South Tyneside and Sunderland
NHS Foundation Trust

# SUNDERLAND HEALTH AND WELLBEING SCRUTINY COMMITTEE

# FEBRUARY 2024

# STSFT CARE QUALITY COMMISSION (CQC) ACTION PLAN UPDATE

## Introduction

The CQC identified 46 actions on their final report in February 2023, following inspections in June and August 2022. The current status and progress of the Trust's CQC Action Plan is as follows:

| Core Service | Completed | Open |
|---|---|---|
| **Maternity** | 10 | 1 |
| **Medicine** | 16 | 5 |
| **Trust wide** | 11 | 3 |
| **Total** | **37** | **9** |

The Trust is aiming to have completed all remaining open actions by 31 March 2024, with no further extensions beyond this date. Details of each action is available at Appendix 1. Actions which have been agreed for closure by the Executive Lead and awaiting final sign off by the Patient Safety and Quality Committee are annotated with an *.

The Trust continue to engage with the CQC relationship team on a regular basis, whereby they are assured with the progress being made and the timely responses made regarding any enquiries or concerns.

Closure of some actions are supported by external review evidence, such as Audit-One reports on Safeguarding (rated as substantial assurance) and Incident Management (rated good).

In maternity, additional assessments such as the Ockenden Assurance Visit conducted by the Local Maternity and Neonatal System (LMNS), in October 2023, provide strengthened evidence of the improvements made over the last year. Furthermore, the national Clinical Negligence Scheme for Trusts (CNST) requires compliance with ten safety actions to demonstrate robust systems in place to support safety of women and babies. Trusts that can demonstrate they have achieved all of the ten safety actions will receive an element of their contribution relating to the CNST maternity incentive fund. The recently published national Maternity Patient Survey (9 February 2024) provides further confirmation of sustained improvement within STSFT maternity services.

The Trust successfully recruited to two substantive positions to support actions around learning disabilities and mental capacity. The appointment of a Mental Capacity Act (MCA) Lead and Learning Disabilities Team Manager have accelerated improvements in safeguarding and MCA mandatory training, clinical record systems and Deprivation of Liberty Safeguarding (DoLS) monitoring and oversight.

A Dementia Care Bundle has been introduced, with a new electronic submission for the 'This is Me' document, which informs personalised care plans for patients with dementia.

## Future developments

The Trust's CQC Assurance Programme is being refreshed to emulate the CQC's new Single Assessment Framework. As part of this, an evidence schedule will be co-produced with the CQC to facilitate their data intelligence assessments. An evidence repository is being developed to manage this data flow and supports audit processes. Audit-One are currently conducting an independent audit of the CQC assurance programme, with the report due this quarter.

## Recommendations

Members are asked to note the progress to date.

**Melanie Johnson**
**Director of Nursing Midwifery and Allied Health Professionals**

Appendix 1

| Core service (CQC) | CQC statement | Action ID | Action | Status | Update |
|---|---|---|---|---|---|
| Maternity | The trust must ensure risk assessments including clinical service risk assessments are up to date, thoroughly assessed and documented and benchmarked against national statutory and best practice guidance. The trust must ensure records of risk assessments are effectively maintained. (Reg 17) | MAT10 | Changes to ways of working or environments which affect patient care should have a completed risk assessment in place, approved by the directorate's quality and safety meeting. Records of the risk assessments must be maintained, including on the risk register system. | Complete | Risk assessment for interim second theatre approved. Second theatre has been used 3 times with no incidents. Agreed closure but should incidents occur, further risk assessment to be undertaken. Risk assessment to be carried out for the newly refurbished theatres. |
| Maternity | The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service (Reg 17) | MAT11 | Review the clinical governance arrangements to ensure quality and safety is assessed and monitored to drive improvements. This should as a minimum include the review of incidents, complaints and audit to inform improvements required and identify risk. | Complete | Quality and safety structure agreed with the national maternity support team has been implemented. |
| Maternity | The trust must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. (Reg 17) | MAT4 | 1) Expedite the progress of the maternity incidents which require review, prioritising those which are graded as moderate and above harm. | Complete | All older incidents closed. Closure agreed.<br><br>New maternity and neonatal oversight meeting held weekly. MDT review incidents and agree level of harm for CIRG approval.<br><br>Monthly updates to the Board of Directors showing compliance. |

| Core service (CQC) | CQC statement | Action ID | Action | Status | Update |
|---|---|---|---|---|---|
| Maternity | The trust must ensure audit information is up to date, accurate and properly analysed, areas for improvement are identified and action is taken to make improvements to the quality and safety of care (Reg 17) | MAT8 | Ensure the audit forward plan is comprehensive and robust which includes but not limited to CTG fresh eyes, records audit, WHO checklist. The plan should be reviewed regularly, identifying areas of improvement. | Complete | Audit plan in place, agreed with the National Maternity Improvement Advisor |
| Maternity | The trust must ensure effective risk and governance systems are implemented that supports safe, quality care. (Reg 17) | MAT9 | Develop clear terms of reference for the quality and safety structure, demonstrating a clear process of how ward to board assurances are gained about the quality and safety of services. | Complete | Quality and safety structure agreed with the national maternity support team has been implemented. |
| Medicine | The trust must ensure staff understand and work within the requirements of the Mental Capacity Act 2005 whenever they work with people who may lack the mental capacity to make specific decisions. (Reg 13) | MED3 & MED 13 | 1) MCA/LSP Lead post agreed and advertised - MH qualification included in job description.<br><br>2) Package agreed by mandatory training panel for immediate implementation. All clinical staff to complete within 6 months of going live then completed annually. | Complete | MCA and DoLs Lead in post.<br><br>Training compliance high and internal audit showed 'substantial' assurance.<br>MCA 1 = 94.44% and L2 = 84.53%. |
| Medicine | The trust must ensure staff appropriately record mental capacity assessments and decisions made in service user's best interests. (Reg 13 | MED4 & MED14 | 1) Mandate the question in Meditech (the Trust's electronic patient record) in relation to patients not having capacity to consent to admission and subsequent mandatory MCA completion.<br>2) Focussed engagement with core consultants to improve | Complete | 1) Meditech documentation changed to add mandatory question in relation to person having capacity to consent to admission.<br>2) Engagement with Consultants completed.<br>3) Comms sent Trust wide re: changes. |

| Core service (CQC) | CQC statement | Action ID | Action | Status | Update |
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| | | | recording of MCA and Best Interests decisions within Meditech. | | |
| Medicine | The trust must ensure service user records are audited appropriately to evidence ongoing compliance with the requirements of the Mental Capacity Act 2005 and to identify missed opportunities to safeguard service users. (Reg 13) | MED6 & MED16 | 1) Development of a Launchpad report to identify patients per ward whereby the mandatory question of has capacity to consent to admission equals 'No' and also has DoLS.<br>2) Conduct regular audits of those whereby 'No response' and ensure DoLs in place, reporting compliance to CGSG and necessary actions.<br>3) Audit plan extended to review those records whereby 'Yes' has been response to ensure correct clinical decision made, will be monthly for 3 months then quarterly once Meditech documentation is live. | Complete | 1) Complete - Launchpad report on MCA/DoLS implemented.<br><br>2) Audits ongoing, with escalation where required.<br><br>3) Audit plan extended. |
| Trust wide | The trust must ensure directors have an appropriate disclosure and barring service check and ensure this is repeated where required or the risks of not repeating checks are considered and assessed. (Reg 5) | TW10 | Ensure all Directors, including Non-Executive Directors, have had a DBS completed annually. | Complete | All Directors, including Non-Executive Directors, have had a DBS completed in the last year and will have their DBS status checked annually along with all other checks currently undertaken on an annual basis. |
| Trust wide | The trust must maintain effective records to evidence adherence to the fit and proper persons | TW12 | Remind staff managing the element of the recruitment process of the need to ensure all | Complete | Completed at time of inspection. |

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| | Regulations for directors. (Reg 5) | | references all on file in line with Trust policy. | | |
| Trust wide | The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. (Reg 17) | TW14 | The IPC team to continue to undertake quarterly IPC environmental audits, escalating poor compliance where appropriate. | Complete | Quarterly environmental audits continue as business as usual. Themes reported in the IPC Group highlight report to Patient Safety and Governance Committee |
| Trust wide | The trust must ensure risk assessments including clinical service risk assessments are up to date, thoroughly assessed and documented and benchmarked against national statutory and best practice guidance. The trust must ensure records of risk assessments are effectively maintained. (Reg 17) | TW2 | Amend the Trust's Options Appraisal template to include formal risk assessment appendices. | Complete | Completed. The Trust's Business Case Template, Cost Improvement Programme and Workforce Changes templates include options appraisal and risks assessments. |
| Trust wide | The trust must implement an effective system to learn from deaths which ensures deaths are appropriately and consistently screened, further review is undertaken where required and lessons learnt are effectively identified and shared with teams. (Reg 17) | TW8 | 1) Commission an independent review of Mortality Governance by NHSE/I<br>2) Conduct biannual peer reviews at Mortality Review Panel<br>3) Discuss with NHS Digital regarding Trust SHMI statistics and methodology<br>4) A framework for directorate/speciality mortality meeting to be circulated and | Complete | 1) The exercise was deemed robust and reassuring by the external members of the group.<br>2) Complete: Introduced in May 2022.<br>3) Complete - St Benedict's hospice data will not be included in future SHMI releases.<br>4) Complete: Addendum added in October 2022 to policy<br>5) Complete |

| Core service (CQC) | CQC statement | Action ID | Action | Status | Update |
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| | | | implemented, adding as addendum to Trust Mortality Review and Learning from Deaths Policy<br>5) Introduce standard agenda item at MRG to summarise mortality meetings from directorates<br>6)Once embedded, develop a quarterly bulletin and circulate in the Trust<br>7) Develop a reporting process to feedback proportion of stage 1 mortality reviews completed each month | | 6) Bulletin published<br>7) A new mortality review performance dashboard has been developed which demonstrates compliance with reviews. |
| Maternity | The trust must ensure staff complete the WHO safety checklist when required, and ensure this is recorded, monitored, and audited with actions taken to improve compliance. (Reg 12) | MAT2 | Compliance monitoring of WHO safer surgery checklist to continue to be monitored via Maternity and Neonatal Quality and Safety Report, however clear action plan to be developed and monitored to improve compliance to 100% in each element. | Complete* | Performance as below:<br>100% in all elements July - September. In October 1 case not completed for sign out or session, reducing compliance to 99%.<br>Medical Director agreed closure of action and monitor through Maternity/Neonatal Quality & Safety Report. |
| Maternity | The trust must implement an effective system to ensure service users in established labour receive one to one care in line with best practice. (Reg 17) | MAT5 | 1) Compliance monitoring of 1:1 care in labour to continue to be monitored via Maternity and Neonatal Quality and Safety Report, however clear action plan to be developed and monitored to improve compliance to 100%.2) Birth to midwife ratio to be | Complete* | Maternity and Neonatal Safety Champions agreed closure, continue to monitor in QR and through CNST.<br>Consistently 1:1 is now provided to over 90% of women.<br>Midwife vacancy is less than five posts. |

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| | | | monitored in Maternity and Neonatal Quality Safety Report, escalating where this falls below the target. | | |
| Medicine | The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service (Reg 17) | MED10 & MED19 | Review the clinical governance arrangements to ensure quality and safety is assessed and monitored to drive improvements. This should as a minimum include the review of incidents, complaints and audit to inform improvements required and identify risk. | Complete* | PSIRF launch and review of Clinical Governance.<br>Close action, to be picked up as part of these work streams.<br><br>Audits of CG meetings concluded. |
| Medicine | The trust must ensure staff undertake and appropriately record intentional rounding of all service users and ensure this is recorded, monitored, and audited with actions taken to improve compliance. (Reg 12) | MED2 & MED 12 | Implement weekly programme of audit to review recording of intentional rounding, reporting results and necessary actions. | Complete* | Standard operating procedure implemented.<br>Improvements to Meditech made, rolled out in ST and SRH medical and surgical wards January 2024. |
| Medicine | The trust should ensure patients living dementia have personalised plans of care which consider their individual needs and preferences. | MED20 & MED 21 | Introduce the 'This is Me' documents to inform personalised care plans for patients with dementia. | Complete* | Dementia care bundle agreed, with communications sent by the Nurse Consultant.<br><br>New electronic submission for This is Me introduced July 2023, plus V6 system. |
| Medicine | The trust must ensure staff undertake assessments for patients who have a learning disability, where care needs are assessed and planned to meet their individual needs. (Reg 17) | MED7 & MED 17 | Review the use of the electronic flagging system to identify patients who have a learning disability, through robust assessment and documentation. | Complete* | Meditech documentation changed to ensure that advice and guidance is easily accessible to the whole MDT. |

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| Trust wide | The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line (Reg 17) | TW1 | 1) Implement the new Sepsis Guidance based on the 'Surviving Sepsis Campaign 2021'<br>2) Develop an improvement plan<br>3) Amend data collection in line with new guidance and introduce clinical validation of the data | Complete* | 1) Completed<br>2) Completed - Sepsis Improvement Plan in place. Sepsis performance is good. Patient Safety and Quality Committee agreed to move as business as usual, continuing to report via the Quality report.<br>3) Completed |
| Trust wide | The trust must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. (Reg 17) | TW11 | Review the AuditOne internal audit into incident management report (when published) and complete identified recommendations | Complete* | Director of Nursing agreed closure. PSIRF launched November 2023 which is changing the incident management process/culture.<br><br>Audit-One report = 'Good' assurance, with all actions completed. |
| Trust wide | The trust must ensure any patient presenting and assessed by staff as having a learning disability regardless of whether this is identified on GP systems have their individual needs assessed and reviewed by specialist learning disability staff. (Reg 17) | TW5 | Following appropriate assessment and identification of patients with potential learning disabilities, staff to flag this in Meditech for the specialist LD team to review and provide support to meet their needs. | Complete* | Flagging for patients with a learning disability has been reviewed and improved in Meditech, with robust assessment. |
| Trust wide | The trust must implement an effective system to identify, | TW7 | 1) Amend the incident reporting system to capture incidents of | Complete* | 1) Datix (the Trust's incident reporting system) has been |

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| | report and learn from incidents involving the use of restrictive interventions including restraint and rapid tranquilisation. (Reg 17) | | restraint (of all types) and rapid tranquilisation<br>2) Monitor the reporting of such incidents in the mental health steering group | | amended accordingly<br>2) incidents captured and monitored via incident quarterly report and Violence and Aggression Group to identify further improvement and learning. |
| Maternity | The trust must ensure staff undertake cardiotocographies (CTGs) and ensure this is recorded, assessed, monitored and escalated as appropriate with fresh eyes assessments. (Reg 12) | MAT1 | 1) Inclusion of CTG audits on the directorate's audit programme for a regular cycle of audit<br>2) Conduct a re-audit with specific timescales for completion where compliance falls below standards<br>3) Review the compliance of CTG training by staff group, continuing to report this in the maternity quality and safety report. Escalating where this falls below target | Complete* | 1) Completed: CTG audit in the audit plan. This is audited as part of SBL.<br>2) Weekly audit continues as is reported monthly in Quality report.<br>3) ongoing CTG compliance training is continuing to be consistently above 90% |
| Maternity | The trust must implement systems to ensure that midwifery staff are suitably qualified, skilled and competent to care for and meet the needs of patients within all areas of the maternity services, including in the community. (Reg 12) | MAT6 | 1) Validate the accuracy of ESR to ensure mandatory training and appraisals are captured correctly.<br>2) Identify those staff overdue as a priority and arrange these to be completed.<br>3) Diarise those appraisals due to expire in the next three months to ensure these are completed within timescale | Complete* | Appraisal rates are above 85%.<br><br>Mandatory training is above 85% for all staff groups.<br><br>Close action, continue to monitor through Quality Report. |
| Trust wide | The trust must ensure all staff have an appropriate disclosure and barring service check and | TW9 | Trust policies to be updated to reflect periodic checks (three yearly) for all staff. Due to the | Complete* | The Trust implemented a new policy for rechecking with the disclosure and barring service |

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| | ensure this is repeated where required or the risks of not repeating checks are considered and assessed. (Reg 19) | | volume this, it will be implemented over a two year period. | | every three years. However there is no legal requirement to mandate the frequency of checks.<br>No concerns have been flagged through this process. Agreed at Executive Committee that the cost outweighs the risk and to cease three yearly checks.<br>All new appointments and promotions continue to be subject to re-checks. |
| Maternity | The trust must ensure medicines are stored appropriately, and records of medication including controlled drugs, are maintained appropriately. (Reg 12) | MAT3 | Conduct regular audit on the storage and record keeping for medication, including controlled drugs | Complete* | Improvements made, however further monitoring continuing as business as usual. |
| Medicine | The trust must ensure staff appropriately monitor, assess, and escalate when service users' physical healthdeteriorates in line with best practice, this should be monitored and audited with actions taken to improvecompliance. (Reg 12) | MED1 & MED 11 | Conduct weekly NEWS escalation audits across all wards, developing action plans with ward manager and matron where compliance is poor. | Complete* | Formal e-mails sent by the Medical Director and Deterioration Recognition and Resuscitation Group (DRRG) Chair to Clinical Directors, Clinical Governance Leads and Clinicians outlining responsibilities around the use of NEWS.<br>Executive Committee and Patient Safety and Quality Committee to receive further |

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| | | | | | update on performance in March 24.<br>Performance as at 31 January = Accuracy 100%, Monitoring plan in place = 99.99%, Timeliness =73.76% and escalation = 99.6%. |
| Trust wide | The trust must implement an effective system to ensure that medical, nursing and midwifery staff have the skills, knowledge, and experience to care for and meet the needs of service users within their service area. Training must include but is not limited to cardiotocograph (CTG) interpretation, multidisciplinary skills and drills training including infant abduction, the needs of service users presenting with mental health needs and learning disability and the use of restraint. (Reg 17) | TW3 | 1) Review the training provided to Trust staff in relation to mental health, learning disability and the use of restraint. This will be in conjunction with CNTW or other specialist provider.<br><br>2) Request CNTW to audit those patients presenting with mental health needs have an appropriate risk assessment and management plan. | Complete* | 1) LD and Autism diamond mandatory training compliance as of 05/01/2024 = 96.53% for Level 1 and 96.30% for Level 2. The mental health team have delivered bespoke and formal training to staff.<br><br>2) There are quarterly reports from CNTW regarding assessment and patients detained on mental health acts at STSFT to support ongoing learning and improvement. |
| Medicine | The trust must implement an effective system to ensure patients receive timely medicines reconciliation. (Reg 12) | MED8 | Implement a focussed quality improvement project to improve medicines reconciliation across the trust. | In Progress | Chief Pharmacist is developing an improvement plan to be reviewed at Executive Committee and Patient Safety & Quality Committee in March 24. |
| Trust wide | The trust must ensure staff undertake assessments for | TW4 | 1) Review the use of the electronic flagging system to identify patients | In Progress | LD Team Manager recruited and in post. |

| Core service (CQC) | CQC statement | Action ID | Action | Status | Update |
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| | patients who have a learning disability, care needs are assessed and planned to meet their individual needs. (Reg 17) | | who have a learning disability so as to allow a through robust assessment and documentation<br>2) Develop and implement a LD strategy to support workforce, pathways, education, communication and governance | | 1) Flagging system improved in Meditech.<br><br>2) LD Annual Plan developed and in draft, awaiting sign off in March 2024. |
| Maternity | The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. (Reg 17) | MAT7 | The IPC team undertake quarterly environmental audits. There will be a fortnightly environmental audit done by IPC in the deliver suite till end of November and then monthly until the end of March 2024. | In Progress | Delivery suite and theatres show continued high compliance with environmental standards. Escalation and action plans in place as business as usual if compliance dips. |
| Medicine | The trust must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Reg 18) | MED 9 and MED 18 | Ensure mandatory training and appraisal compliance is above trust target. | In Progress | As of 31 December show medicine directorates above 85% with exception of Rehabilitation and Elderly Medicine = 84.52% and Cardiothoracic = 84.35%. Action plan in place to continue and sustain rates.<br><br>Compliance at 31 December showed mandatory training was all above 85% target for medicine. |
| Medicine | The trust must ensure staff appropriately monitor, assess, and escalate when service | MED 5 & MED 15 | 1) Review the risk assessment to include on Meditech.<br>2) Review the SLA with CNTW to | In Progress | 1) Completed |

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| | users' mental health deteriorates. (Reg 12) | | strengthen support and education to STSFT staff. | | 2) Medical Director presenting an update to Executive Committee and Patient Safety & Quality Committee in March 24. |
| Trust wide | The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed. (Reg 17) | TW13 | 1) Implement escalation process of those risks overdue to Divisional Directors<br>2) Table the BAF to be reviewed by the Board of Directors on a quarterly basis.<br>3) Revise the Trust's Risk Management Strategy and Policy, making coherent links with the Board Assurance Framework | In Progress | 1) Completed – SOPs developed.<br>2) Completed – BAF review changed to quarterly.<br>3) Trust Risk Maturity Assessment is in progress to underpin a new risk framework. Completion date March 2024. |
| Trust wide | The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs. (Reg 17) | TW6 | 1) Development of a Mental Health Strategy<br>2) Development of Launchpad reports to monitor key measures in relation to quality for these patients | In Progress | The draft Mental Health Plan was considered by PSQ Committee and Executive Committee in November 2023. Update report due at Executive Committee and PSQ Committee in March 24.<br><br>Improved data collection in Datix to identify whether a patient has LD, Autism or MH. Supports broader triangulation of themes and learning. |