Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: CQC Annual Assurance Report			Meeting date: 25th May 2022
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice, South Devon Quality and Compliance Manager		
Report provenance	Reports on all aspects have been provided to Quality Improvement Group (QIG), Quality Assurance Committee (QAC) and the Trust Board, through the year.		
Purpose of the report and key issues for consideration/decision	To provide an annual update for assurance, for the period April 2021 to March 2022, on: • Compliance with CQC standards and response to previous CQC inspections • The Trust's current registration status • The CQC's monitoring activity of the Trust • Preparation for future inspections and monitoring activity.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to receive and note: • The Statement of Purpose • Changes to CQC Regulatory approach • Update on Trust actions against findings from recent inspections • Preparation for future monitoring		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** x; **Valuing our workforce** **Improved wellbeing through partnership**; **Well-led** x		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** x; **Risk score** 20 **Risk Register** x; **Risk score** 12		

<table>
<tr><td></td><td>BAF Objective 4: To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td>x</td></tr>
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Report sponsor	Chief Nurse	
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1. Introduction

This report provides the 2021/22 annual update to the Trust Board on the following:

- Trust's registration status (Section 2)
- Statement of Purpose updates (Section 3)
- Update on future changes to CQC's regulatory approach (Section 4)
- CQC formal Trust inspections and ratings 2021/22 (Section 5)
- CQC's ongoing monitoring of the Trust (Section 6)
- Preparation for future monitoring/inspection visits (Section 7)

The CQC became fully operational in 2009 as the independent regulator of health and social care in England. Since 2010, all providers of health and social care in England have been legally required to register with the CQC.

From 1 April 2015, new Health and Social Care Act Regulations came into force, setting out the Fundamental Standards of care that all providers must meet, and below, which the care they provide must not fall. The Key Lines of Enquiry (KLoE) and all CQC activity has its bedrock in these standards.

2. Trust's Registration Status

Torbay and South Devon NHS Foundation Trust (T&SDFT) is currently registered with the CQC to provide the following regulated activities, with no conditions or restrictions on its registration:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Personal care
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

3. Trusts Statement of Purpose Updates

The Statement of Purpose is a document legally required by Trusts that includes a standard set of information about the services we provide. TSDFT's Statement of Purpose was last updated in 2nd February 2022 to reflect changes brought about due to COVID, such as service location moves, temporary stops and restarts. The document had also been updated earlier in the year, as the Trust finessed its Covid response plans.

This document will be reviewed again, in May 2022, as the Trusts normalises more services as we move to *Living with Covid-19* as part of the Governments new phase of managing Covid nationally.

4. Update on Future Changes to the CQC's Regulatory Approach

In May 2021 the CQC released its five-year strategy, following extensive public consultation.

The CQC launched the new strategy with the aim of making a positive impact on patient care while regulating providers in a much more targeted and risk-based way. The refocus also reflects the dramatic way health and social care have changed over the past 10 years and the CQC wanted its focus to be people and community centric. To this end they have set out 4 themes, two core ambitions and 12 outcomes.

Themes:

1. People and communities – CQC's regulation will aim to be driven by people's needs and experiences
2. Smarter regulation – the new strategy will focus on deploying a more dynamic and flexible approach by providing up-to-date and high-quality information and ratings
3. Safety through learning – CQC will have a complete focus on safety by requiring a culture that enables people to voice concerns, allowing for shared learning and improvement opportunities
4. Accelerating improvement – lastly, the CQC will encourage health and care services as well as local systems to access support to help improve quality of care.

Core ambitions:

1. Assessing local systems: Providing independent assurance to the public of the quality of care in their area
2. Tackling inequalities in health and care: Pushing for equality of access, experiences and outcomes from health and social care services

CQC outcomes:

People and communities' outcomes

1. Our activity is driven by people's experiences of care.

2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation outcomes

1. We are an effective, proportionate, targeted, and dynamic regulator.
2. We provide an up-to-date and accurate picture of quality.
3. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.

Safety through learning outcomes

1. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
2. People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement outcomes

1. We have accelerated improvements in the quality of care.
2. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions: Assessing health and social care systems, and tackling inequalities in health and social care

1. We have contributed to an improvement in people receiving joined-up care.
2. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

What this means for the Trust

The Hospital ratings system will remain, however being rated by physical inspections according to a set time frame is coming to an end and a continuous assessment based on risk will be deployed. Any site-based inspections will likely be reserved for those care providers which cause the CQC's internal systems to alert them to an unacceptable increase in risk, based on the information and data they have gathered.

The complicated and multiple 'key lines of enquiry' will be replaced by one simpler system of questions rooted in what people expect of services. These questions focus on statements which the CQC considers to be more relatable both to providers and the public at large than is the case presently. Currently the thought is these will be called Quality Statements.

The five key questions the CQC apply to inspect will remain and any contact/inspection/assessment will still be based on the following: are services safe, effective, caring, responsive and well led? The 12 fundamental standards, (person

centred care, dignity & respect, consent, safety, safeguarding from abuse, food and hydration, safe premises, complaints, good governance, safe staffing, fit & proper staff and duty of candour) also remain unchanged. These are the basis of what and how we deliver care and the focus of the Trust in terms of CQC preparedness.

The Provider Information Request (PIR) is no longer required. This was a substantial and broad data gathering exercise that took place a number of weeks before an inspection. In the new strategy the CQC will look to be more specific in respect of the data & evidence required to demonstrate that a service is good or outstanding. There will also be a scoring system for each piece of evidence that will be required to be provided. This will allow more transparency of the CQCs inspection process and aid Trusts in their preparations.

The CQC will also continue to use its monthly Direct Monitoring Approach (DMA) in assessing core services via their monthly meetings. Here, under the 5 key questions (as mentioned earlier) the Trust provides information demonstrating compliance which is discussed via the pre-arranged Teams meeting with the CQC inspectors.

Timescales for revised approach

Their strategy is not set in stone and is likely to be refined further as the CQC develop the tools and documents they need to explain their new regulatory approach.

To date, we are waiting for further information to be released by the CQC but in the interim, the Trust must continue its focus on delivering the fundamental care standards and in maintaining or improving the quality of the care it gives in conjunction with its community and partners.

5. CQC Formal Inspection Visits and Trust Ratings

With effect from February 2022, the CQC have resumed normal inspection activity, paused due to COVID in 2020. This includes a return to inspect and rate NHS trusts that are rated Inadequate (I) or Requires Improvement (RI). They have continued necessary inspections, based on risk during Covid and this methodology continues. Additionally, the CQC will continue with their programme to inspect in-line with risk for emergency departments and the findings from the Ockenden Report will form a natural part of their Maternity activity.

During the period April 2021 to March 2022, TSDFT has received one formal CQC inspection.

The CQC carried out a short announced Focused Inspection on 1 December 2021 where they visited the Emergency Assessment Unit 4 (EAU4), Forrest Ward (the trust's escalation ward at the time of the inspection) and for comparison, George Earle Ward. The CQC carried out this inspection because a number of concerns had been raised with them relating to: staff shortages; concerns that patients were not receiving enough nutrition and hydration on Forrest Ward; and, concerns that staff were not completing observations on patients in a timely manner on both wards.

In March 2021, the CQC published the report from the above announced inspection. In response, and prior to its release, the Trust had developed a comprehensive improvement plan which became and still remains a priority for the organisation.

The CQC report recorded 3 Must Do improvement actions and these are:

- Ensure risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h)).
- Ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)).
- Ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).

As well as 3 Should Do improvements:

- Improve governance processes to have clear identification of patient risk.
- Improve processes to identify the acuity of patients on EAU4 and adjust staffing levels appropriately.
- Review the Core Training Policy which includes statutory and mandatory training.

The following table sets out our approach to improvement against these requirements:

<table>
<tr><th>Improvement Requirement</th><th>Action</th><th>Current Position</th></tr>
<tr><td colspan="3">Must Do Improvement Actions</td></tr>
<tr><td>Ensure patient risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h)).</td><td>• A comprehensive action plan was created in December 2021
• The overarching risk assessment framework has been revised and amended
• Daily clinical audits
• Monthly Matron audits
• Monthly reports at Quality Improvement Group and IGG</td><td><table><tr><th>Risk assessment</th><th>Compliance</th></tr><tr><td>Falls</td><td>83.1%</td></tr><tr><td>Capacity</td><td>90.9%.</td></tr><tr><td>Pressure ulcers</td><td>83.4%.</td></tr><tr><td>End of Life (TEP)</td><td>86.7%</td></tr></table></td></tr>
<tr><td>Ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)).</td><td>All staff follow the Six Steps to Patient Safety that the Trust has created:</td><td>83.3%
(Taken from monthly Safety Assessment audit)</td></tr>
<tr><td>Ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).</td><td>• Daily electronic auditing of the care booklet continues
• All patients are discussed at the Ward Safety Brief
• The Audits results are discussed with the ward manager matron meetings and to the weekly Matron ADNPP meetings too
• Standing agenda item on all ISU IGG's and ISU leads aware.
• Reported at QIG and exception reporting to QAC
• GGI have been commissioned by the organisation to review and strengthen clinical governance processes</td><td>There is more work to do to strengthen our governance process and emend this as a priority. This includes;
➢ Peer to peer review of evidence of audits
➢ Work with GGI to strengthen governance processes in ISU
➢ In the interim a "Good Governance Guide" is being developed for clinical leaders</td></tr>
<tr><td colspan="3">Should Do Improvement Actions</td></tr>
<tr><td>Improve governance processes to have clear identification of patient risk.</td><td>• The auditing process and focus on the patient assessment booklet Trustwide has provided a clear way to assess and identify the risks patients may have as well as ensuring the correct action are taken to meet their needs</td><td>The auditing process and results are discussed at the relevant board rounds, and meetings to ensure the clear identification of patient risk is paramount</td></tr>
<tr><td>Improve processes to identify the acuity of patients on EAU4 and adjust staffing levels appropriately.</td><td>• There is a process in place to review staffing and patient acuity data electronically at the twice daily Safe Staffing meeting
• Monthly reporting to the Nursing & Midwifery Workforce Council to ensure oversight and scrutiny.</td><td>More work is needed to ensure improvement in compliance of recording patient data. This is being led by the ISU ADNPP with support from the Safer Staffing Lead.
55% of days in the month patient acuity scores were completed in March
36% of days in the month acuity scores were completed in March</td></tr>
<tr><td>Review the Core Training Policy which includes statutory and mandatory training</td><td>• A new assurance framework has been completed and approved at PEGG</td><td>Policy review is in place with an expected close date of Sept 2022</td></tr>
</table>

The Table below lists the Trusts Core Services and their CQC activity in 2021/22, as well as their rating and when that was attained. Please note the Trust has an overall CQC rating of Good

Table 1. Core Services Ratings by CQC as of Year End 2021/22 and areas visited

CQC designation	Core Service	Current rating (date rated)	April 2021 to March 2022 CQC activity (not rated)
Acute (Torbay Hospital)	Urgent and Emergency	Requires improvement (2020)	
	Medical care (inc older people's care)	Requires improvement (2020)	Dec 2021 on-site Focused Inspection on EAU4 and Forrest ward – 3 Must Do actions DMA – Oct 2021
	Surgical Care	Requires improvement (2020)	DMA – Aug 2021
	Critical care	Good (2016)	DMA Canx by CQC due to Covid - Jan 22
	Maternity Care	Requires improvement (2020)	DMA - April 2022
	Gynaecology	N/A	DMA Canx by CQC due to Covid - Jan 22
	Children and young people	Good (2020)	DMA Canx by CQC due to Covid - Feb 22
	End of life care	Good (2018)	DMA Canx by CQC due to Covid - Mar 22
	Outpatients	Good (2018)	DMA – Dec 2022
	Diagnostic imaging	N/A	
Community health	Community adults	Outstanding (2016)	
	Community children and young people	Good (2018)	
	Community inpatients	Good (2020)	
	Community end of life	Requires improvement (2018)	
	Community dental	Outstanding (2016)	
	Community urgent care	Good (2016)	
Mental health	Substance misuse	N/A	
Ambulance	Patient transport services	Outstanding (2016)	DMA Sept 2022
Adult social care	St Edmunds	Good (2018)	

During 2021/22, the Trust continued, despite the Covid pandemic, to progress its improvement plan following the March 2020 CQC inspection. This inspection resulted in 28 Must do and 46 Should Do improvement actions. In April 2022 9 Must Do and 8 Should Do actions remain open. These actions fall into 4 main themes that had been greatly affected by the pandemic: Training compliance, Appraisal compliance, Trustwide clutter and a rolling medical devices replacement programme. The Trust and ISUs continue to work to close these actions and the revised date for close is set for Sept 2022

Of the immense Trust wide work that has resulted in the closure of Must do and 38 Should Do actions, the following is a selection of the work that has been undertaken:

The CQC said we must ensure the Trust has a clear oversight of compliance with resuscitation training levels, to include intermediate and advanced life support training for adults and paediatrics, and that we can assure ourselves that our staff are up to date with their training needs and the patients are ultimately safe.

In response to this an improvement plan was created via the Education team. Their first steps were to look at the Training Needs Analysis document and obtain the numbers of staff, Trust requirements for intermediate and advanced needs and carry out a gap analysis. Once achieved this allowed for courses to be provided at each level and reports generated to show the growing compliance rate.

The CQC also required The Children's and Young Persons service to ensure they can evidence compliance of paediatric resuscitation in the training needs analysis and this has been fully completed too.

The Resuscitation Committee also helped to monitor the progress of this action

With the new starters included in the reporting mechanisms, a really robust monitoring system is in place, which gives monthly feedback to managers on compliance.

The maternity team were tasked with improving the Maternity Early Obstetric Warning Score (MEOWS) assessment in line with policy. MEOWS is a tool used to help identify deterioration in women and ensure appropriate early intervention is started. The team, through a Task and Finish Group, reviewed the current situation, formulated an improvement plan, carried out the interventions and monitored the outcome through a 12-week audit process the results of which showed compliance higher than the target rate of 80% compliance. The team are continuing to look to improve MEOWS and are looking at electronic versions.

Maternity had also focused on ensuring safety checks on equipment was 100% compliant. Through Key Performance Indicators, Maternity wide communications and Audit, the checks are running at 100% compliance

The Team have also been improving Medical Staff training compliance, this has proved

challenging through the Covid pandemic but training development plans, monthly monitoring and Governance oversight has this action been achieved and this compliance will help with the Clinical Negligence Scheme for Trusts (CNST) processes Maternity has to comply with.

Maternity have shown great teamwork and planning in achieving their CQC Improvement plan objectives.

Our CQC website, under continued improvements in my area has many more of the actions taken to ensure and enhance the care we give

6. CQC's Ongoing Monitoring of the Trust

The local CQC inspectors and the Trust have continued to engage throughout the pandemic and maintain a good working professional relationship.

The Trust has continued to receive routine enquiries from the CQC, as part of their ongoing monitoring of the Trust. The local CQC inspectors request additional information on specific concerns relating to services provided by the Trust, such as specific complaints, safeguarding concerns and patient-related incidents. All of these events are routinely managed internally by TSDFT through established processes and governance routes. When the information on the specific events requested becomes available it is passed to the CQC. The CQC also raises enquiries from feedback received directly by the them, in regards to the services provided by the Trust, to which the Trust will provide a timely response.

To monitor this process the Trust meets the CQC inspectors formally, via the monthly Open Enquiry meetings. These meetings are 1 hour long and are carried out via teams. They are an opportunity to formally discuss issues that have come to the Inspectors attention, and review Safeguarding, Complaints and Clinical Incidents. They also receive updates on the ongoing CQC Must Do improvement action plans.

On a quarterly basis the Trust manages a CQC Engagement meeting. This is a 3-hour meeting and generally involves presentations from the Chief Nurse, Chief Operating Officer and the Chief Executive on Trustwide issues. It may also include presentations or discussions from specific teams, for example, Maternity, People Partners, re topical issues such as the Ockenden report or the NHS Staff Survey. The CQC also update the Trust on their national and regional issues or key findings, as appropriate. The meetings provide a valuable opportunity to share positive stories, and practices and to update the CQC around any concerns relating to specific services. These meetings have been invaluable during Covid.

In 2021/22 the CQC introduced a procedure called Direct Monitoring Approach (DMA), this being a key facet of its new strategy of regular and ongoing assessment of Trust core services via data and compliance. The CQC pose a number of written questions to a specific area in advance, based on their 5 key questions and Key lines of Enquiry, which the area then answers through data, policy and narrative. These documents are discussed and reviewed via the hourly meeting. To date Urgent and Emergency Care, Maternity, Surgical, Medical, Patient Transport & Outpatients Department have had

DMAs. Four planned DMAs were cancelled by the CQC as they stepped down inspection activity during the 3rd wave of Covid, over the 2021/22 winter period.

From these DMAs, the CQC have identified no issues and no further action was required. The teams found them very beneficial and allowed them to showcase any quality improvement work or best practice they had undertaken.

Overall the engagement activity with the CQC in 2021/22 has been very positive, and the new relationships built this year with the 2 new local CQC inspectors has been very productive.

7. Ongoing Assurance and Preparation for future monitoring/inspection visits

Well-Led

Building on the independent Well Led review undertaken by Deloitte in 2020, the Trust has taken a number of steps to strengthen systems of governance under the following headings and by the following actions, (please note these are only a selection from the full action plan):

Leadership

- Further development of the Board & Executive Team Development Programme
- Review of roles and working arrangements via portfolio review
- Development of a Board Concordat
- NED Skill set review

Vision & Strategy

- Strategic Development Group established
- Executive Lead for coordination & integration of the Corporate Strategy
- Strategic Alliance Partnership Board for coordinating the Heath & Care Strategy

Culture

- Successful appointment to the position of Health & Care Strategy Director
- Professional Leaders Group in place chaired by Chief Nurse
- NEDs portfolio and experience reflects the breadth of our community experiences
- Refresh of the Communication's & Engagement Strategy
- Completed review of staff feedback processes

Risks & Performance

- Summary Dashboard presented with the Board Assurance Framework
- Board cover sheets include reference to BAF corporate objectives
- New QIA Framework agreed by QAC in July 2021 and implemented

Stake Holder Engagement

- Planned in person engagement programme limited due to Covid
- Patient experience and engagement conference held and vision and objectives agreed
- Communications and engagement strategy has been developed and due to Board in October 2021

The Trust established an Executive Review Programme to seek further assurance around improvements reported at Core Service level. The aim was to review evidence of improvement work in relation to their Must Do improvement actions, following the 2020 CQC inspection. These occurred over a number of days and via a combination of Teams, Face to Face (F2F) presentations and/or area visits. The review was supported by the Internal Audit team who also acted as an independent critical friend in the process. The formal evaluation of the programme has been given by Internal Audit to the board which showed the process to be very positive and beneficial.

Core services presented their evidence with a view to Executive assessment determining the improvement action having n=been met, partially met or requiring further evidence to assure closure. The process was carried out in a positive manor and of the 29 Must Do Improvement actions, 9 remain open. These actions fall into 4 main themes that had been greatly affected by the pandemic: Training compliance, Appraisal compliance, Trustwide clutter and a rolling medical devices replacement programme.

These actions continue to be monitored at the Trusts CQC assurance group.

Of the improvement actions closed, the variety and volume of work that has been generated during Covid to close them has been very positive.

Evidence via the Ward Accreditation System
The Ward Accreditation system provides objective assessment of wards and departments against a framework of international standards, including the CQC fundamental standards. Action planning by the Ward Manager and Matron follows a review, to enable the ward or department to improve towards or maintain the highest rating. The Ward Accreditation system is part of the wider Nursing and Midwifery Excellence programme, a collaborative approach ensuring oversight and assurance of the key components of nursing and midwifery at Torbay. The Ward Accreditation system is well received by wards and departments.

Peer to Peer review
In 2021/22, a clinically-led peer-to-peer review process for TSDFT was developed and implemented within the Covid limitations.
The aim was for quality improvement through assessment, enquiry and learning between peers.

The process was designed to:
- be positive, supportive experience and provide a ‘critical friend’ to encourage reflection and improvement
- look at evidence against the CQCs KLOEs

- fit with the new Ward Accreditation Scheme, and the leadership and patient safety walkarounds.

From our findings in 2021/22 a new process is being formulated to match the new CQC strategy as they are a valued and productive way to help prepare staff for any inspection or area enquiry. The new approach is being built on the 15 steps and 'fresh eyes approach' and will be more inclusive of different staff at the appropriate grade who use or access the ward areas.

CQC Continuous Assurance Group
The group retains a healthy membership, a high attendance rate and is a key focal point to share CQC information regarding local/national inspections of other Trusts, key publications, the CQC's bi-monthly Insight tool, progress against the CQC actions plans, DMAs, and debate of key issues. The group continues to report monthly to the Quality Improvement Group and bi-monthly to the Quality Assurance Committee.

Internal Website
The Trusts CQC website has been reviewed and developed and is the source for all CQC information. The site includes helpful tips and guides as well as formal assessments and booklets to help staff prepare for a CQC visit. The site also includes the ward infographics of all they have achieved in relation to the Must Do Should Do improvement action journey, newsletters and inspection reports.

8. Conclusion

For assurance, this report has provided an annual update to the Quality Assurance Committee on the Trust's: current registration status; compliance with the CQC standards; response to previous CQC inspections; CQC's monitoring activity, and the preparation for future inspections and monitoring activity. This is in addition to the bi-monthly reports submitted to QAC.

9. Recommendations

The Trust Board is asked to receive and note:

- the Statement of Purpose
- Changes to CQC Regulatory approach
- Update on Trust actions against findings from recent inspections
- Preparation for future monitoring