BOARD OF DIRECTORS

SEPTEMBER 2018

STFT CQC ACTION PLAN

1. INTRODUCTION

Following the Care Quality Commission (CQC) inspection between October and December 2017 and the publication of the report an action plan was developed and agreed at Governance Committee in March 2018.The action plan was developed with the involvement of Executive and all other identified leads with evidence of compliance being collected and included for review.

2. PROGRESS

The inspection report outlined both "must do" and "should do" actions but only the must do actions need to be reported to the CQC. The initial action plan was agreed at Governance Committee and actions are now being monitored through to completion.

All of the must do and should do actions with updated status are outlined on the action plan- Appendix 1.

The must do actions which are not yet closed are:

- Completion of the alterations to the ED for care of patients with mental health needs.
- Achievement of 90% compliance with mandatory training in the ED and Surgery
- Achievement of 90% of patient having a Malnutrition Universal Screening Test (MUST) assessment within 24 hours of admission

Several of the should do actions are not yet completed as below:

- Major incident training for all applicable staff
- Receipt of lockable medical records trollies
- Completion of joint clinical documentation policy
- Completion of clinical guideline policy and process
- Audit results showing compliance with fridge temperature monitoring and CD disposal
- Publication of combined Consent policy
- Achievement of appraisal target rate of 90%

In addition a number of should do actions have been highlighted for potential removal from the action plan- these are highlighted on the action plan.

There continues to be a challenge in receiving evidence of progress and completion of actions from Directorates. This is to be addressed by the Director of Nursing, Midwifery and AHPs in September.

3. CONCLUSION

The Board of Directors is asked to:

i) review the action plan
ii) note the actions taken toward completion and
iii) agree with the assessment of the status of each must do actions.

Melanie Johnson
Executive Director of Nursing, Midwifery and Allied Health Professionals

Appendix 1: CQC must do and should do actions

	Issue	Action	Lead	Exec Lead	Initial target date	As at August 2018	Update as at August 2018	Evidence
Urgent and Emergency Care Services								
	The trust must ensure that the areas used for assessing the mental health or patients in the ED are safe, suitable and appropriately located	Risk assessment to be completed for ligature risk in mental health assessment room	Ceri Bentham/ Lynn Robertshaw	Sean Fenwick	Nov 17		Ligature risk assessment in place until new mental health room completed as part of capital build	Risk assessments for mental health room
		Assessment of ligature risk in ED	Ceri Bentham/ Lynn Robertshaw	Sean Fenwick	Nov 17		Ligature risk assessment in place for majors/ minors/ paediatrics and relatives room Plans in place to identify anti-ligature curtain rail areas to staff with colour coding	Risk assessments for ED
		Improvement alterations to ED following risk assessment	Steve Jamieson	Sean Fenwick	May 18	Nov 18	Work commenced 06/08, completion of whole scheme (GP Streaming) which includes mental	

							health room, 30/11.	
		Ligature risk assessment across the hospital	Steve Jamieson	Steve Jamieson	May 18		Task and finish group minutes	CQC guidance specifies there are no specific requirements over the management of ligature risks in hospital facilities outside of the mental health sector, although services that may deal with patients with mental health needs (such as A&E departments) should be aware of the risks and have management plans to meet them (see attached – Policy Position section). A task and finish group has been established to review those services that may deal with mentally disordered

								patients (other than the A&E department as this is covered in previous action point).
	The trust must ensure all staff in the ED are supported to become compliant with all aspects of mandatory training	Devise and implement a targeted plan to improve mandatory training within the ED	Lynn Robertshaw/Karen Sheard/ Mickey Jachuck	Kath Griffin	April 18		Plan and progress monitored through Directorate and Divisional Governance meeting	Plan available
		Achieve 90% compliance for all staff in the ED with all mandatory training	Lynn Robertshaw/Karen Sheard/ Mickey Jachuck	Kath Griffin	April 18	Oct 2018	There have been improvements in training rates to 80% for mandatory training but not to 90% and information needed on staff group training compliance within ED	
	The trust should ensure the trust and ED update major incident plans and	Major Incident policy to be updated and circulated for comment	Christine Bullmore	Carol Harries	Nov 17		Draft circulated for discussion at Resilience Forum 14.11.17 and then published	
		Major Incident Policy approved	Christine Bullmore	Carol Harries	Dec 17			

	procedures	by Board						
		Major Incident Policy available on trust Intranet and available in wards/departme nts	Christine Bullmore	Carol Harries	Dec 17		Published in Dec 2017	
		All wards and departments to maintain up to date emergency cascade lists	Ceri Bentham	Sean Fenwick	Nov 17		Emergency cascade lists updated and tested as part of Exercise Pelican 11.4.18 Plan to update and test Sept 2018 as part of Exercise Pelican 2	
		ED staff to have major incident training – in line with requirements in major incident policy	Christine Bullmore	Carol Harries		Sept 18	Majax training planned. 12 staff have completed and more is planned for October.	
		Managers/Senio r staff to have major incident training	Christine Bullmore	Carol Harries		Sept 18	Majax training planned for September 4th. Evidence to be forwarded after this date.	
		Exercise to be carried out in line with Major Incident Policy	Christine Bullmore	Carol Harries		Sept 18	Majax exercise completed December 17 and April 18. More is planned for September 18.	

	The trust should ensure major incident equipment in the ED is checked at the appropriate frequency	Inventory and check of all equipment in emergency preparedness cupboard to be developed	Ceri Bentham	Sean Fenwick	Nov 17		Inventory in place with monthly audits	
		Process of documented monthly equipment checks to be introduced	Ceri Bentham	Sean Fenwick	Nov 17			
	The trust should ensure chairs in the ED waiting area are free from tears and splits	Ensure that there is an effective process for maintaining seating within the ED waiting room	Ceri Bentham	Sean Fenwick	July 18		Weekly audit in place	
	The trust should ensure that staff working on the reception desk in the ED have appropriate guidance about which conditions require immediate escalation to	Develop guidance for ED reception staff on escalation	Lynn Robertshaw/Karen Sheard	Sean Fenwick				

	a member of the nursing staff							
Medical Core Services								
	The trust must ensure all patients on medical wards are assessed for risk of malnutrition	Review policy re nutrition risk assessment.	Pat Liston	Melanie Johnson	April 18	Sept 2018	Policy is being reviewed with completion date September 2018	
		Remind all nursing staff of the importance of MUST risk assessment.	Karen Sheard	Melanie Johnson	April 18		Complete	
		Undertake audit programme re documentation of risk assessment.	Ward Managers/ Karen Lapworth	Melanie Johnson	April 18		Audit has been undertaken and is being repeated in September.	
		All patients on medical wards will have a MUST assessment within 24 hours of admission	Karen Sheard	Melanie Johnson	April 18	Sept 2018	Current audit figures do not prove that this has been achieved. Target in quality strategy for 2018/19 is 90%.	

	The trust should ensure that oxygen is prescribed on medicine administration charts	Medical staff and independent prescribers to be reminded of need to prescribe oxygen on medicine administration charts	Mickey Jachuck	Shaz Wahid	May 18			
		Nursing teams to reinforce the need to prescribe oxygen and to correctly record oxygen administration on the medicine administration charts	Karen Sheard	Shaz Wahid	May 18			
	The trust should ensure that all patient care records on the medical wards are stored securely	Review patient record storage on medical and care of the elderly wards and identify improvements required	Lee Whitfield	Sean Fenwick	Nov 17		Review completed of all wards – need for locked medical records trollies identified, action as below	
		Implement new standardised approach to secure storage with locked	Lee Whitfield	Sean Fenwick	Sept 18	Sept 18	Locked medical records trollies ordered for 3 medical and 1 surgical ward –	

		trollies across all ward areas					August 2018	
	The trust should ensure all staff on medical wards complete patient care records in line with the guidance issued by their registering bodies.	Review policy re: documentation in patient care records.	Louise Burn/Gary Schuster	Melanie Johnson	Nov 18	Nov 18	Joint clinical documentation policy being developed	
		Implement audit programme re documentation	Pat Liston		June 18		Monthly audits commenced (evidence audit results)	
	The trust should ensure all patients on medical wards have an individualised plan of care that includes goal-setting and patient outcome measures	Review nursing documentation Implement audit programme re individualised care plans.	Pat Liston	Melanie Johnson	July 18			
		Amend documentation audit tool to reflect new documentation	Pat Liston		Oct 18	Oct 18	Documentation updated, however Trust decision re risky behaviour CQUIN prior to roll out	
	The trust should ensure that care	Review clinical guidelines and SOPs on medical wards	Diane Palmer	Shaz Wahid		Sept 18	Draft policy is currently being developed re implementation of	

	pathways for patients on medical wards are reviewed and that these contain references to show that they are in line with evidence-based, best practice guidance	to ensure that these are evidence based.					clinical guidelines and SOPs.	
	The trust should aim to provide seven day consultant cover for the medical wards	Consider forward plan for providing seven day consultant cover for medical wards.	Lee Whitfield/ Mickey Jachuck	Shaz Wahid	April 2020		? Remove: This work is part of the Clinical Service Review of medical specialties as part of Path to Excellence phase 2	
Surgical Core Services								
	The trust must ensure that nursing and medical staff in the surgical directorate are compliant with mandatory	Devise and implement a targeted plan to improve mandatory training within the surgical directorate	Helen Turnbull/ Karen Sheard/ Darshan Boregowda	Kath Griffin	April 18		Plan available Plan and progress monitored through Directorate and Divisional Governance meeting	
		Achieve 90% compliance with	Helen Turnbull/	Kath Griffin	April 18	Oct 2018	There have been improvements in	

	training, in particular resuscitation and safeguarding	mandatory training for the surgical directorate	Karen Sheard/ Darshan Boregowda				training rates but not at 90% and information needed on staff group training compliance within Surgery	
	The trust must ensure all staff are engaged and participate in all steps of the WHO checklist	Promote importance of full compliance with WHO checklist to all theatre users	Darshan Boregowda	Shaz Wahid	Nov 17		Rolling monthly audit in place	DB report on WHO audit compliance Audit tool QRA Minutes of CGSG
		Use recent audit results to highlight key areas of poor/inconsistent compliance and provide targeted message to those areas	Darshan Boregowda	Shaz Wahid	Nov 17		Complete	
		Monitor compliance – through regular re-audit (MONTHLY)	Darshan Boregowda	Shaz Wahid	Ongoing			
	The trust should ensure the number of controlled drugs record books is reduced on the surgical	Agree how many CD books are needed and develop a process to improve	Graeme Richardson	Shaz Wahid			Confirmation that CD books rationalised in March	

	inpatient unit to reduce the likelihood of errors							
	The trust should ensure that staff in theatres complete administration records for controlled drugs fully, including the amount administered and the amount discarded	Advise staff of the drug administration policy	Graeme Richardson	Shaz Wahid			Confirmation of actions and planned audit	
		Ensure via audit that CD records are fully completed					Quarterly audits by Pharmacy have shown some improvement but also that more improvement is needed. Audit report will be sent when available.	
	The trust should ensure that fridge temperature monitoring is in place in surgical areas and that action is taken when minimum or maximum temperatures are exceeded	Review policy and practice to implement improved processes	Karen Sheard	Sean Fenwick			Cold Chain SOP agreed MOG 7.8.19	
		Advise staff of the revised SOP						
		Ensure via audit that temperature monitoring is undertaken					Monitored via Matrons and the medicines safety walkabout and is fed back each month at the medicines safety group.	
	The trust	Continue	Ann Carson	Shaz			The attached report	

	should continue to work on improving outcomes in relation to the hip fracture audit and the risk of readmission for elective and non-elective trauma and orthopaedic cases	improvement work in relation to improving outcomes	and Soham Gangopadhya y	Wahid			shows improvement across a range of KPIs in the National Hip Fracture Database up to April 2018, whilst highlighting areas to improve. This report has been reviewed at Mortality Review Group on 24/7/18 with a plan to present it at the CGSG as well. There has been a specific focus on mortality reviews and a report on the 2016 deaths is attached. The same process is ongoing for the 2017 deaths and monitored through the Mortality Review Group. A fractured neck of femur working group is in operation that monitors performance.	
	The trust should ensure best-practice guidance is	The current consent for examination or treatment policy is to be updated	Darshan Boregowda	Shaz Wahid	Dec 2018	Dec 2018	Dr Wahid had updated the current consent policy. A joint policy is now	

	followed in respect of patients consenting to surgery	in light of recent legal rulings (Montgomery) and updates from professional bodies (e.g. GMC) with an impact on consent					being developed by Dr. McAndrew	
		Once updated the policy should be implemented with an appropriate training programme				Dec 18		
		Audit programme to be implemented to review consent process against policy				Dec 18		
	The trust should consider protected non-clinical time to ensure management responsibilities on the surgical centre	Consider the recommendation, implementation and implications	Karen Sheard	Melanie Johnson			It has been confirmed, in line with standard practice across the Trust, that there is already 0.2wte included in the budget to provide one day per week for non-clinical activities such as management. It is	

	inpatient unit can be delivered						acknowledged that at times of staffing pressures, when staffing escalation, including backfill with temporary staffing, has not been possible, then clinical activities will take priority.	
	The trust should continue to address areas of concern in relation to culture and inappropriate behaviour in theatres	Discussion with all staff working in theatres about acceptable behaviours	Darshan Boregowda	Shaz Wahid	Nov 17			
		All staff advised that inappropriate behaviour within theatres should be escalated appropriately through the line management route so that appropriate actions can be taken	Darshan Boregowda	Shaz Wahid	Nov 17			
Critical Care Core Service								
	The trust must ensure	Agreed governance	Helen Turnbull/	Melanie Johnson	May 18		Terms of reference updated	Terms of reference from

	that there are formal governance arrangements within Critical Care	structure and reporting lines to be in place for Critical Care	Darshan Boregowda				Governance reporting structure in place.	Critical Care Delivery Group
	The trust must provide evidence-based clinical guidelines, specific to critical care	Develop and approve evidence-based clinical guidelines for critical care	Helen Turnbull/ Darshan Boregowda	Shaz Wahid	June 18	Sept 2018	Clinical based guidelines available on intranet – approval process via critical care delivery group – awaiting minutes of meeting to evidence approval process. Requested but evidence not received.	
	The trust must introduce a comprehensive clinical audit programme to support and monitor compliance within critical care	Introduce a comprehensive clinical audit programme, ensuring the findings are reported through the governance structure	Helen Turnbull/ Darshan Boregowda	Shaz Wahid	June 18	Sept 2018	The annual audit programme has been developed, monitoring and reporting through the Critical Care Delivery Group.	Annual audit programme for anaesthetics and critical care
	The trust must improve the management	Include risk registers as a standard agenda item in	Helen Turnbull/ Fiona Kay	Melanie Johnson	April 18		Amended terms of reference for critical care delivery group	Email confirmation that

	of risks within critical care	governance meetings						risk register is standard agenda item
		Clear escalation process to be adhered to for those identified as high risk					Escalation process described in governance reporting structure	
	The trust should provide a follow-up ITU clinic in line with the national guidelines for the Provision of Intensive Care Services standards	Consider the national guidelines, and explore whether the CHS follow-up clinical can be used in the interim, with a view to introducing a follow-up clinic at STFT. *NB: guidance states that follow-up clinics do not necessarily have to be provided by the hospital that the patient was treated in – it could be delivered on a regional basis.*	Helen Turnbull/ Darshan Boregowda/ Govindan Balaraj	Shaz Wahid	On-going	Presentation to Clinical Governance Steering Group July 2018 Presentation to Clinical Governance Steering Group July 2018	?Remove- would require investment/ discussion at CMT, impact of CSR. This was discussed at the 30th July 2018 Clinical Governance Steering Group. It was noted that good progress had been made with the 4 standards however to achieve full compliance would require a significant investment of circa £96K. This was discussed at Corporate Management Team on 1st and 8th August 2018. It was felt that the most cost effective,	

							sustainable and realistic method of achieving full compliance is through the phase 2 service reviews that are on-going via Path to Excellence instead of submitting a business case. As this process is not expected to complete until late 2019 with an implementation into 2021 at the earliest can this should do action please be removed.	
	The trust should provide rehabilitation support for critical care patients in line with NICE clinical guideline 83	Develop a 'Rehabilitation Pack" including information about support groups, invitation to follow up clinics and a rehabilitation manual.	Helen Turnbull/ Darshan Boregowda/ Govindan Balaraj	Shaz Wahid	On-going		? Remove- would require investment/ discussion at CMT, impact of CSR as above	
	The trust should monitor, record and	Introduction of Open and Honest board to include	Julie McDonald	Melanie Johnson		Oct 2018		

	display nurse staffing levels in critical care to determine the impact of requests to provide support to other wards	expected and actual staffing per day						
	The trust should ensure there are enough healthcare assistants in the critical care ward staffing establishment to cover all night shifts	Requirement to be identified as part of summer 2018 workforce review (WFR)	Sharon McDowell	Melanie Johnson			WFR completed-requirements to be included in recommendations/ impact of CSR to Exec Committee.	
	The trust should ensure there are enough training and development opportunities for critical care nurses	Scope a training needs analysis for critical care nursing staff, seeking opportunities for staff development with the Critical Care Educator	Sharon McDowell	Karen Sheard			Current position unclear	
	The trust should ensure new local safety standards for	Develop clear LocSSIPs for critical care	Darshan Boregowda/Govindan Balaraj	Shaz Wahid	June 2018		Current position unclear	

	invasive procedures are implemented in critical care							
	The trust should ensure there are more formal processes for sharing outcome, themes, trends and lessons learned from incidents with frontline staff in critical care	To update action re TOR/agenda	Helen Turnbull	Sean Fenwick			Current position unclear	
	The trust should ensure all appropriate members of staff in critical care contribute to North of England Critical Care Network meetings, sharing learning and best practice	Critical care manager to ensure that the team are given sufficient opportunity to contribute and attend NECCN meetings	Helen Turnbull	Sean Fenwick	Complete d			

	with the team							
Hospital wide								
	The trust should ensure that information from audits is used to improve quality	Lessons learned from audits to be captured centrally by the clinical audit team	Pat Liston	Melanie Johnson		TBC	This action requires more work- wider than nursing- Julie McDonald to redraft	
		Monitor completion of actions from audits, sharing lessons learned as appropriate	Karen Sheard/ Matrons	Melanie Johnson				
		Achieve compliance with Trust target of 90% for appraisal with business managers taking action where this falls below the Trust's target (90%)	Business managers	Sean Fenwick			Current appraisal rates remain below 90%	
	The trust should ensure there are robust actions in place to improve performance against	Continue to monitor Trust performance against national targets, escalating any identified risks or issues through the	Alison King	Peter Sutton			? Remove The Trust has a formal process in place for reporting and discussing performance against national targets and a clear escalation process in place	

	national targets	formal governance routes.					where performance is below target levels. Regular (weekly)performance monitoring reports are provided with operational management teams and risks against performance flagged Performance is discussed at contract meetings, Finance and Performance Committee, and Board. In view of this the action can be removed from the CQC should do action plan	
	The trust should consider employing a dementia specialist nurse to support staff	Consideration to be given to employing a specialist dementia nurse	Ceri Bentham	Melanie Johnson			? Remove- Whilst the concept of a Dementia Specialist Nurse is supported in principle, there are a number of competing priorities for nurse staffing resources.	
	The trust should ensure that information about how to	Ensure that the complaints posters and leaflets are visible and	Gemma Evans	Melanie Johnson	Nov 17			

	complain is clearly displayed throughout the hospital and that complaints are responded to in a timely way	accessible across the hospital						
		Complaints response times are monitored regularly to ensure completion within the policy timeframe					Response times monitored via weekly Sitrep.	
Elmville								
	The trust should consider processes to review restrictive practice on the ward	Head of Nursing to review current practices and ensure that individualised care is in place that is not restrictive	Melanie Milburn	Melanie Johnson				
	The trust should consider how to document and review ligature anchor points on the ward	Environmental risk assessments to be carried out and documented robustly	Melanie Milburn	Melanie Johnson				
	The trust should review night shift staffing levels to ensure staff and patients are	Head of Nursing to review night shift staffing levels in line with national guidelines	Melanie Milburn	Melanie Johnson				

	safeguarded							
	The trust should consider the use of staff personal alarms, particularly at night when only two members of staff would be on duty	Trust's security group to consider the use of personal alarms for Elmville staff	Melanie Milburn	Melanie Johnson				
	The trust should ensure that the electronic case management system is implemented by February 2018. This should include effective processes to identify patient risk.	Ensure that the electronic management system is implemented, with risk identification.	Melanie Milburn	Melanie Johnson				
	The trust should consider how to make patient information	Easy read leaflets to be made available in the ward area, and given to carers.	Melanie Milburn	Melanie Johnson				

	leaflets more accessible within the service							

Key			
Must do		**Action completed**	
Should do		**Action partially completed**	
? Remove		**Action outstanding**	