Agenda Item: 6.7

CCG GOVERNANCE BOARD
EXECUTIVE SUMMARY SHEET – PART ONE

DATE: 10th and 11th March 2020

TITLE OF PAPER: Shrewsbury & Telford Hospitals NHS Trust Quality & CQC Update Report

EXECUTIVE RESPONSIBLE: Mrs Chris Morris, Executive Director of Quality
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CG OBJECTIVE: To improve commissioning of effective, safe and sustainable services, which deliver the best possible outcomes, based upon best available evidence.

For Information [ ] For decision [ ] For performance monitoring [x]

EXECUTIVE SUMMARY

This paper aims to update the Board on the actions identified at the three risk summits held relating to quality and safety at Shrewsbury and Telford Hospitals NHS Trust (SaTH). Risk summits were held on 13th December 2019 and 21st January 2020 following the CQC inspection in November 2019 and the imposition of section 31 breach notifications.

A further inspection of the two emergency departments was carried out on 17th and 18th February 2020 which resulted in further Section 31 breach notices. To this end another risk summit was called on 25th February 2020 chaired by NHSEI Regional Medical Director. Further actions were identified and the group will reconvene in 4 weeks.

The CQC confirmed there are currently 21 conditions on the Trust’s registration in place.

It is expected that the CQC inspection report will be with the Trust in the next few weeks prior to its publication.

Improvement plan updates recognise there is much work to be done to build robust sustainable assurances relating to patient safety and workforce.

The next meeting of the Safety oversight and assurance group in March will be last of this forum as the System Improvement Board will commence in April 2020.

FINANCIAL IMPLICATIONS: There are no direct financial implications within this paper

EQUALITY & INCLUSION: There are no specific issues related to equality and inclusion
**PATIENT & PUBLIC ENGAGEMENT:**
Both Shropshire and Telford & Wrekin Healthwatch Chairs are members of the group.

**CONFLICTS OF INTEREST:**
None evident related to this area.

**RISKS/OPPORTUNITIES:**
The quality of services provided by SATH to both Shropshire and Telford & Wrekin residents is listed as risk within the CCGs risk register.

**RECOMMENDATIONS:**
The Governance Board is asked to:
- Review the content of the report and identify further assurances that may be required.
1.0 Aim

This paper aims to update the Governance Board in relation to quality and safety at Shrewsbury and Telford Hospitals NHS Trust (SaTH) following Care Quality Commissions inspections in November 2019 and February 2020.

2.0 Background

SaTH was rated inadequate by Care Quality Commission (CQC) following an inspection in September 2018 and prior to the CQC report publication NHS Improvement placed the Trust into special measures. An improvement plan was put in place and monitored via the NHSEI led Safety Oversight and Assurance Group. There has been senior CCG attendance at this meeting throughout the past year.

CQC inspected the Trust again in April 2019 to review Maternity and carried out a full inspection in November 2019. The report of this will be with the Trust in the near future for accuracy checking and then publication. Following the February 2020 inspections of the two emergency departments the Trust was notified of additional regulatory breaches of Section 31 of the Health and Social Care Act 2008

3.0 Section 31 breaches

Section 31 allows the CQC to serve a Notice of Decision upon a provider if it has reasonable cause to believe that, unless it acts any person will or may be exposed to the risk of harm. Such a notice would suspend a provider’s registration for a period of time, or impose, vary or remove conditions on your registration with immediate effect. The CQC is considering action including but not limited to:

- Imposing a condition on the trust’s registration which limits the operating hours of the emergency department service at one or both locations.
- Imposing a condition on the provider’s registration which limits, or totally stops the conveyance of children to Princess Royal Hospital, except in life threatening scenarios.
- Imposing a condition on the provider’s registration which restricts the number of ambulances conveyed to the emergency department at one or both locations.

A presentation was shared with board members in a confidential session on 10th and 11th December 2019 just after the CQC notified the CCGs of a Section 31 notification being issued placing conditions in the Trust registration. This focused on the following areas:

- Deteriorating patient & management of patients with signs of sepsis
- Care of patients with mental health and compliance with the Mental Capacity Act
- Application of Mental Capacity Act & DOLS
Further breach notifications were received in February 2020 related to what the inspectors described as poor care within the two emergency departments. The CQC have reported there are now 21 conditions in place in relation to the Trust.

The Trust public board meeting in February received a briefing on the issues identified by the CQC.


5.0 NHSE/I Roundtable

A system level roundtable executive meeting was held on 4 February 2020. The Roundtable event identified work streams across the health economy to support SaTH and the development of a system improvement board to drive and monitor quality improvement. This will supersede the Safety Oversight and Assurance Group (SOAG) that has been in place since November 2018 and will commence in April 2020.

6.0 SOAG 18th February 2020

Key points

The following points were raised at the February 2020 SOAG meeting:

- Emergency Department Consultants - 4 substantive in post supplemented by locum workforce – mitigating actions in place
- Therapy workforce is reported to be challenging across the Trust and this is under review
- Sepsis screening and time of antibiotic treatment initiation was discussed as requiring improvement.
- A review of how risk management is strengthened from floor to the Board is to be discussed at a future meeting along with assurances to partners as to how actions are signed off as completed within the trusts improvement plan
- The Trust is developing a single improvement plan to ensure impact can be measured.
- The next meeting in March will be last of this forum as the System Improvement Board will commence in April 2020.

The CCGs Executive Director of Quality and Head of Quality carried out unannounced visits to both emergency departments on the weekend of 22nd and 23rd February to test if the immediate actions put in place by the Trust were being enacted to manage patient safety, privacy and dignity. The outcome of this was that paediatric nurse cover was not in place at PRH and the audit outcomes from records reviewed continued to align with the CQCs previous findings.

Conclusion

The CCGs need to continue to work closely with the Trust, regulators both NHSEI and CQC, along with Healthwatches in the monitoring of actions and improvement plans, testing compliance in real time as well as through contractual routes to ensure the required improvements are progressed and sustained.
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3rd March 2020