Report to the Board of Directors

Northumbria Healthcare NHS
NHS Foundation Trust

Title of Report	CQC Action Plan – January 2017 follow up
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Responsible sub-committee	N/A
Date of meeting	26th January 2017
Executive Summary	Following the CQC inspection in November 2015, the Trust had a total of 38 issues which needed to be addressed (5 must do actions and 33 should do actions). The Trusts action plan was approved by Board in May and submitted to the CQC in June with no further amendments required by the CQC. Monthly monitoring of the action plan commenced at Safety and Quality Committee in July. Of the 38 actions, there are currently 2 actions on-going with 36 declared as complete by the Business Unit. Of those complete actions, evidence to support this conclusion has been supplied in 32 instances (or is n/a). Following an initial review of progress in September, the CQC are planning a more in depth review of evidence to support completion of actions in January.
Assurance Framework reference	N/A
Alignment to Trusts Annual/Strategic Plans or business unit annual plans	N/A
Risk rating (very high, high, medium, low risk)/ any recommended changes	N/A
Compliance/ regulatory requirements (if applicable)	N/A
Actions required by the Board	The Board is asked to note the progress made to complete the attached action plan.

Northumbria Healthcare NHS Foundation Trust

CQC Inspection 2015 – Action Plan

1. Introduction

1.1. The Care Quality Commission (CQC) conducted an announced inspection of the Trust from 9th to 13th November 2015, followed by an unannounced visit on the 2nd December.

1.2. Both prior and during the inspection, the Trust provided a large amount of documentation to the CQC. As part of the inspection, the CQC spoke to patients, visitors, carers and staff to gain a view of the eight service areas and to rate each of these in relation to five domains:

- Were services safe?
- Were services effective?
- Were services caring?
- Were services responsive to people's needs?
- Were services well-led?

1.3. Although the Trust was rated as overall 'Outstanding' there were a limited number of instances where the Trust was required to take action to address areas of non-compliance with the Health and Social Care Act 2014. The CQC reports also identified a number of improvement actions for the Trust to consider.

1.4 There are five actions that the Trust is required to undertake (referred to as 'must do actions'). Four of the actions are specific to Maternity Services with the other related to medical care.

1.5 In addition, there are a total of 33 actions which the CQC recommend the Trust to consider (these are referred to as 'should do actions'). These actions relate to the following areas:

- Maternity and Gynaecology – 11 actions
- Medical care – 3 actions
- Wards for people with mental health problems – 4 actions
- Outpatients/diagnostics – 1 action
- Emergency Care Centre/Department – 5 actions
- Critical Care – 3 actions
- Children and young people – 5 actions
- General – 1 action

1.4 In May, the Trust Board approved the action plan to address all of the issues raised in the CQC reports, together with an agreement for monthly monitoring of the plan at Safety and Quality Committee with quarterly updates to Assurance Committee and Trust Board. The plan was submitted to the CQC in early June and accepted as an adequate response to the issues highlighted.

2. Action Plan Progress

2.1 Business Units are responsible for monitoring the completion of the actions against the stated timescales. Monitoring of the action plans is undertaken on a monthly basis by the Safety and Quality Committee, with the first review of progress in July.

2.2 The detailed action plan and current status is shown in **Appendix 1**. In summary, the completion status of the plan is as detailed in the table below:

Area	No. of actions		Total actions	No. BU stated as complete	No. where evidence submitted[1]
	'Must' Do	'Should' Do			
Maternity and Gynaecology	4	11	15*	14	13**
Medical Care	1	3	4	4	3**
Wards for people with mental health problems	0	4	4	4	3**
Outpatients/diagnostics	0	1	1	1	1
ECC/ED	0	5	5	4	4
Critical Care	0	3	3	3	3
Children and young people	0	5	5*	5	4
General	0	1	1	1	1
Total	**5**	**33**	**38**	**36**	**32**

Note: [1] Also includes those actions where supporting evidence is n/a

*One action allocated to maternity rests with child health (hearing screening)

** Although some evidence has been submitted, additional evidence is still required

3. Review by CQC

3.1 In line with the new CQC strategy, the Trust has bi-monthly engagement meetings with the CQC. The next scheduled meeting will take place on 25th January 2017. This meeting will include a review of evidence by the CQC to ensure that the proposed changes have taken place.

3.2 In addition, the CQC have attended a trust meeting:

- 16th September - O&G Governance Group

Arrangements are in place for them to attend further meetings:

- 20th January – BUGG
- 15th March - Mortality and Outcomes Data Group

4. Recommendations

The Board is asked to note:

- Progress made in addressing the actions arising from the CQC action plan.
- The Safety and Quality Committee will continue to monitor the completion of the action plan on a monthly basis.

CQC Inspection November 2015 – Action Plan

Ref	Inspection Report	Issues identified	Action to be taken	Responsibility	Target Date	Current Status	Evidence Submitted
Maternity and Gynaecology							
MD1	HGH Al Ber NTGH NSECH WGH Trust	The service must complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.	Full review of Kirkup report undertaken.	Clinical Director/ Head of Midwifery	May 2016	Gap analysis completed. Action Plan devised. Discussed at away day 06/05/2016. Discussed at relevant boards. Structured programme of monthly skills drills/training commenced in all midwifery locations. A record of the drills undertaken will be kept.	Gap analysis document, minutes of meetings
MD2	HGH Al Ber NTGH NSECH WGH Trust	The service should ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.	Review maternity & Gynaecology dashboard.	Clinical Director/ Governance lead	August 2016	Maternity and Gynaecology dashboard has been reviewed and modified. New dashboard now operational from August 2016	Revised dashboard and minutes of meetings
MD3	NSECH Trust	Ensure that the entry and exit to ward 16 in Maternity are as safe as possible to reduce the risk of infant abduction.	Review the processes in place to reduce the risk of infant abduction.	Head of Midwifery/ OSM/ Matron	December 2015	Full security review undertaken immediately following CQC assessment by our Estates department lead. Door mechanisms adjusted to reduce opening times.	Risk assessment paper, live drills, minutes of meetings and volunteer role description

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						All staff reminded of abduction policy and security breech drills performed. Skills drills continued and central record held. Identified additional security measures which resulted in installation of door exit monitoring as well as door exit via exit bell which requires visitors to be let out of unit by staff or for staff to use their swipe cards to exit the department. CCTV equipment also installed. Additional ward clerk hours allocated to ward to support door monitoring. Further ward clerk cover required and General Manager completing a Business Case to get funding for additional hours.	

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						Agreement in place from Workforce committee that department can recruit volunteers to 'meet & greet' visitors at the door of the department. Pilot agreed for 3 months. 2 x volunteers on duty. Proposed hours for pilot 9am – 12pm and 1pm – 4pm. If pilot successful will try and introduce a late shift until 8pm. Volunteers pilot now in place. Meeting with Ray Pate, Trust Security Lead on 21st July to discuss further security options for the ward. Baby tagging has been discussed however unsure whether this is required. Require further advice from Ray Pate before moving forward with any baby tagging option.	

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						Risk Assessment walk around held with Ray Pate, Trust Security Lead, Paul Brayson, NSECH Estates Lead, Janice McNichol, Head of Midwifery, Kathryn Hardy, Modern Matron and Rob Graham, OSM. Risk Assessment undertaken by Ray Pate and options paper written to assess the security risk now that actions have been taken and whether further actions such as baby tagging are necessary. Risk Assessment paper presented at Obs & Gynae Board on 29th July 2016 and agreed that baby tagging is not required. Marion Dickson, Deputy Director and Eliot Sykes, BUD are now taking the paper for EMT discussions and decision.	

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						Agreed at EMT 14.09.16 that baby tagging not required and actions already undertaken have satisfactorily reduced the infant abduction risk on the unit	
MD4	NSECH Trust	Ensure that the storage of emergency drugs, within maternity services, is stored safely in line with the trust's pharmacy risk assessment.	Ensure safe storage of emergency drugs.	Matron	November 2015 July 2016	Emergency trolleys were moved immediately from the general ward areas and stored within a secure locked room. This room is only accessible by staff with a swipe card. Spot audits undertaken weekly to ensure the correct storage of these trollies. Tamper proof emergency trolleys were sourced and ordered and delivery date Mid July 2016. Trolley delivered 14th July. Spot checks weekly by Matron to check if trolley locked	Spot audits

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SD1	HGH Al Ber NTGH NSECH WGH	Ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.	Ensure that the maternity & Gynaecology strategy is shared with all staff	Clinical Director/ Head of Midwifery	May 2016	Obs and Gynae 5 year plan agreed and circulated to the team.	5 year plan
SD2	Al	The trust should ensure that delivery rooms are fully inspected following delivery and ensure that homeopathic remedies are removed and destroyed or returned the patient.	Ensure delivery rooms are fully inspected following each delivery	Matron	December 2015	Room check in place when each room is cleaned. Sign off sheet utilised to confirm room has been cleaned and left on bed in room to give assurance to patients that room is cleaned. Matron spot checks commenced to ensure compliance. Weekly spot check audit commenced to ensure compliance	Spot audits

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SD3	AI NSECH	The trust should ensure that record keeping is consistent across all services.	Ensure all staff completes the standardised maternity record as per guideline.	Matron/ Supervisor of Midwives		Check compliance via annual audit of record keeping standards and devise action plans as necessary. 15 step visit took place at NSECH on 30.06.16 & Hexham MLU on 28.07.16. This included patient notes audits which both departments received 100% compliance in. Action green however will be downgraded if required depending on results of annual service notes audit to take place in November 2016	Some evidence supplied – more needed
SD4	AI Ber	Consider a formal programme of staff rotation to provide assurance of clinical competence.	Review staff rotation to provide assurance of clinical competence.	Head of Midwifery/ Matron	April 2016	Evidence already supplied in September. However due to constraints in the service it was agreed to keep amber on action plan as a formal rotation process is difficult to implement.	Rotation record sheet and skill drills

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SD5	Al	Ensure that storage and collection practices of placentas are consistent across all areas providing maternity services.	Review placental storage	Matron	November 2015	Placenta storage and collection pathway was devised. Infection control measures including cleaning schedules were devised standardised across the trust. Spot checks commenced to ensure safe placental storage and disposal occurs	Spot audits
SD6	Ber	Consider reviewing the provision of hearing screening services in the remote parts of the trust, to meet the needs of the local community.	Local clinics are provided to meet screening timescales in agreed areas based on efficiencies and capacity as close to home as possible.	General Manager (Child Health)	May 2016	Due to capacity we provide a clinic at Alnwick. The majority of babies are screened before discharge. Parents of missed babies are contacted directly to offer OPD appointments at a convenient time	n/a
SD7	NTGH	Consider the provision of separate accommodation for women undergoing pregnancy loss and termination of pregnancy.	Due to forthcoming reconfiguration of surgical services a purpose built, separate accommodation for women undergoing pregnancy loss and termination of pregnancy is planned to be created.	General Manager	1st September 2016	As stated in September Pregnancy Loss Unit has now opened on ward 6 NTGH. Opened 5th September 2016.	n/a

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SD8	NSECH	Ensure all Patient Group Directives are signed by staff as appropriate.	Staff to sign off patient group directives.	Matron/ Pharmacy	December 2016	Central file of PGD's that all staff sign within the first month of commencing employment. Senior midwives check at appraisal that all staff have signed off PGD of medicines that they prescribe. Sign off process validated through appraisal and central register check. PGD developed in collaboration with pharmacy. Audit undertaken with pharmacy to confirm system in place	PGD Audit
SD9	NSECH	Consider storing emergency drugs in tamper evident boxes if they are stored in an open ward area.	Ensure safe storage of emergency drugs.	Matron	July 2016	Emergency trolleys were moved immediately from the general ward areas and stored within a secure locked room. This room is only accessible by staff with a swipe card. Spot audits undertaken weekly to ensure the correct storage of these trollies.	Spot audits

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						Tamper proof emergency trolleys were sourced and ordered and delivery date Mid July 2016. Trolley delivered 14th July. Matron spot checks weekly to check if locked	
SD10	NSECH	Consider reviewing midwifery staffing levels across the trust to ensure the midwife to birth ratio and NSECH is reduced from 1:36 to 1:28 as recommended.	Review staffing levels across the trust.	Head of Midwifery	April 2016	Six monthly staffing review undertaken as per NICE safer staffing in maternity units 2015. Additional staffing requirements identified to enable ratio of 1:28 for NSECH. Additional investment agreed by Trust board, posts advertised and appointed	Staffing review report
SD11	NSECH	Consider the reconfiguration of pregnancy assessment unit to the Northumbria Specialist Emergency Care Hospital, to improve assess and flow of patients.	Reconfigure pregnancy assessment unit	Business Unit Director	31st July 2016	Centralised PAU now open at NSECH. Opened 5th September 2016.	n/a

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SD12	NSECH	Consider the provision of midwifery support for Teenage mothers in Northumbria in order to provide an equitable service throughout the Trust.	To consider teenage pregnancy service provision	Head of Midwifery	August 2016	Discussions have commenced within the service to review models of care for teenage pregnancies in light of The Cumberledge report 2016. North Tyneside does have a designated midwife. Northumberland due to geography have taken the decision to rather than have a designated midwife community midwives would manage within their caseloads. This was supported by Family Nurse Partners (EMP's)	o/s
Medical Care							
MD5	NSECH Trust	Ensure risk assessments in relation to falls, pressure ulcers, VTE and nutrition are consistently completed for all patients within medical care services.	Conduct full review of current audit processes for falls; pressure ulcers; VTE and nutrition and monitor compliance through the Emergency Medicine Operational Board on a quarterly basis	Deputy Director of Medicine	June 2016	Audit process reviewed and in place. Compliance rates reviewed at EMOB September 2016	Some evidence supplied – more is needed

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SD13	NSECH	Continue to review staffing levels on medical care wards.	Trust wide 6 monthly reviews of staffing levels are undertaken in line with the National Quality Board staffing requirements	Director of Nursing	Ongoing	September review completed. Programme of further reviews in place - Completed	Recommendations and meeting agenda
SD14	WGH	Ensure that resuscitation equipment is checked consistently, in line with trust procedures, on all medical wards.	Introduce monthly spot audits on medical wards to ensure resuscitation equipment is being check consistently, in line with trust procedures. Review of results quarterly by Emergency Medical Operational Board. Action plan to be developed if any issues highlighted	Chief Matron for Medicine	May 2016 onwards	Audit process in place and demonstrates improvement against previous performance	Audit report
SD15	WGH	Ensure that fridge temperatures are checked consistently, in line with trust procedures.	Introduce monthly spot audits on medical wards to ensure fridge temperatures are being checked consistently, in line with trust procedures. Review of results quarterly by Emergency Medical Operational Board. Action plan to be developed if any issues highlighted	Chief Matron for Medicine	May 2016 onwards	Audit process in place and demonstrates improvement against previous performance	Audits 15 steps report

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Wards for older people with mental health problems							
SD16	Mental Health NTGH	The provider should ensure that all steps are taken to maintain the safety, privacy and dignity of patients on mixed sex wards until the wards move into new same sex accommodation.	The Psychiatry of Old Age Service (POAS) Board will review monthly any incidents relating to safety, privacy and dignity of patients on the POAS wards and develop an appropriate action plan where required	General Manager – MECCBU (JD)	June 2016	Service relocated to new premises from 5 July 2016, single rooms throughout - Completed	n/a
SD17	Mental Health NTGH	The provider should ensure that a programme of formal supervision is rolled out following completion of a pilot project.	Pilot has been completed and roll out commenced April	Matron for Practice Development	May 2106	Roll out underway. Increased number of staff trained in supervision - Completed	Policy, minutes of meeting and action points
SD18	Mental Health NTGH	The provider should ensure that ligature risk assessments are comprehensive and consistent across sites.	POAS to repeat ligature risk assessment at each site and ensure patient safety during interim period before moving to new premises (June 6th 2016)	Matron for POAS	May 2016	Ligature reviews completed. Assessment of new build completed prior to opening - completed	Some evidence supplied – more is needed
SD19	Mental Health NTGH	The provider should look to develop service specific key performance indicators to aid performance monitoring.	POAS board in conjunction with Business Unit Senior Team to review regular performance indicators	Deputy Director for MECCBU	August 2016	KPI report for 1st quarter Apr-June circulated to MHSOP board in September - Completed	KPI reports and minutes

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Outpatients and diagnostic imaging							
SD20	HGH NTGH WGH	Ensure waiting time targets in ultrasound continue to improve as more staff are appointed.	Vacant trainee / sonographer posts appointed to, external provider utilised to reduce waiting times via two companies , reduced use of external provider as waiting times within target times Capacity and demand tool used on a monthly basis to monitor referral numbers and avoid backlog Fortnightly meeting held to discuss all modality waiting times Appointment of trainee sonographers undertaken and plan to appoint a further two trainees to commence training in September 2016	Trust Lead Sonographer/ OSM	On-going as and when posts are vacated	On target, no breaches since quarter 3 of 15/16. Actions taken: • Vacant trainee / sonographer posts appointed to, external provider utilised to reduce waiting times via two companies , reduced use of external provider as waiting times within target times • Capacity and demand tool used on a monthly basis to monitor referral numbers and avoid backlog • Fortnightly meeting held to discuss all modality waiting times • Appointment of trainee sonographers with three part time training posts commencing in September 2016.	USS activity and waiting times to Sep 16

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						• From October there is the equivalent of 37.5 hours additional scanning time equating to 400 scans per month • A consultant radiologist specialising in MSK has been appointed who started 5th September 2016 which will add a further 8 hours ultrasound scanning time per week • Referral guidance to clinicians identifying the indications for ultrasound and appropriate referrals An accompanying chart demonstrates the activity and waiting times for non-obstetric ultrasound from April 2015 to September 2016. There was a peak in referrals in November 2015 (5373 requests) with a waiting time of 20.1 and again in June 2016 (5258 requests).	

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						Action taken as detailed above has resulted in a steady decrease in waiting times to March 2016 (10.5 days). There has been an increase in waiting times since April 2016 (25 days) steadily rising to September 2016 (28 days). The gap analysis shows demand has been higher than capacity since Dec 15 which corresponds to an increase (after a lag) in waiting times. The capacity gap was lower in September than the previous couple of months due to an increase in staffing and WLIs, so the rate waiting times is increasing may slow down but while demand remains higher than capacity the gap analysis suggests that waiting times will probably continue to increase.	

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						Close monitoring of capacity and demand is carried out by the Business Unit fortnightly and staffing levels adjusted accordingly for the weeks ahead. It should be noted the diagnostic waiting time target of no more than 1% of patients waiting more than 6 weeks for an appointment is achieved.	
Emergency Care Centre							
SD21	NTGH WGH	Consider circulating guidance to staff about when to stop using the 'see and treat' model when the department is busy and revert to the triage model, to ensure patient safety and improve responsiveness.	Written guidance using consistent methodology for instituting triage to be developed and circulated	Matron for Emergency Care	June 2016	Nurse in charge of department clinically assesses risk of continuing see and treat and change to triage model - Complete	SOP for reverting to triage and prioritisation levels
SD22	NTGH WGH	Consider training for reception staff to help identify patients who may need to be brought to the attention of clinical staff more quickly.	Review current processes and training of reception staff	Matron for Emergency Care	June 2016	Completed with current staff, on-going updates	SOP for reverting to triage and prioritisation levels

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SD23	NTGH WGH	Consider increasing the number of independent nurse prescribers to enable more flexibility in prescribing of medication in the ECC when there are no doctors available.	Emergency Care Sub Business Unit (ECSUB) to review current level of nurse prescribing and make recommendations	Clinical Director for Emergency Care through ECSUB	July 2016	Review of PGDs underway. PGDs are available for all conditions ENPs would see. On-going training for Nurse Prescribing training inc. staff in UCCs	o/s
Emergency Department							
SD24	NSECH	Ensure nursing care documentation is completed consistently throughout the department.	Spot audit to be undertaken during June 2016 using 15 steps template to review current compliance. Result to be reported to ECSUB	Chief Matron for MECCBU	June 2016	COMFORT charts completed, 2 audits completed by Matron confirmed compliance with action - Completed	15 steps reports
SD25	NSECH	Create a more dementia friendly environment (cubicle) to support patients with dementia.	ED currently built to dementia friendly specification. ECSUB to consider 2 rooms to have additional enhancements regarding signage and colour.	Matron for Emergency Care	October 2016	Reviewed and no further action required - Complete	n/a

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Critical Care							
SD26	NSECH	Review the nurse staffing establishment to consider the inclusion of an additional supernumerary registered nurse over and above the clinical co-ordinator as recommended in Core Standards for Intensive Care Units (2013).	Medicine and Emergency Care Business Unit to review current nurse staffing establishment with Director and Deputy Director of Nursing.	Chief Matron MECCBU	September 2016	The critical care unit due to its size prefer the current coordinating method. No further action required - Complete	n/a
SD27	NSECH	Review the provision of the critical care outreach service following the change in model of delivering care and in relation to national critical care outreach standards.	Review of Outreach structure	Head of Service Critical Care	May 2016	Complete	Outreach report
SD28	NSECH	Consider the role of a clinical nurse educator on the unit as recommended in Core Standards for Intensive Care Units (2013).	To be reviewed as per SD26	Chief Matron MECCBU	September 2016	Leads for clinical education identified within existing workforce. Team have reviewed and deem current process to be preferred option. No further action required – Complete	Nurse Educator report and competency record

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Children and young people							
SD29	NSECH	Fully embed the duty of candour with all staff.	Information circulated in CHBU newsletter in Dec 15 to repeat this in June 16 Discuss at team meetings and heads of department	General Manager OSM	June 2016 May 2016	Already sent out via newsletter after CQC visit in Dec 2015 and included again in August 2016	Newsletter and team meetings
SD30	NSECH	Ensure patients clinical records are always available for children attending for day surgery at the hospital.	Process in place for trauma and elective admissions and for records to be available on site prior to surgery Datix to be completed on any occasion that a record is not available	Matron/OSM Ward Manager	May 2016 May 2016	Liaising with new Trauma Co-ordinator pilot for facilitation of orthopaedic attendances and requesting of records. DATIX completed whenever notes not available/or ward not informed of admission	o/s
SD31	NSECH	Address the issue of clerical support at weekends in the Children's Unit, to ensure there is not a delay in sending out electronic discharge summaries to GPs.	Business case being developed To present at operational board in June 2016	OSM	June 2016	All now in post and 7 day working started - complete	n/a

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SD32	NSECH	Ensure that non-qualified staff in the Children's Unit have clearly defined job roles and have robust competencies in place.	Away days arranged with whole nursing team to discuss pathways Meeting scheduled to review ANP job description	Matron/OSM General Manager	June 2016 11.5.16	Planned sessions with staff involved and on-going training plans ANP JD has been revised and assessed by A4C panel	Away day agenda, outcome letter from A4C
General							
SD33	HGH NTGH NSECH WGH	Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2016.	Training compliance continues to be monitored on a monthly basis at Workforce Committee. Business Unit performance is now included in quarterly governance declarations to Assurance Committee.	-	On-going	Target achieved for 2015/16	Training report

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