015.

Each clinical centre have been provided with a centre-specific version of the action plan, this will be reviewed at the performance reviews at the end of July.

Next Steps

Through the engagement meetings with the CQC the Trust will agree the timescale for a focussed re-inspection.

Supports Trust Strategy Map in the following areas

quality & patient safety		**business sustainability**		**operational excellence**		**organisational capability**	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	●
service quality and safety	●	enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below

Report on actions you plan to take

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Account number	SPL1-1590488094
Our reference	RTR
Location ID	
Trust name	South Tees Hospitals NHS Foundation Trust

(For regulations requiring actions: Require one page per regulation)

Regulated activity(ies)	**Regulation**
Treatment of disease, disorder or injury	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	How the regulation was not being met:
	1) Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored. 2) Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department. 3) Ensure that areas containing chemicals hazardous to health are properly secured and at Lambert Memorial hospital in accordance with legislative requirements. 4) Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications, that all controlled drugs are appropriately checked particularly on CCU and that medication omissions are monitored, investigated and reported in line with trust policy 5) Review the quality monitoring arrangements within the urgent care centres including patient outcomes and the provision of pain relief to ensure that there are no unnecessary delays when treating patients. 6) Ensure that evidence-based guidance is available for staff working in urgent care centres and that policies are appropriately reviewed and up to date. 7) Ensure that staff follow the escalation policy when a patient's condition deteriorates.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
1) Resuscitation equipment checks: Centres have reviewed the areas highlighted and ensured that there are robust systems in place. All wards and departments have been made aware of the importance of daily checks. Weekly spot-checks have been implemented in centres. This will be monitored through monthly inspections by the	

clinical matrons.

2) Patients information in outpatients:
Centrally produced leaflets will be monitored by the Public Relations Team, speciality specific leaflets will be monitored by centre governance leads

3) Secure storage of chemicals:
This issue related to cleaning chemicals which were not locked away at one of the primary care hospitals, action was taken immediately during the inspection, a process is in place to ensure continued compliance

4) Medicines – reporting medicines omissions, medicine reconciliation, controlled drugs checks:

- Meetings have taken place to agree high risk medicines; the trust will implement a Golden Rule approach to reporting near misses and actual incidents around theses medicines. A paper will be presented to the Patient Safety Sub-Group in July to agree the proposed list.
- Review the medicines audit programme with the view to using the safety thermometer audit tool focussing on medicines omissions.
- An RPIW on the admissions units has improved the process of medicines reconciliation, the feasibility of rolling this out to other direct admission wards is being considered. A business case is to be developed for additional pharmacists in ward areas outside of office hours. Audit shows that 60% of services have pharmacist reconciliation of drugs within 24 hours. To discuss with the CQC the improvement trajectory through the engagement meetings.
- CCU has reviewed its process and checks are now being completed appropriately. The results of the quarterly controlled drugs audit will be discussed at the Director of Nursing clinical standards meetings with follow up of action plans and appropriate escalation to medical director.

These standards are now included in the STACQ (ward accreditation) assessment and the possibility of including a pharmacist in this process is being explored.

5) Quality Monitoring Arrangement in Urgent care Centre
The urgent care centre has developed a clinical audit plan that is included in the 2015/16 clinical audit plan for the centre. The requirement for provision of pain relief related to patients requiring transfer of care to the main A&E department. The pain medication available in the urgent care centre is appropriate for an urgent care setting. It has been observed that patients waiting for transfer to the acute hospital may require high level of pain relief. A PGD for Oramorph has been developed and will be signed off by the end of June 15. This will ensure that adequate pain relief can be given to more complex cases.

6) Availability of urgent care policies
All policies and procedure including those relevant to the urgent care centre are available to staff through the trusts intranet. All policies and procedural documents will be reviewed and updated where necessary by end of July15.

7) Escalation of deterioration
The current policy for the management of the deteriorating patient does not adequately describe the process for patients in community hospital. When the EWS for a patient in the community hospital escalates in-house nurse practitioners respond and review patients, out of hours an ambulance is called. The policy will be amended and further staff training has been arranged with the critical care educator.

Who is responsible for the action?	Ruth Holt

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Ward standards are checked each month by the clinical matrons and a number of wards go through

the STACQ ward accreditation programme. These processes will be amended to ensure all requirements relating ward process are checked each month. Quality dashboards are produced at ward and centre level. Issues are reviewed and actions agreed through the Director of Nursing clinical standards meeting. Actions to address other requirements will be monitored through regular reporting to the Quality Assurance Committee which reports to the Board.	
Who is responsible?	Ruth James
What resources (if any) are needed to implement the change(s) and are these resources available?	
Additional pharmacists may be required, this is dependent of the review of the feasibility of rolling out the actions agreed at the RPIW to other wards	
Date actions will be completed:	August 2015 Except for medicines reconciliation – agreement of preferred approach by September 15, further timescale is dependent on the course of action

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to quality of services for patients is low, on-going monitoring will identify areas of increased risk and remedial action will be taken.

Completed by: (please print name(s) in full)	Ruth James
Position(s):	Director of Quality
Date:	24th June 2015

Report on actions you plan to take

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Treatment of disease, disorder or injury	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	How the regulation was not being met:
	1) Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained. 2) Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life. 3) Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1)Training and appraisal:

The Board have approved a revised approach to mandatory training which will improve the accessibility of training through an on line portal which will identify and link to role-specific training with an increasing proportion of training available through an e-learning approach. Current compliance is 75%, improvement targets have been set as 80% for December and 90% by March 2016.

In relation to safeguarding and mental capacity act training the recent CQC CLAS inspection team reviewed the safeguarding training action plan and was satisfied it is robust. A video for safeguarding adults training is under production for roll out September. If successful we will take same approach with children's L1 training.

Appraisal rates are currently 68%, each centre will produce an action plan which will ensure that by the end of September 100% of staff at work have had an appraisal.

2) Training in the use of syringe drivers:

An additional palliative care nurse has been approved, recruitment has commenced. The duties of this post will include providing assurance of appropriate use and monitoring of syringe drivers through

spot-checks and education. In addition ward managers will be responsible for undertaking checks to ensure that all documentation is completed for all patients on McKinley syringe drivers. This will be monitored though 6 monthly audits. 3) Assessment of nutrition and hydration needs at end of life New documentation was introduced in January 2015 for both nurses and doctors with specific sections to record this assessment and actions. The Director of Quality, Lead Nurse for End of Life Care & Bereavement and Head of Nursing (Safeguarding) will attend directorate meetings in key areas to ensure staff are aware of their responsibilities and there is clear ownership and accountability. Improvement will be monitored through existing quarterly end of life care audits. The South Tees Keys communication approach will be used to cascade communication about the importance of documentation and to advertise the available training (2 sessions per month).

Who is responsible for the action?	Siobhan McArdle (training and appraisal) Richard Wight (end of life care)

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?
Training and appraisal compliance reports End of life care audits Monitoring of this action plan will be through the Quality Assurance Committee which reports to Board

Who is responsible?	Ruth James, Director of Quality

What resources (if any) are needed to implement the change(s) and are these resources available?
Additional band 6 palliative care nurse – post approved, recruitment commenced

Date actions will be completed:	Appraisal - October 2015 Mandatory training - March 2016 End of life care - November 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to quality of services for patients is low, on-going monitoring will identify areas of increased risk and remedial action will be taken.

Completed by: (please print name(s) in full)	Ruth James
Position(s):	Director of Quality
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Treatment of disease, disorder or injury	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	How the regulation was not being met:
	1) Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department. 2) Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance. 3)Review arrangements and improve arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance. 4) Ensure that patient records are accurate and complete, particularly fluid balance records, venous thromboembolism (VTE or blood clot) assessments and malnutrition universal screening tool (MUST) scores.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
1) Paediatric environment in A&E: Eye casualty has been moved to create childrens' area within the A&E dept., work is on-going to decorate and refurbish this area to make it child-friendly. Longer term the proposed Urgent Care Centre at JCUH provides an opportunity to develop a paediatric A&E. Risk assessments are now available to all staff. 2) & 3) DNA CPR and Mental Capacity Act: The trust conducted an audit in January 2015 following the CQC inspection to clarify the current position. From this a comprehensive action plan has been developed to improve the recording of discussions and mental capacity assessments. This includes an education programme covering the findings from the inspection such as ensuring that mental capacity assessments are filed with the	

DNACPR. The medical director is launching the initiative - '5 core things' that have to be done by consultant staff, in August 2015; the correct completion of DNACPR will be one of these. Ward managers and other staff will be reminded of their duty to promote good practice, check and challenge omissions in documentation – this will be discussed at the leadership away day in July 2015. Review of end of life care and associated documentation to be included in Centres/directorates their mortality reviews. The governance leads in each centre to have this as a fixed agenda item in governance meetings ('end of life care issues'). Completeness and quality of the end of life care bundle documentation will be monitored through the existing weekly mortality reviews, all staff be encouraged to challenge any forms that have not been correctly completed. 4) Patient records This requirement was based on the inspection of the records of community inpatients. In response all registered nurses in integrated medical care centre to undertake a documentation competency assessment, the target date for completion is August 2015. This will be monitored through monthly audits by clinical matrons using the STAQ ward accreditation tool.

Who is responsible for the action?	Richard Wight - end of life care Ruth Holt – nursing documentation
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Completeness and quality of the end of life care bundle documentation will be monitored through the existing weekly mortality reviews. Record keeping will be monitored through monthly audits by clinical matrons using the STAQ ward accreditation tool. Progress with the CQC action plan will be monitored by the Quality Assurance Committee which reports through to Board.	
Who is responsible?	Ruth James
What resources (if any) are needed to implement the change(s) and are these resources available?	
Actions planned within existing resources.	
Date actions will be completed:	October 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Risk to quality of services for patients is low, on-going monitoring will identify areas of increased risk and remedial action will be taken.

Completed by: (please print name(s) in full)	Ruth James
Position(s):	Director of Quality
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Treatment of disease, disorder or injury	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
	How the regulation was not being met:
	Ensure that there are sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, surgical wards and Children's wards, particularly the paediatric intensive care unit (PICU).

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Paediatric inpatient wards
We are not compliant with RCN guidance, we plan to undertake an analysis using the Safer Nursing Care Tool (SNCT) for children when it's published (this is imminent). Results will be presented to the Board of Directors for consideration. As with all areas we monitor monthly staffing fill rate and have escalation processes if increased resource is required.

A&E
The business case has been approved for additional Emergency Nurse Practitioners and consultant cover.

Medical Wards
We had already made progress in relation to night nursing numbers (as per comments in draft report). Roster templates have been changed to 3 RN's in the wards mentioned we are utilising safety crosses to monitor progress. Monthly fill rate is monitored and discussed at the clinical standards meetings. Need to acknowledge the RN supply: demand gap and that if we are unable to source additional RN's we do utilise unregistered staff to support. The band 4 role is being expanded to support the current gap in band 5 staff.

The last SNCT audit (data from 2 Feb – 1 March) showed the average actual RN: patient ratios overnight were:

- Ward 2 1:13
- Ward 3 1:10.4
- Ward 10 1:13.5

- Ward 12 1:13.3

S**urgical Wards**
Surgical wards are consistent with the rest of the organisation and use a combination of NHSP and overtime to cover staff shortages

General

We continue with a proactive approach to Registered Nurse recruitment including Return to Practice and international recruitment. We continue to undertake establishment reviews in line with national recommendation and act on results. The organisation continue to monitor the monthly fill rate

Who is responsible for the action?	Ruth Holt

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

Monthly staffing fill rate report and the quarterly SNCT review discussed at Director of Nursing Clinical standards meetings and reported to Board

Progress with the CQC action plan will be monitored by the Quality Assurance Committee which reports through to Board.

Who is responsible?	Ruth Holt

What resources (if any) are needed to implement the change(s) and are these resources available?

Additional resources for paediatric nursing will be considered following the review.

A&E nursing resources are agreed

Other nursing vacancies are within funded establishments

Date actions will be completed:	On-going (to be further discussed at CQC engagement meeting)

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Escalation processes are in place to ensure that safe staffing levels are maintained through closing beds where necessary.

Completed by: (please print name(s) in full)	Ruth James
Position(s):	Director Quality

Date:	24th June 2015