Cover page	
Meeting	Trust Board
Paper Title	Care Quality Commission Section 31 Update Report
Date of meeting	6th February 2020
Date paper was written	27th January 2020
Responsible Director	Barbara Beal, Director of Nursing
Author	Kara Blackwell, Deputy Director of Nursing

Executive Summary

Following the CQC inspection in November 2019 the CQC varied the conditions already imposed on 13th September 2018, 2nd October 2019 and 18th April 2019 and imposed new conditions in respect of the Trust regulated activities specifically in relation to the care in the Trust.

This report provides an update in relation to the CQC Section 31 varied and new conditions imposed in relation to the two Emergency Departments, the Inpatient wards and to all clinical areas. It also provides an update in relation to the existing Section 31 conditions in place following the CQC inspection in September 2018 and April 2019 for the Emergency Departments and the Maternity Unit.

The Maternity Unit has consistently demonstrated improvements in relation to the weekly reporting against these conditions. For the Emergency Departments, Inpatient wards and conditions applied to all clinical areas the data analysis in this report outlines that although systems, processes, monitoring and actions are in place in relation to the improvements required there is significant work to be done to ensure these actions are embedded and consistently applied.

Previously considered by	*N/A*

The Board is asked to:

☐ Approve	☐ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports*
	☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare
	☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care
	☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities
	☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions
	☑ OUR PEOPLE Creating a great place to work

Equality Impact Assessment	
	◉ Stage 1 only (no negative impact identified)
	○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)

Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*No*

CARE QUALITY COMMISSION SECTION 31 UPDATE REPORT JANUARY 2020

1.0 INTRODUCTION

On the 29th November 2019 following their inspection the CQC notified the Shrewsbury and Telford NHS Trust of the urgent notice of decision to impose and vary the conditions as a service provider in respect of a regulated activity:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Assessment or medical treatment of persons detained under the Mental Health Act 1983

Under Section 31 of the Health and Social Care Act 2008, the CQC decided to impose and vary the conditions already imposed on 13th September 2018, 2nd October 2019 and 18th April 2019 in respect of the above regulated activities specifically in relation to the care in the Emergency Departments and on the Inpatient Wards, and apply new conditions applicable to all clinical areas across the Trust.

The Trust immediately developed further actions in response to the extended Section 31 which is reported to the CQC every Friday. This report provides details of the actions taken and current performance/compliance in relation to these.

2.0 SECTION 31 VARIED/EXTENDED CONDITIONS

2.1 UPDATE ON CURRENT ACTIONS

The table below outlines the current status of the actions in the Inpatient action Plan and the Emergency Department Action Plan. Many of the actions completed/delivered relate to the implementation of processes. The status of a majority of the actions is that they have been implemented but that there is ongoing monitoring as the performance against these actions is not always achieving the required performance levels or fully embedded and therefore assurance in relation to these is more limited.

Inpatient Action Plan – Overall status of all actions	
Not yet started	0
In progress	1
Delivered	5
Delivered ongoing monitoring	10
Overdue	0

ED Action Plan Overall status of actions	
Not yet started	2
In progress	7
Delivered	23
Delivered ongoing monitoring	47
Overdue	0

In addition to the Section 31 conditions already in place, the extended conditions included:

In the Emergency Department the conditions already in the Section 31 were extended to include:

1. The registered provider must ensure that there is an effective system in place to identify, escalate and manage all services users in line with the relevant national clinical guidelines who present with possible sepsis or a deteriorating medical condition
2. Effective management of service users under the age of 18 through the emergency care pathway
3. The registered provider must ensure that there is an effective system in place to ensure mental health risk assessments are completed in line with relevant national guidance.

These are required to be reported separately for the RSH and PRH Emergency Departments.

In the Inpatient Medical Wards the extended conditions included:

- The registered provider to ensure the system in place for effective management of deteriorating patients and sepsis at Shrewsbury Hospitals and the Princess Royal Hospital.

Throughout all clinical areas in the Trust a new condition included:

- The registered provider must ensure that there is an effective system in place to ensure de-escalation management and intervention holds are completed in line with relevant national guidance. This includes but not limited to the use of rapid tranquilisation.

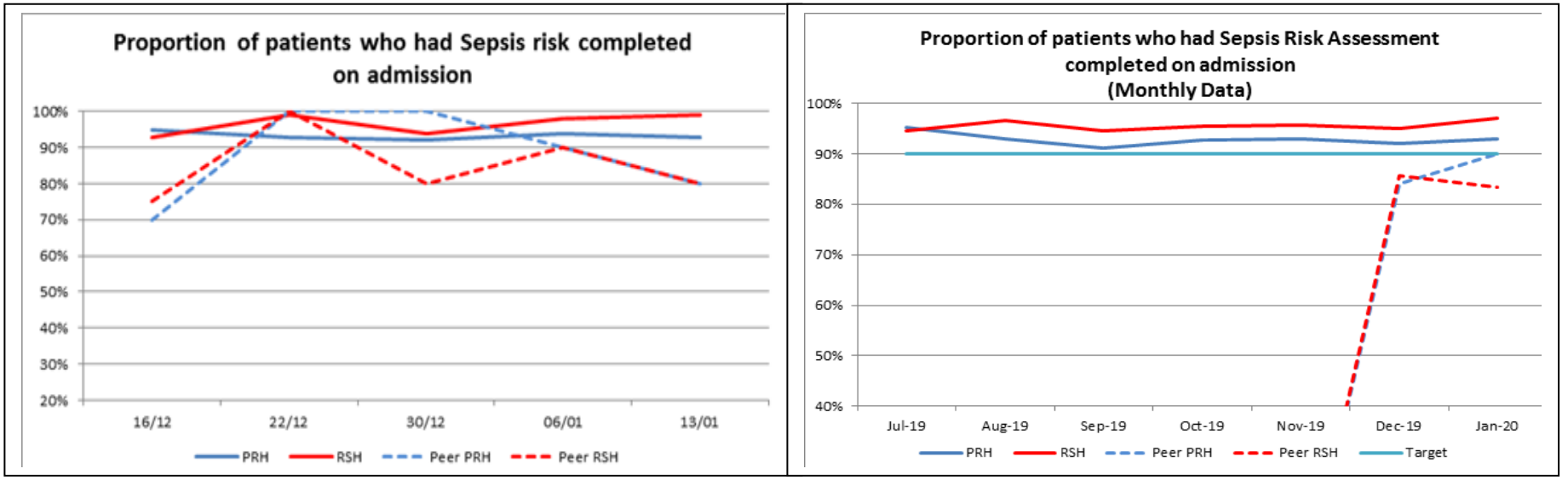
2.2 THE EMERGENCY DEPARTMENT

2.2.1. *The registered provider must ensure that there is an effective system in place to identify, escalate and manage all services users in line with the relevant national clinical guidelines who present with possible sepsis or a deteriorating medical condition*

This condition was previously imposed by the CQC following their inspections but remained a serious concern following their most recent inspection. The condition was varied with the Trust required to report weekly on:

- Confirmation of actions taken to ensure that the system is implemented and is effective.
- Details of action taken to ensure the system it is being audited monitored and continues to be followed.
- Results of monitoring data and audits undertaken that provide assurance that action is taken to improve the quality and safety of services

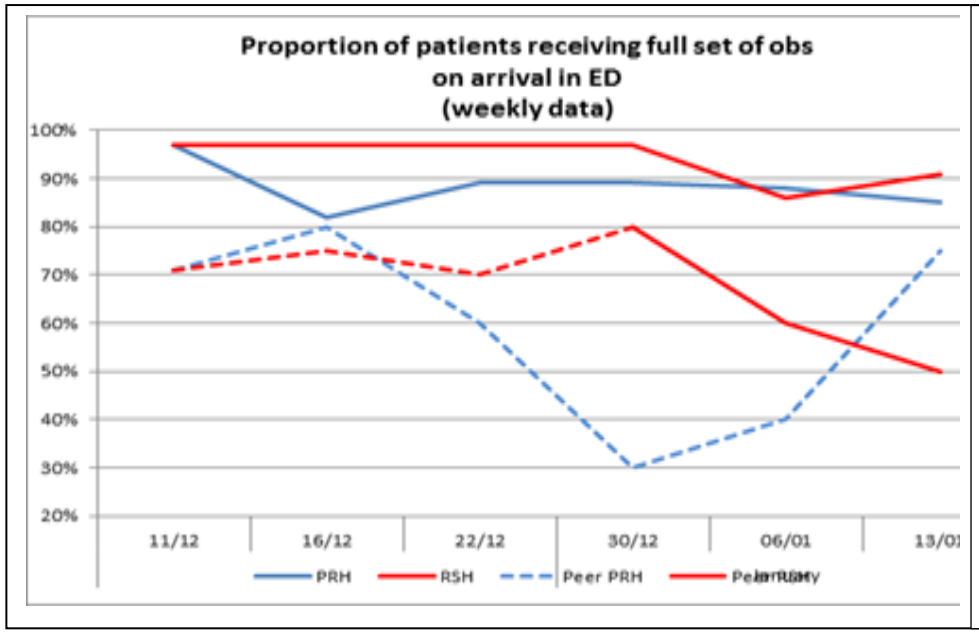
The tables below show the sepsis audit results undertaken by the Emergency Department staff for the last 6 months. Performance for the last 5 weeks for both PRH and RSH Emergency Departments is shown in more detail and compared with the additional peer audits which are now in place and are undertaken on a sample of 10 patients weekly for each sites to provide fresh eyes and assurance.

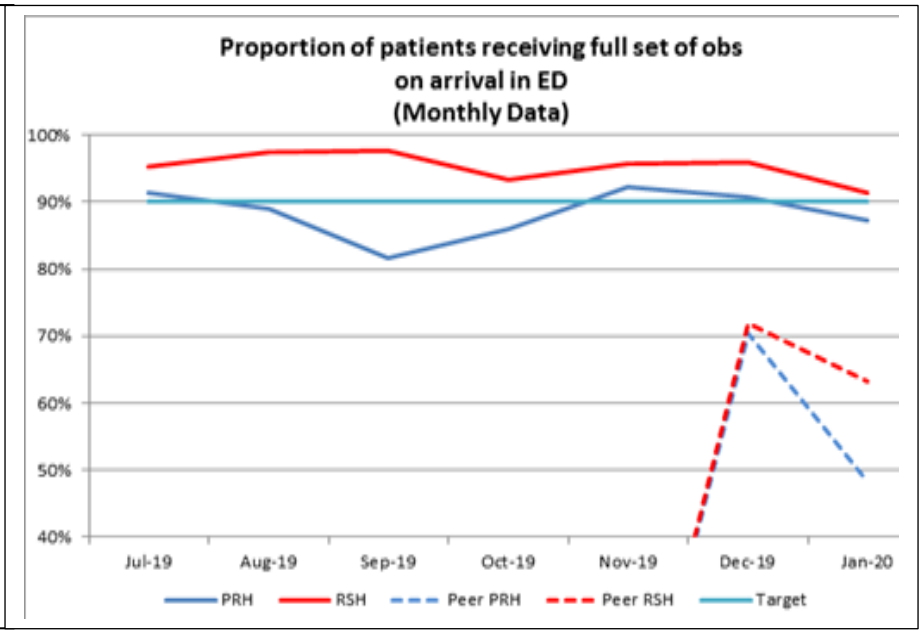


The results of the weekly peer audits show (10 pts per site/week), however, the sample is much smaller than the ED audit which is undertaken daily on 5 pts x 4 audits = 160 patients per site per week (320 patients in total). The Sepsis Specialist Nurse continues to work closely with the two Emergency Departments to improve awareness and understanding. A weekly Deteriorating Patient Group is in place to progress actions to improve performance and compliance against this critical quality measure in relation to safety. Actions include:

- Review of policies, training, sepsis processes and compliance
- Emergency Department compliance heat map to be shared and used as a visual tool at huddles to identify aspects of good compliance and areas for improvement
- Peer assessors undertaking the weekly audit of 10 patient CAS cards address issues directly with the shift co-ordinator at the time of the audits

The audit of the proportion of patients receiving a full set of observations on arrival at the Emergency Department are shown weekly for December-January 2020, monthly performance is also shown.





The audit results show there is variable compliance with undertaking a Patient Full Set of Observations on arrival to the Emergency Departments; they also show variability by site with the results for PRH showing lower compliance than RSH. Performance against this quality measure is impacted in part by there not being a pain score documented as part of this assessment and in line with national guidance. The Peer audits, (again on a smaller sample) show poorer results than those collected in the audit undertaken by the Emergency staff in the Department.

2.2.2 The registered provider will ensure effective management of service users under the age of 18 through the emergency care pathway.

a. The number of service users under the age of 18 not triaged within 15 minutes of arrival to the emergency department or seen by the paediatric medical team within the hour and details of any harm arising as a result of the delay.

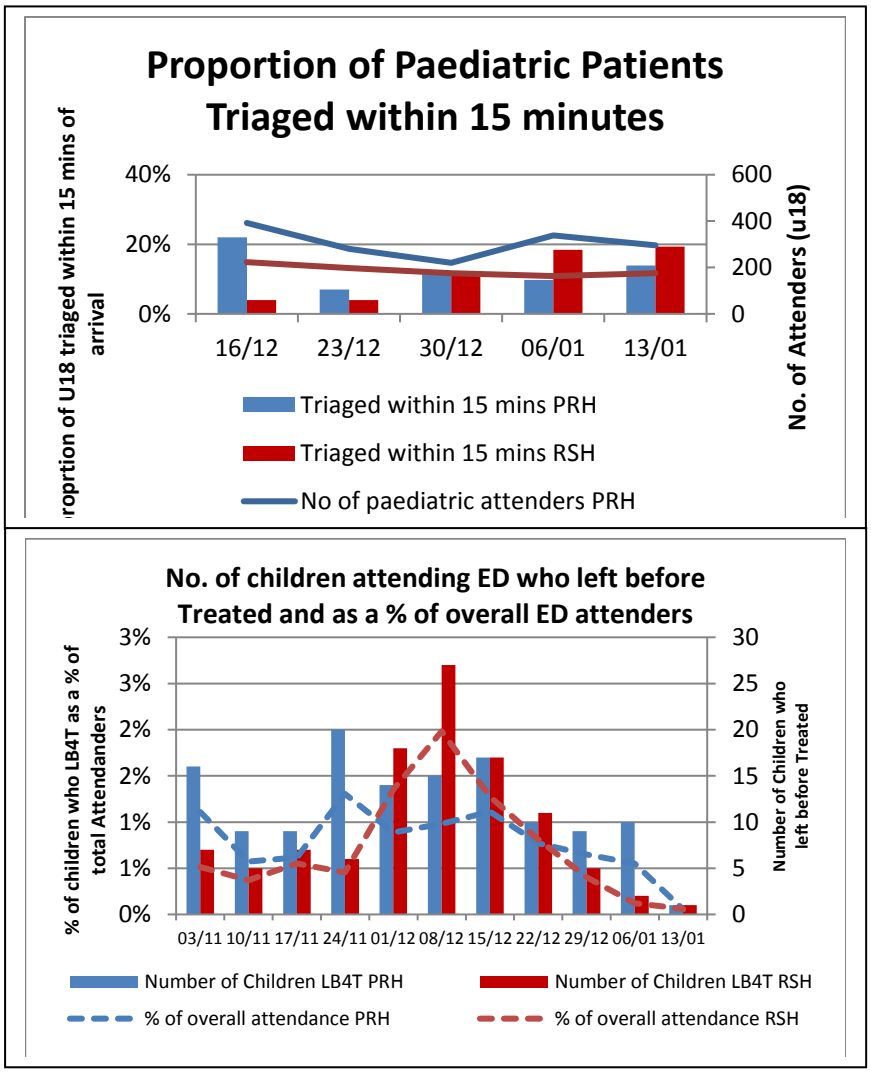
b. Results of monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

c. Details of all children who left the department without being seen.

d. Details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

This was a new condition applied to the Emergency Departments and the Trust is required to report weekly individually for the RSH and PRH sites.

The Charts below show the number of paediatric patients triaged within 15 minutes over the last 4 weeks for both the RSH and PRH Emergency Departments



A majority of the paediatric patients have not had a time recorded for when they were triaged meaning it is difficult to report if they were triaged within 15 minutes. For the week commencing 22nd January 2020 62% of paediatric patients at RSH had no triage time recorded and 55% had no time recorded at the RSH site. For those patients where a triage time was recorded the audit results show that at present only a small percentage of paediatric patients are triaged within 15 minutes; only 15% at the PRH and 19% at RSH.

Actions to improve compliance:

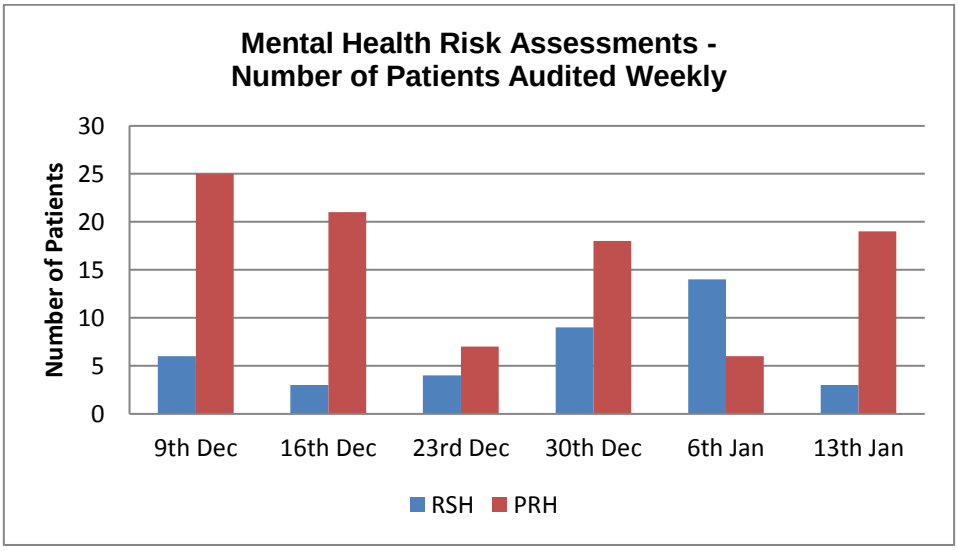
- Registered nurses reminded to document the triage time
- The teams are considering options to have a dedicated Paediatric Triage Nurse
- In addition at the PRH site (where there are more paediatric patients) the team are considering having a ring–fenced area for all paediatric patients to be treated by a separate team, these discussions are in the early stages but need to move forward at pace to improve access to assessment for these paediatric patients

The audits show that the number of children who left the department without being seen has reduced since 22nd December. The records of all children who leave the Department before being seen are reviewed and followed up by an ED Consultant; no harm has been reported from these reviews.

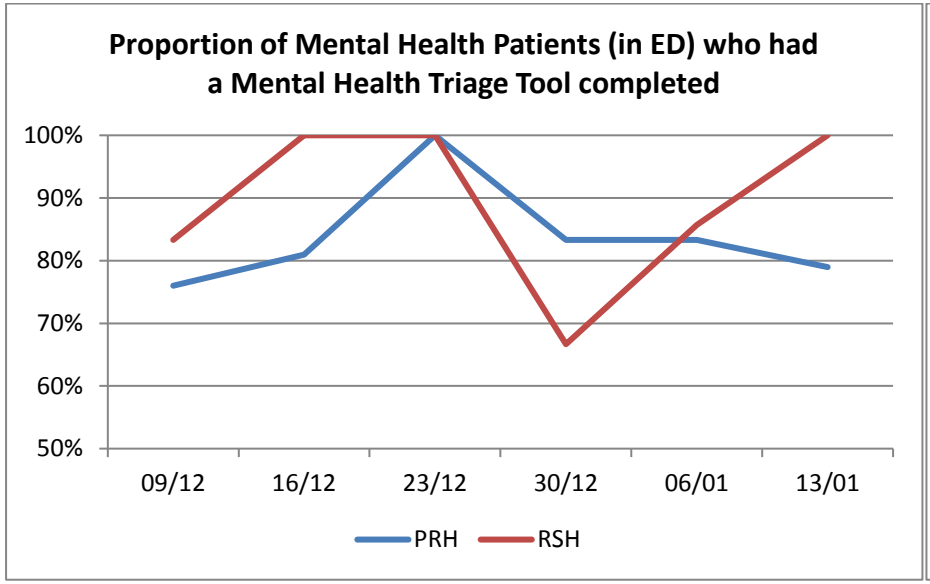
2.2.3 *The registered provider must ensure that there is an effective system in place to ensure mental health risk assessments are completed in line with relevant national guidance.*

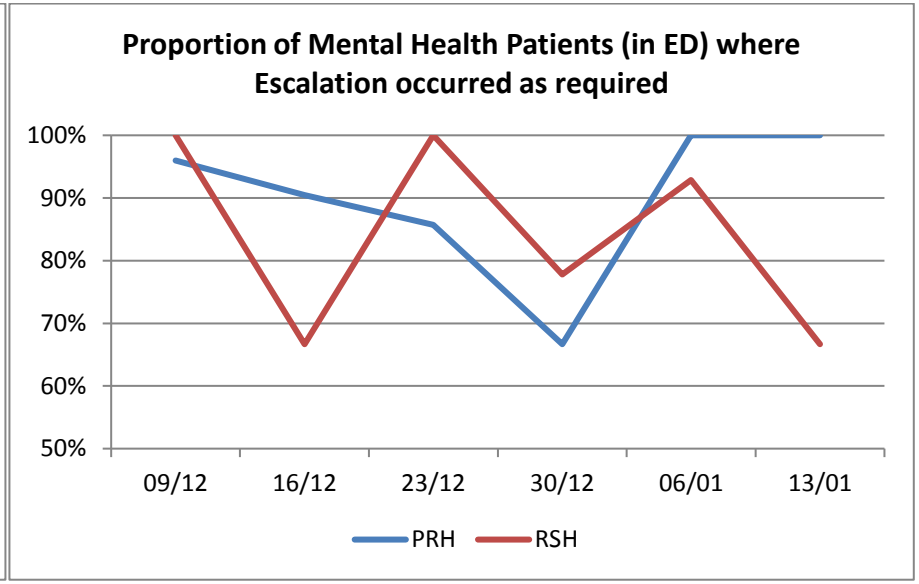
This is a new condition which applies to both the PRH and RSH Emergency Departments.

In response to the conditions applied the Emergency Departments commenced twice daily audits of 3 sets of patients presenting with mental health issues to provide assurance that patients are being triaged and escalated appropriately. Due to the number of mental health attendances to the EDs often the number of patients audited is much lower than this. Overall more patients are audited for the PRH site, reflective of more attendances for mental health issues.



The results of these mental health risk assessment audits are shown below.





The proportion of patients with mental health issues who have had a mental health triage tool completed remains variable. For the week commencing 13th January 2020 79% of patients had an assessment completed compared to 100% at RSH. In comparison escalation following completion of the tool was 100% at PRH and only 67% for RSH. The results continue to show that the use of the mental health tool is still not fully embedded

Actions being undertaken to improve compliance include:

- Mental Health Act training initiated in September 19 extended out to medical and AHP colleagues. Further sessions in February 2020.
- Staff continue to be reminded at daily huddles about completion of the mental health tool
- Ongoing education to all ED staff in relation to completion of the tool
- The Mental Health Liaison team have been providing support to the ED departments in promoting awareness of compliance with national guidance

-

2.2.4 EXISTING SECTION 31 CONDITIONS FOR THE EMERGENCY DEPARTMENT (in place since September 2018).

An update on the Section 31 conditions previously imposed in September 2018 and April 2019 following their inspections which remain in place are outlined**.**

1. The registered provider must ensure there is a system in place to ensure effective environmental risk assessment and management across the emergency department.

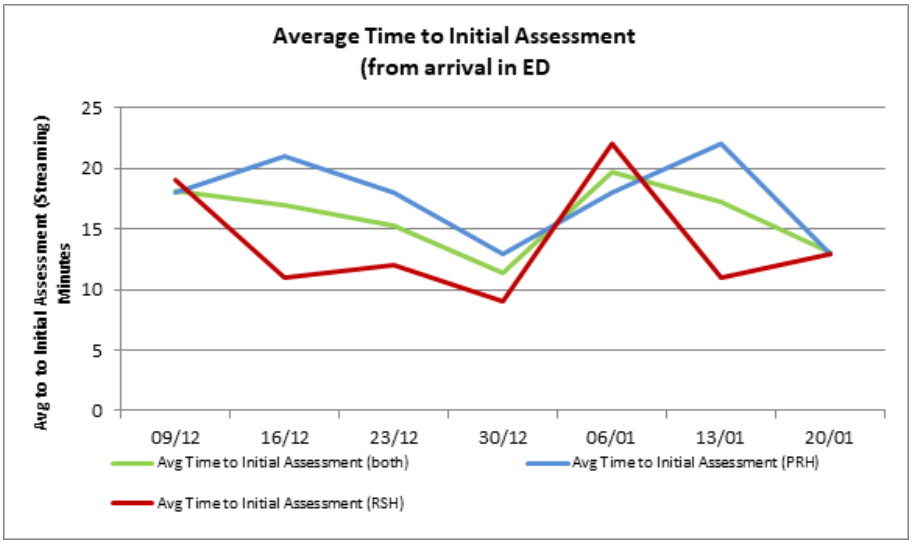
This condition includes:

a. The results of any monitoring data and audits undertaken that provide assurance that the system of risk assessment and risk management in place is effective.

Environmental checks continue in the Emergency Departments and in addition to this the Matron/Lead Nurses are undertaking 3 additional audits per site. These audits include some environmental checks, for example the security in the department. Every effort is being made to ensure doors remain closed and discussions have commenced with security and facilities to agree a plan for a secure unit.

2. The registered provider must ensure all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.

The time to initial assessment is reported weekly to the CQC; the data shows variability in the triage time, with the most recent week (20th January2020) showing that patients were assessed at both Emergency Departments within 15 minutes.



3. The registered provider must ensure that the systems in place across the Emergency Departments account for patient acuity, and the location of patients at all times.

Patient acuity is assessed on admission and displayed on the whiteboard alongside the patient's NEWS score, alerts, time in the department, breach time and treatment updates. Patients are prioritised and oversight is obtained through a 2 hourly huddle between the co-ordinator and a senior doctor. The ED spot check audits provide assurance that the patient's observations and frequency of these are being monitored and actioned.

4 The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.

There are now substantive Clinical Nurse Educators now in post all training is co-ordinated and records are updated regularly. All new staff are given a 4 week supernumerary time to ensure their training is embedded and they are aware of department SOP's and protocols. The Departments continue to implement the training plans (against trajectory) for the Manchester Triage Training.

Training compliance for staff in relation to NEWS2, Sepsis, Paediatrics Basic Life Support and Safeguarding Children are shown below:

Site	NEWS2	SEPSIS	PAEDs BLS	SAFEGUARDING CHILDREN
PRH	93%	93%	79%	72%
RSH	100%	100%	61%	85%

2.3 TRUSTWIDE ALL CLINICAL AREAS

The registered provider must ensure that there is an effective system in place to ensure de-escalation management and intervention holds are completed in line with relevant national guidance. This includes but not limited to the use of rapid tranquilisation.

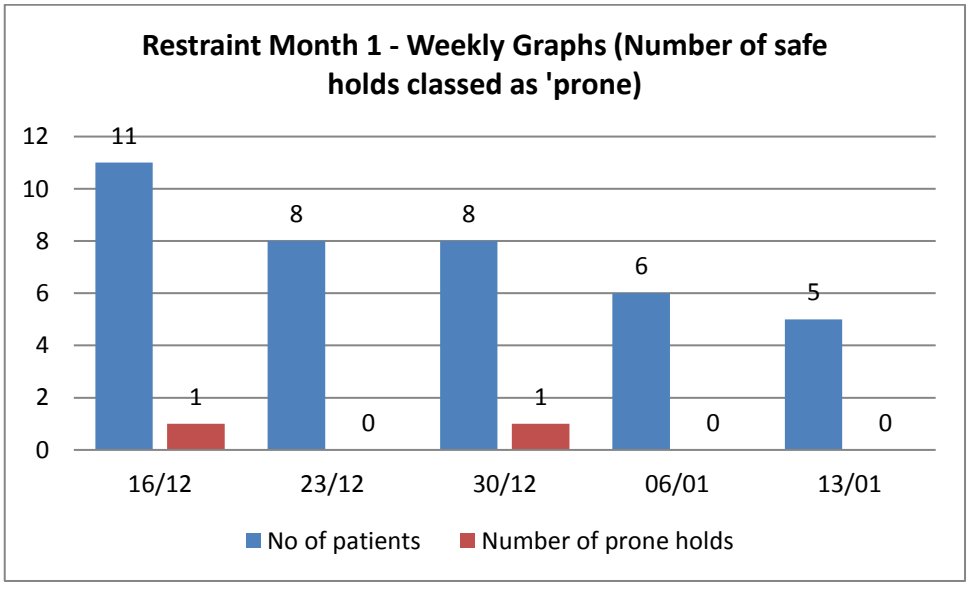
This is a new condition added to the Section 31, and applies to all wards and departments, and includes:

- Details of de-escalation management and intervention holds including type and length of hold and post hold action.
- Results of monitoring data and audits undertaken that provide assurance that a process is in place for the management of physical intervention.

The immediate action taken in response to regulation included:

- One minute brief sent to all staff, which summarised the key point of the Policy for Clinical / Safe Holding of Adults and Children Receiving Care in the Trust (2021).
- Development of SOP and checklist for the restraint of patients in line with current policy.
- A system was put in place to correlate the security data base / reports with the number of Datix.
- Establishment of monthly safe holding review meeting.
- Weekly audit of all patients who have been restrained whilst cared for at the Trust

The results of the weekly reviews of all patients who have been restrained in both the wards and Emergency Departments are shown.



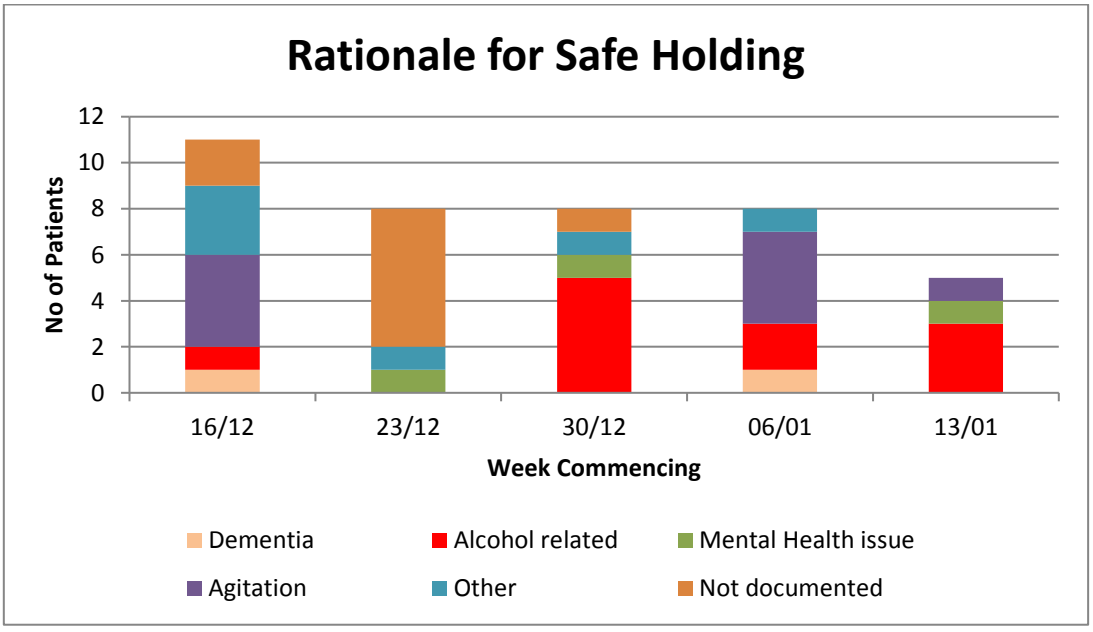
In total 38 patients have been restrained across the Trust since the restraint audits commenced on 16th January 2019; the number of patients restrained in the prone position has been small (5%). Most of these patients were restrained in the Emergency Departments or on the Acute Medical Units.

In line with the bespoke training received by security staff the prone position for restraint is only used as a means of gaining control and staff are required to release the patient as soon as possible so he/she can begin to rise from the floor of their own accord; if further control of the patient is needed restraint can then be re-instated using an alternative position e.g. seated or standing. In this sense and based on the training security staff have received prone is only really used as part of a combination of holds to control a patient. The use of the prone position in isolation is discouraged.

In line with the training given when using the prone position both staff carrying out the restraint are required to lie next to or get down either side of the patient so they can observe the patients breathing; the patient's own arms and hands are positioned beneath the front of the patient's own shoulders so as to provide a space for the chest to expand and breath.

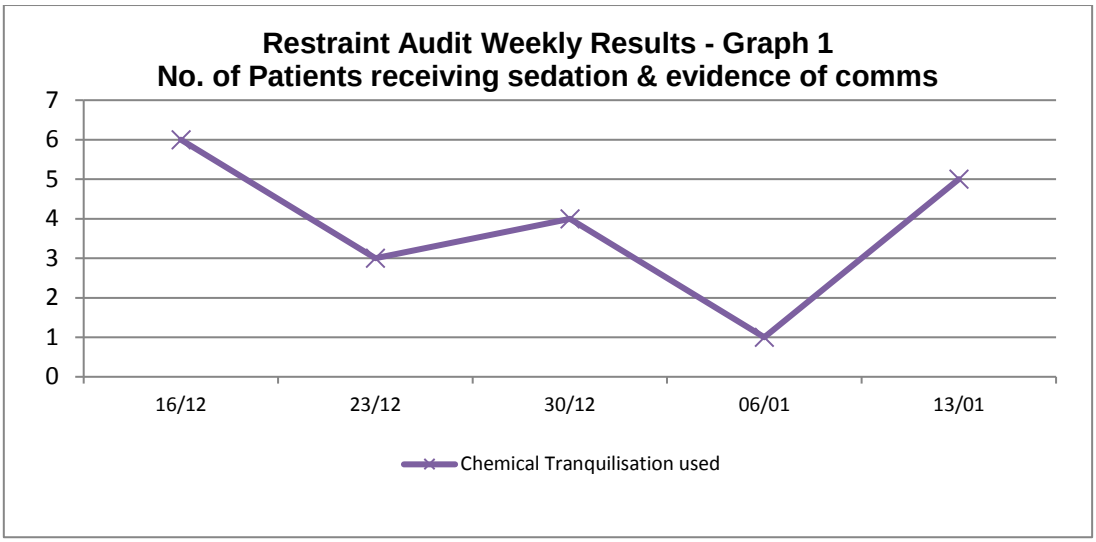
Restraint training for security teams (which includes BLS) is provided by accredited NHS training staff from the Midlands Partnership NHS FT. The training, which consists of a 5 day foundation course, and annual refresher days thereafter. The regular security team have attended their one day annual refresher training in January 2020.

The rationale for the use of restraint for the patients who received safe holding is shown in the chart below:

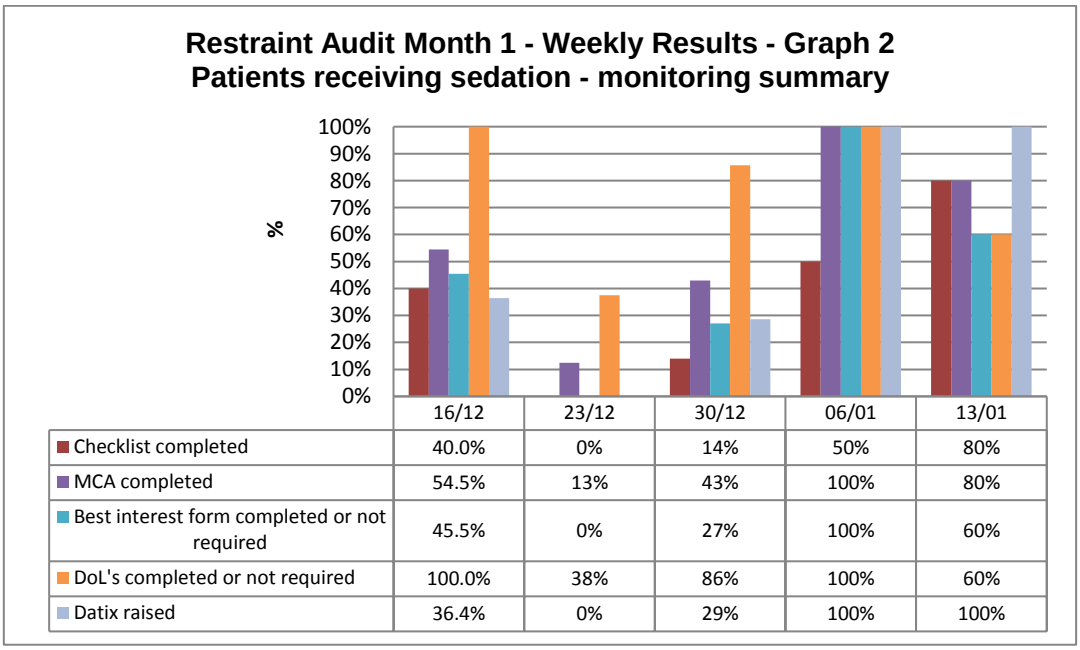


A majority of the patients who were restrained were patients with alcohol related issues who were agitated/aggressive and requiring treatment (29(%) or agitation (24%). Initially for some of the patients restrained the rationale was not documented but this has improved over the last 2 weeks with a rationale documented.

A total of 19 (50%) of patients received chemical restraint.



For patients who have been restrained and those who may also have received chemical tranquilisation compliance with the recently implemented checklist is shown below. The results indicated that the process is not embedded across the Trust and further work is required to consolidate staff knowledge of the process (SOP) and restraints pathway as this alerts staff to the action they are required to complete.



	16/12	23/12	30/12	06/01	13/01
Checklist completed	40.0%	0%	14%	50%	80%
MCA completed	54.5%	13%	43%	100%	80%
Best interest form completed or not required	45.5%	0%	27%	100%	60%
DoL's completed or not required	100.0%	38%	86%	100%	60%
Datix raised	36.4%	0%	29%	100%	100%

2.4. INPATIENT WARDS

The registered provider to ensure the system in place for effective management of deteriorating patients and sepsis at Shrewsbury Hospitals and the Princess Royal Hospital.

This condition was previously applied to the Emergency Departments but has been varied to include all inpatient areas and outlines:

a. Confirmation of actions taken to ensure that the system is implemented and is effective
b. Details of action taken to ensure the system it is being audited monitored and continues to be followed
c. Results of monitoring data and audits undertaken that provide assurance that action is taken to improve the quality and safety of services.

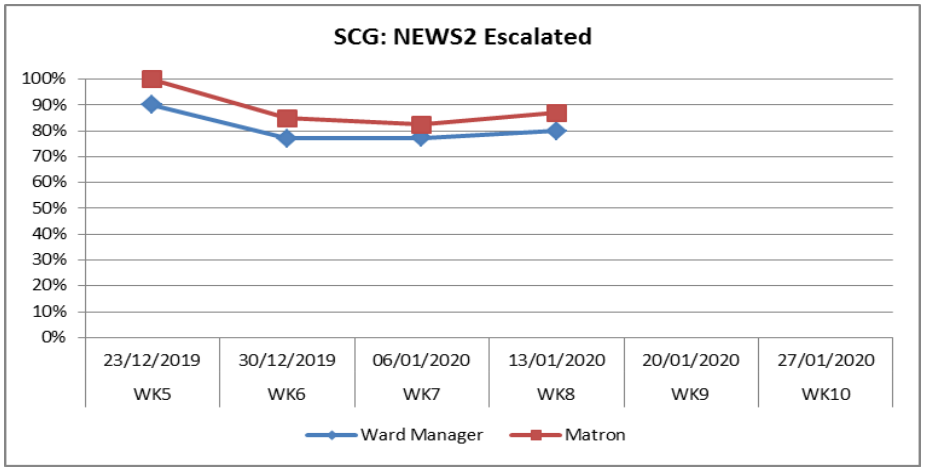
Immediate actions were taken in response to these conditions; these include:

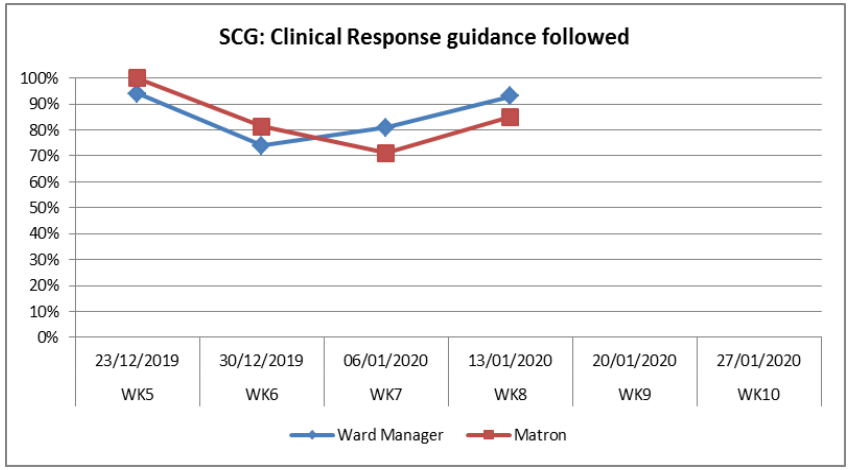
- All patients NEWS scores to be handed over as part of the shift handover on all other adult medical wards and surgical wards.
- Daily check of NEWS observations via Vitalpac at individual ward level by nursing staff; ward Manager and Matrons
- Patients with NEWS higher than 5 are handed over to Hospital at Night Team and the oncoming Critical Care Outreach Team on the day shift.
- Matron weekly spot check of patients with NEWS>5.
- Commenced Corporate Nursing peer monthly peer audit review.
- Commenced weekly deteriorating patient nursing group (task and finish group) whose remit is to ensure action progress on the deteriorating patient action plan. This group will report to the monthly Trust wide deteriorating patient meeting.

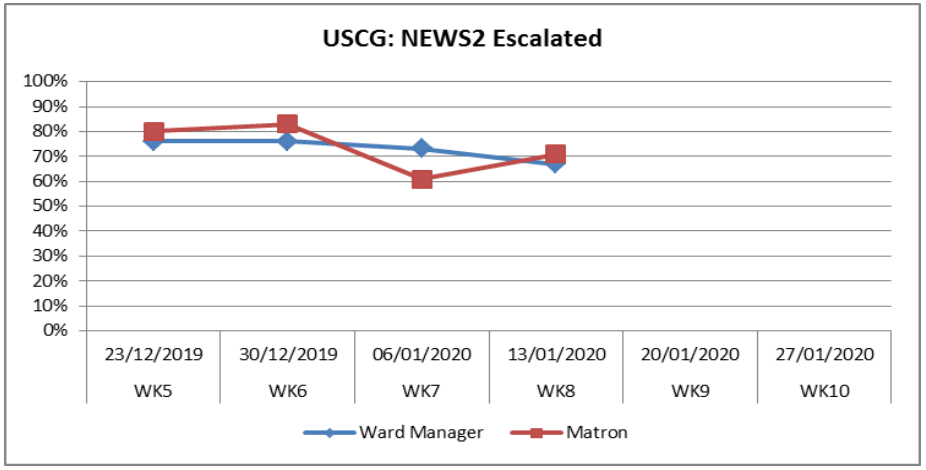
The daily spot checks of the observations on Vitalpac by the ward manager identify any patient that has triggered a NEWS >5 and prompts a review to ensure that the deterioration has been escalated and actioned. The matrons also undertake a weekly spot check of patients who have triggered a NEWS>5. The ward managers have also been challenged to ensure that patients observations are recorded on time and a daily performance report is circulated to all wards, matrons and Heads of Nursing.

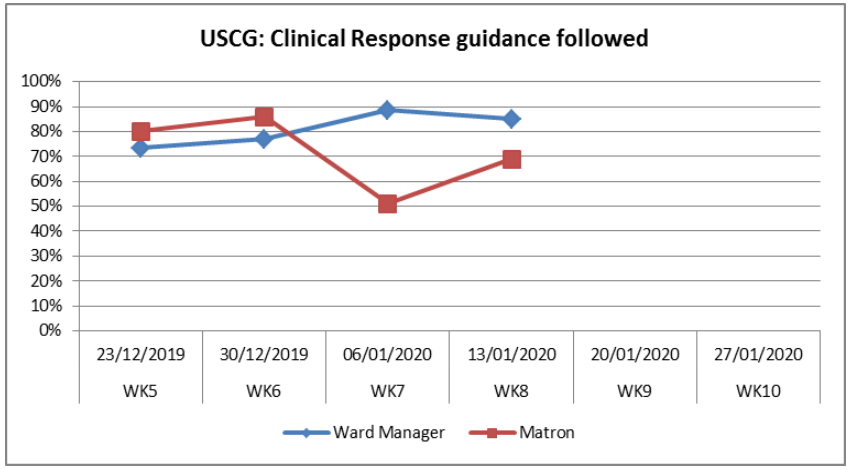
A peer audit undertaken of patients has also commenced, the data is entered manually onto the audit proforma and analysed by the Clinical Audit Department. These peer audit results will be presented in future CQC update reports.

The results of the ward manager and matron spot checks are shown for both the percentage of patients with a NEWS>5 who had been escalated and whether the clinical response guidance was followed. These results are broken down by Scheduled and Unscheduled Care Group and show variation week on week with improvements required in both Care Groups.









3.0 MATERNITY UPDATE SECTION 31

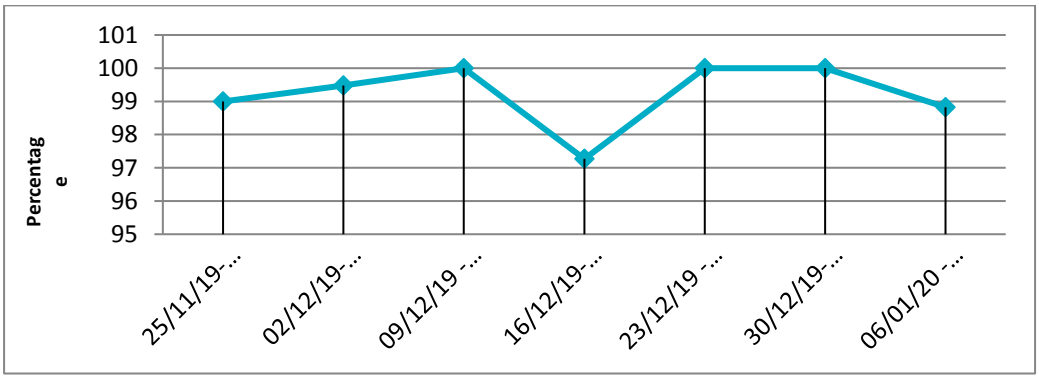
The Section 31 conditions for Maternity Services have been in place since September 2018, none of these were varied and no new conditions were added to maternity services after the inspection in November 2019.

The registered provider must ensure that there is an effective system in place to ensure effective and continued clinical management for low and high-risk patients who present to the midwifery services in line with national clinical guidelines. This includes cardiotocography (CTG), Modified Early Obstetric Warning System (MEOWS), reduced fetal movement and triage guidelines. The provider must ensure that trust guidelines include a clear escalation plan to secure timely review from medical staff.

The previous conditions which remain in place and are reported on weekly include:

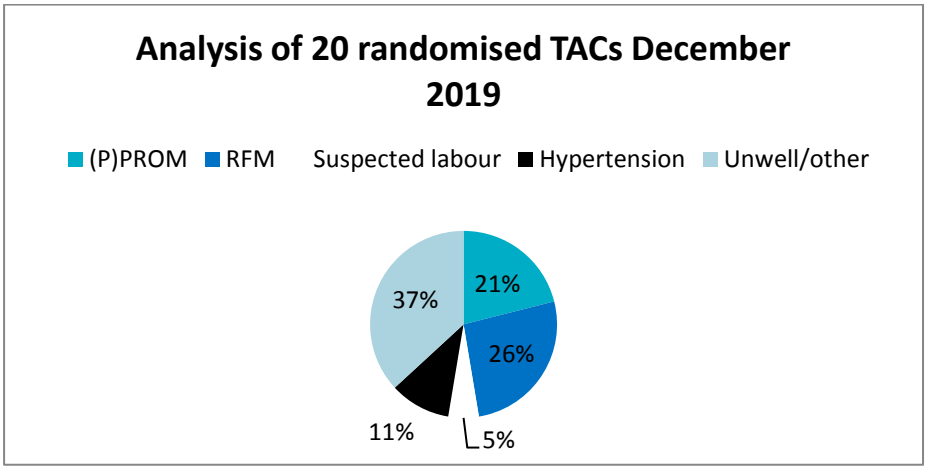
a. The actions taken to ensure that the system is implemented and effective.
b. The actions taken to ensure the system is being audited and monitored and continues to be followed.
c. The report should include results of any monitoring data and audits undertaken that provide assurance that an effective clinical management system is in place, and patients are escalated appropriately for medical support and review in line with national clinical guidelines.

The elements in the Section 31 are included in the clinical incidents case reviews which take place in the Weekly Obstetric Neonatal Risk Meeting. Approximately 10 cases are reviewed from notification of pregnancy to the time of the incident. This includes evidence of accurate completion of MEOWS charts and appropriate interpretation and escalation of CTGs. Good practice and learning is identified and disseminated via the 3 minute brief and case study to staff huddles. Clinical incident reviews are submitted to the CQC on a weekly basis via minutes of meetings, a Case Study and evidence of dissemination of learning.



There were a number of self-discharges from Triage whilst awaiting doctor review. The process for following up self-discharges is being reviewed by the Director of Midwifery.

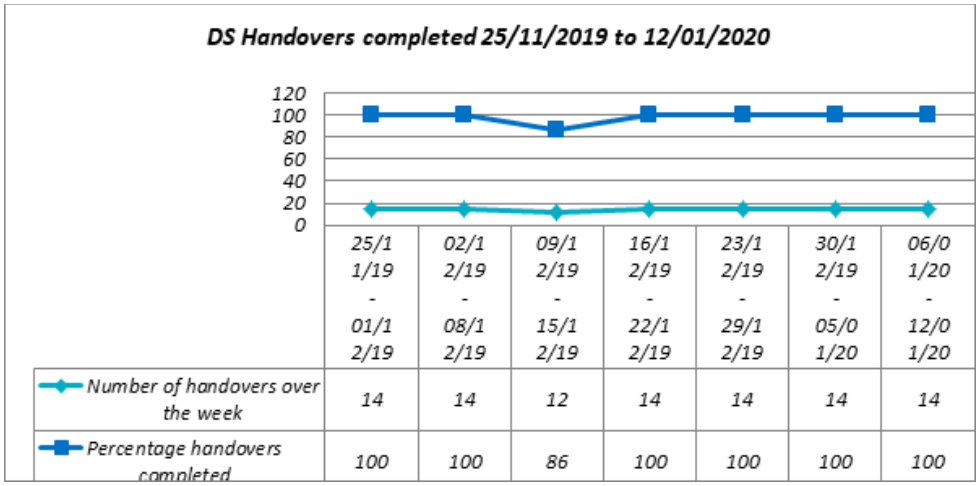
The results of the December TAC are shown below:



The results outline that:

- All Triage attendances were appropriately managed according to guidelines
- Earliest possible follow on appointments were arranged in all instances as required
- MEOWS were completed in all Triage assessments however, there are some instances of incorrect transcription
- 100% of women who were reviewed were either discharged or admitted with a clear plan of care

The twice daily Handover of Care on Delivery Suite continues to be monitored.



	25/11/19 - 01/12/19	02/12/19 - 08/12/19	09/12/19 - 15/12/19	16/12/19 - 22/12/19	23/12/19 - 29/12/19	30/12/19 - 05/01/20	06/01/20 - 12/01/20
Number of handovers over the week	14	14	12	14	14	14	14
Percentage handovers completed	100	100	86	100	100	100	100

Compliance has consistently been achieved at 100% with the exception of Week 68 (09/12/2019). This was the first time in 7 months that complete documentation had not been submitted. The missing information was escalated to the Clinical Director, Care Group medical director and delivery suite ward managers to reaffirm the importance of maintaining the standards achieved. The Delivery Suite Handovers are quality checked by using a “fresh eyes” approach.

4.0 CONCLUSION

This report has provided an update in relation to the CQC Section 31 varied and new conditions imposed in relation to the two Emergency Departments, Inpatient wards and across all clinical areas following the most recent inspection carried out in November 2019. The report also provides an update in relation to the existing Section 31 conditions in place following the CQC inspection in September 2018 and April 2019 for the Emergency Departments and the Maternity Unit.

The data analysis in this report outlines that for the new and varied conditions imposed for the Emergency Department and Inpatient areas although systems, processes, monitoring and actions are in place in relation to the improvements required there is significant work to be done to ensure these actions are embedded and consistently applied. This is also relevant to some of the existing conditions previously imposed in the Emergency Department. The data shows variation in the performance against these improvements and that the improvement work needs to be embedded at some pace given the significant concerns relating to the quality and safety of care.