London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Wednesday 4 February 2015
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Rory Vaughan (Chair) Councillor Elaine Chumnery (Vice-chair) Councillor Hannah Barlow	Councillor Andrew Brown Councillor Joe Carlebach	Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Debbie Domb, HAFCAC

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http://www.lbhf.gov.uk/Directory/Council_and_Democracy

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Date Issued: 27 January 2015

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

4 February 2015

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING** This item will follow.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATION OF INTEREST** If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent. At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken. Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest. Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.	
4.	**NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE** The North West London Joint Health Overview & Scrutiny committee met on 16 October 2014 and approved the terms of reference, set out as appendix 1.	1 - 6

5. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CQC REPORT AND ACTION PLAN 7 - 91

On 16 December 2014, England's Chief Inspector of Hospitals rated the services provided by Imperial College Healthcare NHS Trust (ICHT) as Requires Improvement overall, following a Care Quality Commission (CQC) inspection in September.

The attached documents set out a summary of the findings of the CQC and the Action Plan put in place by ICHT.

The full CQC reports can be found at http://www.cqc.org.uk/provider/RYJ.

6. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY DEPARTMENT WAITING TIMES

There will be an oral update on Accident & Emergency Waiting Times.

7. SHAPING A HEALTHIER FUTURE

This report will follow.

8. WORK PROGRAMME 92 - 93

The Committee is asked to consider its work programme for the remainder of the municipal year.

9. DATES OF FUTURE MEETINGS

Wednesday 4 February 2015
Monday 9 March 2015
Monday 13 April 2015

Agenda Item 4

	London Borough of Hammersmith & Fulham **HEALTH ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **4 FEBRUARY 2015**
NORTH WEST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE	
Report of the Director of Law	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Jane West, Executive Director of Finance and Corporate Governance	
Report Author: Sue Perrin, Committee Co-ordinator	**Contact Details:** Tel: 020 8753 2094 E-mail: sue.perrin@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The North West London Joint Health Overview & Scrutiny committee met on 16 October 2014 and approved the terms of reference, set out as appendix 1.

2. RECOMMENDATIONS

2.1 The Committee is asked to endorse the decision made at its meeting on 22 July 2014 and appoint Councillor Rory Vaughan as the voting member and Councillor Sharon Holder as the alternate member to the North West London JHOSC.

3. BACKGROUND

3.1 The North West London JHOSC was established as part of the statutory consultation process for *Shaping a Healthier Future (SaHF)* in 2012. In November 2012 the JHOSC submitted its final report, but it was agreed

that a cross-borough forum was still required to scrutinise the implementation of SaHF.

3.2 The membership of the JHOSC is formed of a voting member and a non-voting member from each of the eight boroughs. The Local Government Act 2000 requires that council committees be politically proportional and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 confirm that this applies to joint scrutiny committees. Therefore the voting member of the JHOSC is required to be an administration member. As the second member would not have a vote, political proportionality rules would not apply.

3.3 At its meeting on 16th October 2014, the NWL JHOSC considered and re-confirmed the terms of reference. These are attached as Appendix 1.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	None		

Appendix 1

The North West London Joint Health Overview & Scrutiny Committee Terms of Reference

1. Background

The North West London Joint Health Overview and Scrutiny Committee (JHOSC) was formed by the London Boroughs of North West London at the request of NHS North West London as part of the statutory consultation process for *Shaping a Healthier Future (SaHF)*. The JHOSC held its first meeting in July 2012 and completed its review of the hospital reconfiguration consultation in November 2012 with the submission of its final report to the NHS. This submission completed the JHOSCs statutory role in the reconfiguration process[1].

In November 2013, following the final decision on the structure of the reconfiguration setting out which hospitals would be developed as major and local hospitals, the North West London Collaboration of Clinical Commissioning Groups submitted a report to the JHOSC requesting that the JHOSC continued to provide a forum where issues relating to *SaHF,* which cross borough boundaries, could be scrutinized and discussed. This was agreed by the JHOSC. The JHOSC has subsequently met on four further occasions with its last meeting held on the 6th August 2014 at Hounslow.

2. Current Status

At the 6th August meeting the JHOSC operated under provisional arrangements with Cllr Mel Collins (LB Hounslow) acting as interim Chair. At the meeting it was agreed that when the JHOSC reconvened in the autumn it would reconfirm its terms of reference and set out a work programme to reflect the business planning and implementation timeframe of the *SaHF* programme.

The rationale for reconfirming the terms of reference and agreeing a structured work programme is to provide a clear understanding for all stakeholders of the role and remit of the JHOSC. The areas of the SaHF programme that it wishes to focus on, and provide member boroughs with an indication of the timelines and resources required to ensure the JHOSC can effectively fulfil its remit. Undertaking this area of work planning is particularly relevant following the local elections which has resulted in a number of changes being made to the membership of the JHOSC.

3. Terms of Reference

Set out below are draft terms of reference that the JHOSC is asked to consider and agree. These draft terms are informed by the views of JHOSC members as expressed at meetings held between December 2013 and

[1] Local authorities are required to appoint joint scrutiny committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals. When the joint scrutiny committee completes its review they can submit recommendations to the NHS body with the health service required to respond to these recommendations.

August 2014. The terms are also guided by the Department of Health's recently issued new guidance for health scrutiny. This guidance states that the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe.

3.1 Membership

Membership of the JHOSC will continue to be one nominated voting member from each participating council, plus one other nominated member to whom the vote can be transferred (on the basis of that member being an elected member of the council they are representing).

As of 17 September 2014 the membership of the JHOSC consists of the following boroughs and elected members:

London Borough of:	Voting Member	Second Member
Brent	Cllr Aslam Choudry	Cllr Mary Daly
Ealing	Cllr Theresa Byrne	Cllr Joy Morrissey
Hammersmith & Fulham	Cllr Rory Vaughan	
Harrow	Cllr Rekha Shah	Cllr Vina Mithani
Hounslow	Cllr Mel Collins	Cllr Myra Savin
Kensington & Chelsea	Cllr Will Pascal	Cllr Robert Freeman
Richmond	Cllr John Coombs	Cllr Liz Jaeger
Westminster City Council	Cllr David Harvey	Dr Sheila D'Souza

The current position is that the membership of the JHOSC is one nominated voting member from each participating council, plus one other nominated member to whom the vote can be transferred (on the basis of that member being an elected member of the council they are representing).

On 16 October 2014, it was agreed that alternatively a Borough could nominate one voting member only. A substitute member can be nominated by the Borough. The vote could also be transferred to the substitute member where he or she is an elected member of the council and the voting member is unavailable.

3.2 Quorum

The committee will require at least six members in attendance to be quorate.

3.3 Chair and Vice Chair

The JHOSC will elect its own chair and vice chair.

Elections will take place on an annual basis each May, or as soon as practical thereafter, such as to allow for any annual changes to the committee's membership.

3.4 Duration

The planned implementation timeframe for *SaHF* runs up to 2018. It is proposed that the JHOSC operates alongside the implementation programme up to 2018 with its duration expanded should the SaHF programme run beyond this date.

It is important the JHOSC operates on the basis of being able to contribute to the effective scrutiny of cross-borough issues relating to SaHF and provides a forum for cross borough engagement and consultation between its member local authorities, and health service commissioners and providers. As such, it is proposed that the committee will also hold an annual review in May each year, or as soon as practical thereafter, where it will consider and decide whether there is a need for the JHOSC to continue or whether it has fulfilled its remit and should terminate earlier than 2018. This would not preclude individual local authorities from giving notice at the JHOSC annual meeting of their intention to withdraw from the JHOSC. Should there be any proposals for a JHOSC beyond this date, this would be considered by each participating authority in line with its own constitution and policies.

3.5 Remit of the JHOSC

In recognition of the decision of the JHOSC at the November 2012 meeting the committee's remit will be based on performing the following functions:

1. To scrutinise the 'Shaping a Healthier Future' reconfiguration of health services in North West London; in particular the implementation plans and actions by the North West London Collaboration of Clinical Commissioning Groups (NWL CCGs), focussing on aspects with cross borough implications.

2. To make recommendations to NWL CCGs, NHS England, or any other appropriate outside body in relation to the 'Shaping a Healthier Future' plans for North West London; and to monitor the outcomes of these recommendations where appropriate.

3. To require the provision of information from, and attendance before the committee by, any such person or organisation under a statutory duty to comply with the scrutiny function of health services in North West London.

The stated purpose of the JHOSC is to consider issues with cross-borough implications arising as a result of the Shaping a Healthier Future reconfiguration of health services, taking a wider view across North West London than might normally be taken by individual Local Authorities.

At each annual meeting the JHOSC will develop, in consultation with the North West London Collaboration of Clinical Commissioning Groups, a work programme for the forthcoming municipal year based upon their agreed remit.

Individual local authority members of the JHOSC will continue their own scrutiny of health services in, or affecting, their individual areas (including those under 'Shaping a Healthier Future'). Participation in the JHOSC will not preclude any scrutiny or right of response by individual boroughs.

In particular, and for the sake of clarity, as the JHOSC is a discretionary joint committee is not appointed for and nor does it have delegated to the functions or powers of the local authorities, either individually or jointly, under Section 23(9) of the local authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

This means that in accordance with the Regulations and subsequent non-statutory guidance the power of referral to the Secretary of State is not delegated to the JHOSC but retained by individual boroughs.

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **4 February 2015**
TITLE OF REPORT **Care Quality Commission: Imperial College Healthcare NHS Trust Quality Report: Summary of Findings** **Care Quality Commission Chief Inspector of Hospital's Inspection: Follow Up and Action Plan**	
Report of The Care Quality Commission and Imperial College Healthcare NHS Trust	
Open Report	
Classification - For Scrutiny Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care & Health	
Report Author: Care Quality Commission Imperial College Healthcare NHS Trust	

1. EXECUTIVE SUMMARY

1.1 On 16 December 2014, England's Chief Inspector of Hospitals rated the services provided by Imperial College Healthcare NHS Trust (ICHT) as Requires Improvement overall, following a Care Quality Commission (CQC) inspection in September.

1.2 The attached documents set out a summary of the findings of the CQC and the Action Plan put in place by ICHT.

1.3 The full CQC reports can be found at http://www.cqc.org.uk/provider/RYJ.

2. RECOMMENDATIONS

2.1. The PAC is asked to comment on both reports.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	n/a		

Imperial College Healthcare NHS Trust

Quality Report

The Bays,
South Wharf Road,
St Mary's Hospital,
London,
W2 1NY
Tel: 020 3311 3311
Website: www.imperial.nhs.uk

Date of inspection visit: 02-05 September
Date of publication: 16/12/2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Imperial College Healthcare NHS Trust provides acute healthcare services to a population of around two million people across North West London and provides specialist services to patients nationally and internationally. It provides acute services from five locations including St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital, Queen Charlotte &38; Chelsea Hospital and Western Eye Hospital. The trust employs around 10,000 staff.

Imperial College Healthcare NHS Trust is one of the largest NHS trusts in England and together with Imperial College London forms an academic health science centre. It hosts NIHR Biomedical Research Centre and is part of the network of twenty Experimental Cancer Medicines Centres (ECMC) across the UK.

We carried out this inspection as part of our comprehensive inspection programme of all NHS acute providers and we inspected four of the five locations including St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte &38; Chelsea Hospital. We did not inspect Western Eye Hospital.

Overall, this trust was rated as requires improvement. We rated it good for providing effective care and for being caring. We rated it requires improvement for providing safe care, being responsive to patients' needs and being well-led.

Our key findings were as follows:

Safe:

- The standard of cleanliness, infection control and hygiene was inconsistent across the organisation; with some areas demonstrating robust processes for ensuring cleanliness was maintained but one particular area demonstrating very poor standards of cleanliness and hygiene.
- The trust had a system in place for receiving and confirming compliance with patient safety alerts sent by the central alerting system (CAS). There was a nominated CAS liaison officer who acknowledged and updated the statuses of alerts, however, the arrangements for monitoring the management of safety alerts was not adequate; for example, local policies were not always updated following the receipt of patient safety alerts.
- The safety culture was seen to be embraced by the majority of staff; however there had been history of some 'silo' working. The divisional structure was reported to be reducing the silo working and encouraged cross-divisional learning, although these changes were in the early stages.
- Nurse staffing levels were not sufficient with a significant reliance on bank and agency staff, with some shifts remaining unfilled. This was especially applicable to the adult medicine wards.

Effective:

- Clinical outcomes were either better than expected or in line with the national average. The HSMR and SHMI were better than the national average.
- The trust took part in local and national audits and clinical audits demonstrated that outcomes for patients after heart attack and stroke were better than the national average.
- Patients were given information about pain and pain relief was effectively managed and patients' nutritional and hydration needs were assessed and monitored appropriately.
- There was a clear commitment to multidisciplinary team working between all staff involved in patients' care and the divisional directors leading the four clinical divisions were committed to improving cross-divisional and cross-site multidisciplinary team working to improve care through improvements in pathways across the trust.

Caring:

- Patient's feedback and observations during the inspection demonstrated that patients were treated with dignity and respect. Patients and relatives told us that they were treated with compassion and considered their individual care needs.
- Patients felt involved in their care and informed to ensure they had a key role in their care and treatment.

Summary of findings

- The Friends and Family Test results showed the average scores for both inpatients and A&38;E were better than the national figure for 2012/13, however for maternity the average score was marginally below the national average.

Responsive:

- The surgical department had a significant backlog of patients who were awaiting elective surgery; however, the trust did provide trust-wide plans to reduce the backlog. Referral to treatment times in some specialties had breached national targets on an on-going basis.
- The clinical impact of cancellations and delays in surgery and theatre use and productivity were not consistently monitored by the surgical teams
- The trust was not meeting its target for sending out appointment letters to patients within 10 working days of receiving the GPs referral letter consistently. Some patients were not receiving their appointment letters nor did so after the date of their appointment.
- When considering peoples individual needs such as learning disability support, translation services or care for patients living with dementia, there were shortfalls in how the needs of different people are taken into account.
- Complaints management wasn't meeting the trusts internal completion target of 85% within 25 working days. Complaints were not consistently seen as an opportunity to learn; for example there was no process for recording informal complaints received by staff on wards which would assist in identifying trends and inform learning.

Well-led:

- There had been some instability at executive leadership level over recent years, which had resulted in a number of changes being made; the current CEO had been in post since April 2014. Since being appointed the CEO had made changes to the executive team and portfolios had been clarified to ensure there were clear lines of accountability and a robust clinical governance structure.
- Since appointment the CEO had spent a significant amount of time working on the wider strategic vision for North West London in conjunction with developing the clinical strategy with staff, in particular the divisional directors.
- Whilst board level and divisional clinical leadership demonstrated collaboration and alignment to effectively lead the trust and make necessary improvements, the leadership at a more local level at each hospital was markedly varied; with some areas demonstrating good leadership but other areas requiring significant improvement.
- There was a clear drive to empower and develop leaders through five leadership programmes.
- The trust had clear values that had been developed in conjunction with staff, however despite some improvements in staff engagement, there was recognition that engaging with staff was an area for improvement and there were clear plans in place to address this amongst all staff groups.
- Communication generally was recognised to have significantly improved since the appointment of the CEO through staff forums, regular visibility and personal feedback. In addition, the substantive appointment of the whole executive board resulted in a sense of 'optimism' about the future stability of the trust.
- The executive team, the non-executive directors and the divisional directors all recognised the trust was relatively early in the start of a journey to improve standards, standardise processes and improve engagement across all locations.
- Whilst there was a clear governance reporting structure in place there were inconsistencies in its application across divisions and records held at a trust level were not always consistent with those being held at a local level; such as statutory and mandatory training and appraisal rates.
- The staff had a clear sense of pride in their work and a commitment to support the clinical strategy for the trust
- The sustainability of trust services and pathways of care were considered as part of the wider strategy for the trust and "Shaping a Healthier Future " programme for the whole of North West London. These proposed reconfigurations were not reviewed as part of the inspection as they were not in place and remained under consultation.

In addition to the above, we saw specific areas of outstanding practice:

- The trust hosts a NIHR Biomedical Research Centre and has a strong focus on translational research

participating in and leading national research projects. An example of this is the evaluation of magnetic resonance imaging to predict neurodevelopmental impairment in preterm infants..
- The impact of the new CEO on all staff groups through staff forums and regular visibility and the evident optimism among staff for the future with a permanent executive team in place.
- The leadership programmes available to staff, which aimed to 'drive exceptional performance through engaged people, create inspirational leaders and effective managers whilst ultimately improving patient experience'. These programmes were clearly set out in five separate courses from 'Foundations' to 'Certificate in Medical Leadership'
- Some of the clinical services we inspected achieve nationally leading outcomes for patients. Examples include the Trauma Centre at St Mary's Hospital and the stroke service at Charing Cross Hospital.

However, there were some areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

St Mary's Hospital

- Improve the standards of cleanliness of premises and equipment.
- Increase the number of cases submitted to the audit programme for the World Health Organization (WHO) surgical safety checklist to increase compliance with the 'Five steps to safer surgery'.
- Develop and implement systems and processes to reduce the rate of patients who do not attend their outpatient appointment or surgical procedure.
- Review the level of anaesthetic consultant support and/or on-call availability to ensure it is in line with national recommended practice.
- Review the arrangement for medicines storage and ensure medicine management protocols are adhered to.
- Ensure all staff are up to date with their mandatory training.
- Ensure all equipment is suitably maintained and checked by an appropriate person.
- Ensure adequate isolation facilities are provided to minimise risk of cross-contamination.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.
- Review the provision of the paediatric intensive care environment to ensure it meets national standards.
- Review the provision of services on Grand Union Ward to ensure the environment is fit for purpose.

Charing Cross Hospital

- Correct the problems associated with the administration of appointments which was leading to unnecessary delays and inconvenience to patients.
- Address the high vacancy rates for nursing staff and healthcare assistants in some medical wards, and the level of medical staffing out of hours for the intensive care unit (ICU) and level 2 beds.

Hammersmith Hospital

- Correct the high number of vacant nursing and healthcare assistant posts on the medical wards.
- Address the problems associated with the administration of outpatient appointments which was leading to unnecessary delays and inconvenience to patients.
- Reduce the significant backlog of patients who are awaiting elective surgery in the surgical department.

Queen Charlotte &38; Chelsea Hospital

- Review the staffing levels and take action to ensure they are in line with national guidance.
- Review the capacity of the maternity and neonatal units to ensure the services meet demands.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.

In addition, the trust should:

St Mary's Hospital

- Improve the handover area for ambulances to preserve patient dignity and confidentiality.
- Ensure that there is a single source of up-to-date guidelines for A&38;E staff.
- Seek ways of improving patient flow, including analysing the rate of re-attendances within seven days.

Summary of findings

- Improve links with primary care services to help keep people out of A&38;E.
- Ensure that all patients who undergo non-urgent emergency surgery are not left without food and fluids for excessively long periods.
- Review the literature available to patients to ensure it is available in languages other than English in order to reflect diversity of the local community.
- Ensure same-sex accommodation on Witherow Ward to ensure patients' privacy and dignity are maintained.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Develop a standardised approach to mortality review which includes reporting to the divisional boards and to the executive committee.
- Review patients' readmission and length of stay rates to identify issues which might lead to worse-than-average results.
- Review the processes for ensuring compliance with statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust-wide records.
- Review the double-checking process for medication to ensure that staff are compliant with trust policies and procedures.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Review the provision of adolescent services and facilities to ensure the current provision is able to meet the needs of patients.
- Ensure that there is sufficient capacity to accommodate parents/carers while their child receives intensive care support.Ensure that the children and young people's service has representation at board level.

Charing Cross Hospital

- Take sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice at Charing Cross Hospital.
- Implement the trust-wide plans to reduce the backlog of more than 3,500 patients awaiting surgical intervention would be tackled.
- Ensure that all patients who undergo non-urgent emergency surgery are not without food and fluids for excessively long periods.
- Increase the capacity in the outpatients department to address the increased demand and adequately respond to people's needs.
- Assign sole responsibility for the outpatients department to one division so that quality and risk issues could be managed more effectively.
- Meet its target of sending out appointment letters to patients within 10 working days of receiving the GPs referral letter.
- Ensure outpatient letters to GPs occur within its target time of 10 days following clinics.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Reduce the backlog of patients who are awaiting elective surgery.
- Increase capacity to ensure patients admitted to the surgical services can be seen promptly and receive the right level of care.
- Avoid cancelling outpatient clinics at short notice.
- Minimise number of out-of-hours transfers and discharges from the medical wards.

Hammersmith Hospital

- Improve patient transport from the outpatients department so that patients are not waiting many hours to be taken home.
- Improve the management of medicines on the medical wards.
- Ensure patients' records are always appropriately completed.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Ensure cleaning of equipment is always carried out.
- Improve access to the one pain clinic that is available in the trust.
- Reduce the high number of out-of-hours transfers and discharges.
- Monitor the clinical impact of cancellations and delays in surgery.
- Ensure that surgical patients are not cared for in inappropriate areas such as in the theatre overnight.
- Improve the responsiveness of the outpatients department with regards to clearing the backlog of GP letters from the gastroenterology clinic and reducing the waiting times for patients to get an initial appointment.
- Avoid cancelling outpatient clinics at short notice.

Summary of findings

- Ensure there is accurate performance information from the outpatients department.
- Ensure that quality and risk issues in the outpatients department are managed effectively.
- Consider reviewing the processes for the capturing of information to help the service to better understand and to measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the provision of children's outpatient services to ensure there is parity across the hospital campus.
- Consider reviewing the operating times of the David Harvey Unit to ensure the service is accessible to the local population to which it serves, at the right time of day.

Queen Charlotte &38; Chelsea Hospital

- Review the current training matrix for statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust-wide records.
- Ensure that the risk management process within the neonatal division is suitably robust and fit for purpose to ensure risks are assessed, investigated and resolved in a timely manner.
- Explore how staff can learn from minor incidents and near misses to avoid similar incidents occurring.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust is one of the largest NHS trusts in England and together with Imperial College London forms an academic health science centre. It hosts a NIHR Biomedical Research Centre and is part of the network of twenty Experimental Cancer Medicines Centres (ECMC) across the UK.

There are five sites and a number of satellite services. The main five sites include St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital, Queen Charlotte & Chelsea Hospital and Western Eye Hospital. There are seven renal satellite services. The trust employs around 10,000 staff across the sites and provides around 1.2 million patient contacts in 2013/14.

The services include specialist centres for heart attack, hyper acute stroke unit, major trauma centre, as well as having paediatric, gynaecology and ophthalmic emergency rooms. The clinical imaging, renal and transplant centres are the largest in Europe. The trust has 19 specialist cancer teams as well as a large maternity and neonatal unit.

The trust has managed to improve their financial position to a period of stability recently from an underlying financial deficit of £40 million in 2011 to achieving a year-end surplus of £15 million in March 2014. However, the trust continues to face significant challenges going forwards to continue to make financial saving and efficiencies. The trust is working towards achieving Foundation Trust status.

There had been significant changes in executive board leadership over recent years, but at the time of the inspection there was a full substantive executive board in place, with the CEO having commenced in post in April 2014. The clinical services of the trust had recently been re-organised into four Divisions which each contained a range of specialties being clinically led by a divisional director.

The trust strategic vision was part of a programme to improve NHS services across North West London "Shaping a Healthier Future", which was being led by eight clinical commissioning groups across North West London's eight boroughs. This programme included both clinical reconfiguration and an estates strategy. At the time of the inspection, part of this programme was to close Hammersmith Accident and Emergency department the following week and consequently we did not inspect this service.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, MRCP FRCR

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission (CQC)

The team of 35 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics and palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses, a student nurse and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of findings

The inspection team inspected the following eight core services at Imperial College Healthcare NHS Trust where applicable (please see individual hospital reports to see which core services were inspected at each Hospital):

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Trust Development Authority (TDA), NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in the London Borough of Hammersmith and Fulham on 02 September 2014, when people shared their views and experiences of the Imperial College Healthcare NHS Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 02 and 05 September 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 11 September 2014. We looked at how the hospital was run out of hours and the levels and type of staff available and the care provided.

What people who use the trust's services say

Adult Inpatient Survey

In the Adult Inpatient Survey in 2013 Imperial College Healthcare NHS Trust performance across all areas of care measured were average in comparison with other trusts. However, they scored below average for two questions in the survey namely: patients being told how they would feel after operations and discussions between staff and patients regarding equipment and possible adaptations needed after leaving the hospital.

NHS Staff Survey

The results of the 2013 NHS Staff Survey demonstrated that Imperial College Healthcare NHS Trust performance showed variation in scores over the 28 key areas covered in the survey, which included trust scores were:

- in the top 20% (best) for all acute trusts in 4 key areas
- in the bottom 20% (worst) off all acute trusts in 11 key areas
- average in 6 key areas
- better than average in 2 key areas
- worse than average in 5 key areas

Friends and Family Test

Friends and Family Test results showed the average scores for both inpatients and A&E were better than the national figure for 2012/13, however for maternity the average score was marginally below the national average. In addition, the response rate for inpatient was better than the national percentage but for A&E and maternity the response rate was lower. Specific figures for each were:

A&E

- Response rate lower than England average 15.9%, England average 19.5%
- 88% would recommend service, slightly higher than England average of 86%

In patient

- Response rate slightly higher than England average 37.2% compared to 36.2% - not statistically significant

Summary of findings

- 95% would recommend the service compared to national average of 93%

Maternity

- On average across the four areas measured the trust scores for people who would recommend the service were 92.5% lower than the England average of 94.2%.
- The trust response rate was low in all areas.

Cancer Inpatient Survey

The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that out of 69 questions, for which the trust received sufficient response to base measurements for 54 questions.

Out the 54 questions the trust performed below average in 46 questions, and average in six questions asked.

The trust scored above average in two questions, patients receiving information about cancer research in the hospital and patients having discussions about taking part in research programmes.

Facts and data about this trust

Context

- Around 1400 beds
- Serves a population of around 2 million people
- Employs around 10,000 staff across all hospital locations

Activity

- Around 192,168 inpatient elective admissions (including day case activity)
- Around 891,308 outpatient attendances per annum
- Around 133,041 A&E attendances per annum
- Around 3674 births at St Mary's and 5140 births at Queen Charlotte and Chelsea Hospital per annum

Intelligent Monitoring

Safe: Items = 9; Risks = 1; Elevated = 1; Score = 3

Effective: Items = 31; Risks = 0; Elevated = 0; Score = 0

Caring: Items = 18; Risks = 0; Elevated = 0; Score = 0

Responsive: Items = 11; Risks = 0; Elevated = 0; Score = 0

Well led: Items = 20; Risks = 2; Elevated = 0; Score = 2

Key Intelligence Indicators

Safety

- Four never events took place from April 2013 until August 2014, two within in the Surgery specialty, and one, relating to a misplaced feeding tube.
- A further never event took place in June 2014 'Unexpected Death' related to a misplaced NG tube.
- STEIS- 127 Serious Untoward Incidents (April 2013 - March 2014)
- Infection control
  - C-diff – higher than expected overall, with an inconsistent trend. An overall decline in trend was visible until Feb 2014; after which there has been an increase in cases
  - MRSA - number of MRSA cases are higher than expected

Effective

- HSMR - 76.3 (better than national average)
- SHMI - 74.7 (better than national average)

Caring

- Friends and Family Test:

- 91% of A&E patients would recommend the service which is higher (better) than the England average

- Overall in patients test scores are lower (worse) than the England average

- 90% of maternity patients would recommend the service –lower (worse) than the England average

- Cancer Patient Experience:

- In the bottom 20% for 55 of the 69 questions asked.

- Ranked number 3 in the bottom 10 poorest performing trusts

- CQC Adult Inpatient Survey -Scored " Average" in all sections

Summary of findings

Responsive

- A+E 4 hour target consistently met 4 hour waiting time target for the last two quarters
- •Referral to treatment:

- 86% of admitted treatment started within 18 weeks lower than the NHS operational standard of 90%.

- 95% of non-admitted treatments started within 18 weeks, in line with NHS operational standards

- Cancer 2 week wait: In line with national average
- Cancer 31 day wait: In line with national average
- Cancer 62 day wait: slightly better than national average

Well-led

Staff survey 2013:

Out of the 28 key areas covered in the survey:

- Trust scores were in the top 20% (best) for all acute trusts in 4 key areas
- Scores were in the bottom 20% (worst) off all acute trusts in 11 key areas
- Scores were average in 6 key areas
- Scores were better than average in 2 key areas
- Scores were worse than average in 5 key areas

Trust scores were in the top 20% of all acute trusts in the following areas:

- Percentage of staff agreeing that their role makes a difference to patients
- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- Percentage of staff having well-structured appraisals in last 12 months
- Staff motivation at work

Trust scores were in the bottom 20% off all acute trusts in the following areas:

- Support from immediate managers
- Percentage of staff receiving health and safety training in last 12 Months
- Percentage of staff suffering work-related stress in last 12 months
- Percentage of staff saying hand washing materials are always available
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Percentage of staff experiencing physical violence from staff in last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell
- Staff job satisfaction
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion
- Percentage of staff experiencing discrimination at work in last 12 months

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services in the trust as requires improvement. For specific information relating to each hospital location, please refer to the reports for St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte & Chelsea Hospital. Whilst the majority of staff demonstrated a positive incident reporting culture, there were some staff that were not always encouraged to proactively report incidents. In addition, there was a variation in reporting by staff group; with doctors proportionately under reporting. Learning and improvements from incidents was seen in many areas of the trust, however there was a tendency to share learning locally rather than proactively sharing learning trust wide. The safety culture was seen to be embraced by the majority of staff; however there had been history of some 'silo' working. The divisional structure was reported to be reducing the silo working and encouraged cross-divisional learning, although these changes were in the early stages. The standard of cleanliness, infection control and hygiene was inconsistent across the organisation; with some areas demonstrating robust processes for ensuring cleanliness was maintained but other areas demonstrating poor standards of cleanliness and hygiene. Processes for ensuring cleanliness and infection control practices were maintained to a high standard were not consistently followed by all areas, and this was especially noted within the ED at St Mary's Hospital. Medicines management was good in the majority of areas; however there were areas which demonstrated standards of medicines management and storage fell below the acceptable levels. The trust infection rates for Clostridium difficile and MRSA were slightly worse than the average range for England, even taking into account the trust size and the national level of infection. All cases were investigated and senior managers described that most actions to address root causes of each case had been implemented. Equipment was not consistently checked and maintained throughout the trust. Records were well maintained in many clinical areas; however there were examples of record keeping that fell below the required standard. The WHO checklist was not consistently completed in accordance with national standards and there had been two never	**Requires improvement** 

events that had involved the WHO checklist not being comprehensively completed. There had been four never events in the organisation in the previous 12 months, with one being immediately prior to the inspection.

Statutory and mandatory training levels were inconsistent and there were discrepancies between records and compliance rates locally and those held at trust level. The trust were taking steps to improve the recording of statutory and mandatory training.

The trust had a system in place for receiving and confirming compliance with patient safety alerts sent by the central alerting system (CAS). There was a nominated CAS liaison officer who acknowledged and updated the statuses of alerts; however, the arrangements for monitoring the management of safety alerts were not adequate. Staff told us the medical devices management group had not taken place since February 2014 and the next one was due in November 2014. We were told during the inspection that there was not an identified board member who had personal oversight of all alert compliance, implementation and sign-off or a named individual to lead on the practical implementation of each alert in accordance with national guidance. However, the trust later told us that the medical director was the board level patient safety alert compliance person.

Nurse staffing levels were not sufficient in all areas and there were some instances of shifts remaining unfilled with a significant use of agency staff. Medical staffing was in the majority of areas good. Around 50% of the doctors employed by the trust were specialist registrar doctors who were supported by consultants (30% of all doctors). The number of middle grade doctors was higher than the England average of 39%. The number of junior doctors employed by the trust was lower than the national average. Only 18% of all doctors were junior grades compared to the England average of 22%. The trust advised this was due to the high degree of specialist care provided by the trust.

Are services at this trust effective?

Good

Overall, we rated the effectiveness of the services in the trust as good. For specific information relating to each hospital location, please refer to the reports for St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte & Chelsea Hospital.

Care pathways, policies and procedures were based on evidence-based guidance and national recommendations. Clinical outcomes were either better than expected or in line with the national average such as outcomes for patients who had undergone major,

Summary of findings

orthopaedic and vascular surgery were better than the England average. The HSMR and SHMI were better than the national average. Staff were seen to use care pathways for the assessment and management of patients' effectively.

The trust took part in local and national audits and clinical audits demonstrated that outcomes for patients after heart attack and stroke were better than the England average.

Patients were given information about pain and pain relief was effectively managed in the majority of cases. Patients' nutritional and hydration needs were assessed and monitored appropriately.

Staff competence and knowledge was good where necessary staff training supported in many cases. There was a clear commitment to multidisciplinary team working between all staff involved in patients' care and the divisional directors leading the four clinical divisions were committed to improving cross-divisional and cross-site multidisciplinary team working to improve care through improvements in pathways across the trust.

Are services at this trust caring?

Good

Overall, we rated the caring aspects of services in the trust as good. For specific information relating to each hospital location, please refer to the reports for St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte & Chelsea Hospital.

Patient's feedback and observations during the inspection demonstrated that patients were treated with dignity and respect. Patients and relatives told us that they were treated with compassion and considered their individual care needs. Patients felt involved in their care and informed to ensure they had a key role in their care and treatment.

The Friends and Family Test results showed the average scores for both inpatients and A&E were better than the national figure for 2012/13, however for maternity the average score was marginally below the national average. In addition, the response rate for inpatient was better than the national percentage, but for A&E and maternity the response rate was lower.

The National Cancer Patient Experience Survey , for which the trust received sufficient response to base measurements for 54 questions, resulted in the trust performing below average in 46 questions, and average in 6 questions. The trust had taken significant steps to make improvements and understand the concerns being raised.

Summary of findings

Are services at this trust responsive?

Requires improvement

Overall we rated the responsiveness of services in the trust as requires improvement. For specific information relating to each hospital location, please refer to the reports for St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte & Chelsea Hospital.

The surgical department had a significant backlog of patients who were awaiting elective surgery; however, the trust did provide trust-wide plans to reduce the backlog. Referral to treatment times in some specialties had breached national targets on an ongoing basis. The clinical impact of cancellations and delays in surgery were not monitored and there was a lack of robust and consistent formal data collection in relation to theatre use and productivity.

There was insufficient bed capacity to ensure patients admitted to the surgical services could be seen promptly. Consequently, staff told us that patients were frequently cared for in inappropriate areas, such as in theatre overnight. There was some effective cross-divisional working to manage bed capacity issues. Whilst there wasn't a significant number of medical patients who were provided with treatment on non-medical wards due to lack of beds availability, they were often cared for on their speciality ward.

Bed occupancy was worse than the England national average and in line with the wider strategy to the North West London 'Shaping a Healthier Future' and the trust's clinical strategy, bed numbers had reduced in some specialties

There had been significant improvements made in the cancer pathway performance over the previous 18 months where the trust had improved from meeting only two of the eight Cancer standards to meeting seven out of eight at the time of the inspection, with projections to meet all eight standards for the next quarter.

In the outpatients department, the trust had not responded consistently responded to the gradual increase in clinic attendances. The number of clinics had not increased in the last two years at St Mary's despite an increase in patients. Patients were waiting longer for an initial appointment and also waiting longer in clinic. Doctors consistently arrived late for clinics without explanation. The trust was not meeting its target for sending out appointment letters to patients within 10 working days of receiving the GPs referral letter consistently. Some patients were not receiving their appointment letters nor did so after the date of their appointment.

When considering peoples individual needs such as learning disability support, translation services or care for patients living with dementia, there were shortfalls in how the needs of different people

Summary of findings

are taken into account, for example dementia care plans were not fully implemented at St. Mary's hospital. Availability of written information available in languages other than English was either limited or non-existent across the trust.

Complaints management wasn't meeting the trust's internal completion target of 85% within 25 working days. Complaints were not consistently seen as an opportunity to learn; for example there was no process for recording informal complaints received by staff on wards which would assist in identifying trends and inform learning.

Are services at this trust well-led?

Requires improvement

The trust's leadership was rated as requires improvement. For specific information relating to each hospital location, please refer to the reports for St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital and Queen Charlotte & Chelsea Hospital.

There had been some instability at executive leadership level over recent years, which had resulted in a number of changes being made and the current CEO had been in post since April 2014. Since being appointed, the CEO had made changes to the executive team and portfolios were clarified to ensure there were clear lines of accountability and a robust clinical governance structure. In addition, since appointment the CEO had spent a significant amount of time working on the wider strategic vision for North West London in conjunction with developing the clinical strategy with staff, in particular the divisional directors.

Whilst board level and divisional clinical leadership demonstrated collaboration and alignment to effectively lead the trust and make necessary improvements, the leadership at a more local level at each hospital was markedly varied; with some areas demonstrating good leadership but other areas requiring significant improvement.

There was a drive to empower and develop leaders through five leadership programmes, which aimed to 'drive exceptional performance through engaged people, create inspirational leaders and effective managers whilst ultimately improving patient experience'. Staff described how leadership development and these specific programmes had improved their knowledge confidence as a leader.

The trust had clear values that had been developed in conjunction with staff, however despite some improvements in staff engagement, there was recognition that engaging with staff was an area for improvement and there were clear plans in place to address this amongst all staff groups. Communication generally was recognised to have significantly improved since the appointment of

the CEO through staff forums, regular visibility and personal feedback. In addition, the substantive appointment of the whole executive board resulted in a sense of ”optimism” about the future stability of the trust.

The executive team, the non-executive directors and the divisional directors all recognised the trust was relatively early in the start of a journey to improve standards, standardise processes and improve engagement across all locations. This was fundamental to the overall strategy for Imperial Healthcare NHS Trust, which comprised of the trust vision, their strategic objectives, their clinical strategy and their supporting strategies (estates, people, patient transport, informatics, education and research, public and patient engagement). These were aligned with the wider plans for North West London “Shaping a Healthier Future”.

Whilst there was a clear governance reporting structure in place there were inconsistencies in its application across divisions and records held at a trust level were not always consistent with those being held at a local level; such as statutory and mandatory training and appraisal rates. There was an alignment between the executive team and non-executive director responsible for quality on key issues that needed to be addressed and the majority of the board were seen to be visible, especially the new CEO, however some staff expressed a desire to see more of the executive team on an informal walkabout basis.

The staff had a clear sense of pride in their work and a commitment to support the clinical strategy for the trust even where this had a direct impact on their future role, with a commitment from the trust to support staff in their development. Staff demonstrated a culture of multidisciplinary teamwork across locations, however there had been some ‘silo’ working in some areas which had improved since the divisional structure had been implemented.

Whilst being part of the first AHSC demonstrated some evidence of the positive impact on clinical care provided to patients through leading innovations, there was little evidence that being part of a AHSC had an impact on all staff groups and in the day to day running of the hospital or patient experience in an innovative manner. This was recognised by the executive team and there was a clear vision that being part of the AHSC would also have a key role in developing the day to day working practices and patient experience measures.

Summary of findings

The sustainability of trust services and pathways of care were considered as part of the wider strategy for the trust and "Shaping a Healthier Future" programme for the whole of North West London. These proposed reconfigurations were not reviewed as part of the inspection as they were not in place and under consultation.

Vision and strategy for this service

- The trust vision was "being committed to being a world leader in transforming health through innovation in patient care, education and research"
- The trust values were developed with staff as a set of five, which included, "respect, innovation, care, achievement and pride". Most staff were able to describe the values and what they meant to them; however some staff were not clear in terms of how these values translated into their work.
- The trust's overall strategic vision was part of a wider clinical reconfiguration and estates programme to improve NHS services across North West London "Shaping a Healthier Future", which was being led by eight clinical commissioning groups across North West London's eight boroughs. This strategic vision across North West London was fundamental to the future of Imperial Healthcare NHS trust in terms of both clinical care and improvements to the estates across the trust. However, at the time of the inspection it was in the process of being agreed and significant improvements were dependant on this strategy going ahead over the next 3 to 5 years.
- The strategic vision to address estates challenges in particular were less clear if the wider strategy involved in "Shaping a Healthier Future" did not progress or things that needed to be addressed earlier. However, the trust had spent a significant amount of time working on the strategic vision aligned with "Shaping a Healthier Future" and consequently they were working through the options and requirements to improve Imperial Healthcare NHS Trust specifically in conjunction with the wider vision.
- The overall strategy for Imperial Healthcare NHS Trust in the longer term comprised of the trust vision, their strategic objectives, their clinical strategy and their supporting strategies (estates, people, patient transport, informatics, education and research, public and patient engagement). These aspects were aligned with the plans for "Shaping a Healthier Future".
- Since the new CEO commenced in post there had been a significant amount of work done to ensure staff at all levels were involved, understood and were aligned to the clinical strategy of the organisation.

Governance, risk management and quality measurement

Summary of findings

- There were standardised governance systems and processes in place to manage risk; however these were not always consistently followed across the all locations and divisions, with some areas maintaining local records that were not always feeding into the wider governance system.
- In addition, the continuous improvement cycle was not being consistently followed due to feedback and learning not always being implemented into practice and actions being taken trust wide.
- There was a committee structure that demonstrated evidence of escalation and progress of issues, although there were examples of actions not being progressed in a timely manner as per plans.
- The structure and accountability of clinical governance had been disjointed; however the new CEO recognised this as a priority and realigned the accountability to the medical director in order to give more clarity and consistency to address clinical governance in a robust manner.
- The Quality and Safety Committee was chaired by a non-executive director who demonstrated good evidence of how clinical governance had improved during the last year, with evidence of triangulation of managing risk through robust challenge and 'probing' at the committee combined with regular communication with divisional directors and walkabouts that fed back into aggregation of information with subsequent improvements being made.
- There were examples of 'board to ward' and 'ward to board' communication, however this wasn't consistent across all locations; although there had been a recognised improvement since there had been more stability in the executive team and the new CEO had commenced in post.
- There had been a change in structure to four clinical divisions, which were clinically led by divisional directors with clear lines of accountability for all aspects of their division reporting into the chief operating officer (CoO).
- The four divisional directors met with the medical director every week individually and as a group to discuss clinical issues and incidents from that week; which provided a forum for issues to be shared across divisions in a timely manner and actions to be taken at a senior level where necessary. Although there were actions clearly taken as a consequence of these meetings they were not documented and therefore difficult to monitor process and efficacy in a robust manner.

- Whilst there had been a recognised reduction in 'silo' working since the divisional structure had been implemented, there was not a consistent and robust approach for communication across divisions, which had been recognised and was being reviewed.
- In the majority of cases there was a culture of incident reporting amongst staff groups, however there were some staff groups that were not reporting as consistently as others and there had not been any specific focused work on to improve incident reporting amongst certain staff groups.
- There was not an effective audit programme in place to align national and local audits and monitor improvements being made in a robust and consistent manner. This had been recognised by the trust and the medical director was reviewing the process in conjunction with the divisional directors at the time of the inspection.
- There was not a robust system in place for monitoring national guidelines, including patient safety alerts and NICE guidance. This had been recognised by the new medical director since he commenced in post but this had not been addressed at the time of the inspection.
- The systems in place for monitoring statutory and mandatory training and appraisals trust wide were not consistent with the records being kept locally in the divisions and locations themselves, which demonstrated areas where the board was not able to take assurance from the data being presented to them in these areas.
- Whilst there were examples of learning from incidents, complaints and compliments this was not consistently shared across divisions or trust wide.
- As a consequence of the number of recent changes at board level it was difficult to assess the level of challenge present at the board in ensuring governance was managed proactively and in a robust manner; however, the executive team had recently become substantive and there was evidence to suggest that although there were multiple areas where processes needed to be improved to ensure a cycle of continuous improvement was present, this had been recognised by the executive team and they were taking steps to strengthen all aspects of governance and quality improvement.
- In addition, there was clear evidence that there had been significant improvements made in the processes in the last twelve months, such as the improvements in the management and processes associated with waiting times for patients.
- The complaints process was being reviewed and improved as the trust was not meeting their own internal target of a

response within 25 days in 85% of complaints and the policy was out of date. However, there was clear commitment to improving the complaints process. The CEO only signs complaint response letters that were from MPs or from complainants who specifically asked that the CEO saw their letter.

Leadership of service

- There was a leadership and development programme at the trust, which aimed to 'drive exceptional performance through engaged people, create inspirational leaders and effective managers whilst ultimately improving patient experience'. These programmes were clearly set out in five separate courses from 'Foundations' to 'Certificate in Medical Leadership' including:
  - Foundation – Introduction to management
  - Headstart – Management into leadership
  - Aspire – The leadership way
  - Horizons – Strategic leadership
  - Certificate in medical leadership – Inspirational leadership
- Each level of the leadership programme was aimed at different staff groups to proactively develop emerging top leaders with the divisional directors all having attended the certificate in medical leadership.
- There was evidence of various staff groups attending these courses with a clear focus on supporting development of talent throughout the organisation to provide effective leadership.
- The CEO had been in post since April 2014 and had made a significant impact on the organisation since commencing in post. Staff at all levels described the positive impact the new CEO had made in such a short period of time, which resulted in staff describing positivity for the future of the trust with a substantive executive team in place.
- Since commencing in post the CEO had made some significant changes to the executive team, including change of medical director and appointment of deputy CEO (additional role give to COO), which had given confidence to staff at all levels that the leadership the trust required was in place after a period of instability.
- Whilst board level and divisional clinical leadership demonstrated collaboration and alignment to effectively lead the trust and make necessary improvements, the leadership at a more local level at each hospital was markedly varied; with some areas demonstrating good leadership but other areas requiring significant improvement.

- The executive team as a whole recognised they were a relatively new team working together and described the support they had in place to ensure they developed effectively as a team.
- The CEO had done open forums and other forms of staff engagement since appointment and she was well known by staff at all levels for being visible and approachable. In addition, staff reported that if they raised an issue with the new CEO they received a response to their concerns.
- The divisional directors that led the new structure of the four clinical divisions demonstrated both an alignment and understanding of the issues that needed to be addressed trust wide as well as a constructive level of challenge between themselves. However, as the new divisional structure was a recent change, it was too early to assess the impact of this.
- The operational management team had been through a complete restructure following the appointment of the CoO, which was embedded at the time of the inspection having led some of the challenges associated with waiting times and processes. The CoO was recognised to have an open leadership style and held general manager forums to provide leadership to operational staff in conjunction with the deputy CoO.
- The medical director was relatively new in post, however he had been working in the organisation previously and therefore had built up relationships with colleagues prior to being appointed and provided professional leadership to the divisional directors working closely with the CoO and director of nursing (DoN) to address quality issues.
- The DoN held weekly meetings each Friday to ensure all nursing staff communicated issues in a timely manner and to share good practice between themselves across sites. Videoconferencing was used to ensure different locations were sharing information.
- The director of people (DoP) provided a key leadership role in staff engagement and there was evidence of good visibility across the organisation to ensure she understood the views of staff and the culture across all locations. There were clear plans to improve staff engagement across all staff groups and ensure the executive team understood the views of staff throughout the trust.
- The Chair and non-executive directors demonstrated a clear understanding of the strategy of the trust and key issues to be addressed throughout the trust. There was evidence of the non-executives holding the executive team to account in a

challenging but supportive manner in more recent months and they were visible throughout the organisation. The chair and non-executive director leading on quality were reported to be visible to staff.
- There was consistent feedback among all staff groups and levels that the CEO had improved communication and demonstrated the values through significant visibility and commitment.
- Since the CEO had commenced the executive team portfolios of work, lines of responsibility and accountability relating to their portfolios were much clearer allowing improved systems and processes to become established and embedded.
- Despite being a relatively new executive team, there was evidence of a cohesive and clear strategy that they were all aligned to; with clear recognition that they were at the beginning of a 'journey' to implement the overarching and clinical strategy to make improvements, some of which have been related to longstanding issues.
- Although some members of the executive team were reported to be highly visible and approachable, the were some of the executive team that staff told us they would like to see more regularly in open forums or informal walkabouts.

Culture within the service

- The culture throughout the organisation was open and transparent, which was reported to have become a specific focus since the appointment of the CEO as a key part of improving patient experience.
- The staff demonstrated a culture of multidisciplinary teamwork across locations, however there had been some 'silo' working in some areas which had improved since the divisional structure had been implemented.
- There was a culture of research and development and innovation among some staff groups, but this was more prevalent in some hospital services than others.
- Although the trust was part of the first Academic Health Sciences Centre, there was not a consistent and clear alignment among all staff groups in relation to the impact of this on their day to day working practices.
- There was a clear culture of staff working with a sense of pride in their work, with a commitment to improve patient care.
- There was a sense of 'optimism' among staff since regarding the future of the trust as a consequence of the CEO commencing in post providing clear leadership in conjunction with the rest of the executive team.

Public and staff engagement

Summary of findings

- The staff survey in 2013 results showed that of the 28 key findings, 4 were in the top 20% nationally and 11 were in the bottom 20% nationally. This included staff feeling motivated at work being in the top 20%, but staff job satisfaction was within the bottom 20% nationally.
- Whilst there had been evident improvements in staff engagement, there was significant work that needed to be done to embed the improvements and ensure the engagement was improving across all staff groups. The executive team recognised this and there were clear plans in place to address this, including quarterly engagement survey sent out to staff.
- An element of the sense of optimism amongst staff was due to the engagement with staff regarding the clinical strategy for the organisation.
- The trust values were known by the majority of staff and they were developed in conjunction with some staff groups.
- The CEO open forums provided an opportunity for staff to feedback directly raising issues or opportunities for development. Staff reported positively about these forums and the commitment the CEO had demonstrated, to personally respond to staff that raised an issue.
- The executive team all provided opportunities to engage with staff but it was recognised that these could be improved to ensure staff felt engaged with all of the executive team members.
- The non-executive team carried out regular walkabouts and some staff were able to describe examples of improvements being made as a consequence of staff raising concerns.
- The majority of staff were aware of the proposed clinical and overarching strategy including the reconfiguration of services and were able to describe the reasons for the necessity of the changes.
- Where staff were going to be personally affected by the changes of the reconfiguration in the coming years there were examples of staff describing how they were involved in discussions around the plans and how they were going to ensure patient experience was maintained until the point of change.
- In addition, where staff were concerned about the future of their job following changes they described a commitment from the trust to ensure they were developed prior to the changes to empower them to secure another post in a proactive manner.
- The overarching strategy for the clinical reconfiguration of services had been out to consultation and patients were able to comment on the developments.

- There were examples of patients being involved in the development of services and pathways of care; however this was not consistent across all locations and areas within the trust.

Innovation, improvement and sustainability

- Research and development and clinical innovation was fundamental part of the trust, particularly through the work linked to the AHSC. This innovation clearly provided opportunities for patients to be involved in clinical trials and have access to leading improvements in healthcare.
- However, whilst there were many examples of how the AHSC improved clinical care directly there was less evidence that being part of an AHSC had an impact on all staff groups and in the day to day running of the hospital in an innovative manner.
- This focus on clinical innovation was recognised by the executive team and there was a clear vision that the AHSC has a key role in developing the day to day working practices and patient experience measures, whilst continuing to develop innovations in clinical care through research and development.
- In addition, innovation at a local level was encouraged among staff groups and there were examples where improvements were made following staff proposing innovations.
- Whilst improvement in delivery of care were evident during the inspection, there were differences between hospitals which demonstrated aspects of 'silo' working where best practice and basic standards were not consistent throughout the trust.
- There had been significant improvements in the management of the cancer pathway, which involved collaborative working and leadership at a number of levels throughout the organisation to embed and deliver transformation at a clinical level, as well as improve key pathways and processes to ensure any potential breaches in patient pathways can be tracked real time and brought back on track rapidly.The sustainability of services and pathways of care were considered as part of the wider strategy for the trust and "Shaping a Healthier Future" programme for the whole of North West London. These proposed reconfigurations were not reviewed as part of the inspection as they were not in place and under consultation.

Overview of ratings

Our ratings for St Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for Charing Cross Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Inadequate	Inadequate	Inadequate

Overview of ratings

Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Hammersmith Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Queen Charlotte and Chelsea Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity & gynaecology	Good	Good	Good	Good	Good	Good
Neonatal services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Good

Our ratings for Imperial College Healthcare NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall

Overview of ratings

Overall trust	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency and Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

- The trust hosts a NIHR Biomedical Research Centre and has a strong focus on translational research participating in and leading national research projects. An example of this is the evaluation of magnetic resonance imaging to predict neurodevelopmental impairment in preterm infants..
- The impact of the new CEO on all staff groups through staff forums and regular visibility and the evident optimism among staff for the future with a permanent executive team in place.
- The leadership programmes available to staff, which aimed to 'drive exceptional performance through engaged people, create inspirational leaders and effective managers whilst ultimately improving patient experience'. These programmes were clearly set out in five separate courses from 'Foundations' to 'Certificate in Medical Leadership'
- Some of the clinical services we inspected achieve nationally leading outcomes for patients. Examples include the Trauma Centre at St Mary's Hospital and the stroke service at Charing Cross Hospital.

Areas for improvement

Action the trust MUST take to improve

Action the hospital MUST take to improve

St Mary's Hospital

- Improve the standards of cleanliness of premises and equipment.
- Increase the number of cases submitted to the audit programme for the World Health Organization (WHO) surgical safety checklist to increase compliance with the 'Five steps to safer surgery'.
- Develop and implement systems and processes to reduce the rate of patients who do not attend their outpatient appointment or surgical procedure.
- Review the level of anaesthetic consultant support and/or on-call availability to ensure it is in line with national recommended practice.
- Review the arrangement for medicines storage and ensure medicine management protocols are adhered to.
- Ensure all staff are up to date with their mandatory training.
- Ensure all equipment is suitably maintained and checked by an appropriate person.
- Ensure adequate isolation facilities are provided to minimise risk of cross-contamination.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.
- Review the provision of paediatric intensive care to ensure the department meets national standards.
- Review the provision of services on Grand Union Ward to ensure the environment is fit for purpose.

Charing Cross Hospital

- Correct the problems associated with the administration of appointments which was leading to unnecessary delays and inconvenience to patients.
- Address the high vacancy rates for nursing staff and healthcare assistants in some medical wards, and the level medical staffing out of hours for the intensive care unit (ICU) and level 2 beds.

Hammersmith Hospital

- Correct the high number of vacant nursing and healthcare assistant posts on the medical wards.
- Address the problems associated with the administration of outpatient appointments which was leading to unnecessary delays and inconvenience to patients.
- Reduce the significant backlog of patients who are awaiting elective surgery in the surgical department.

Outstanding practice and areas for improvement

Queen Charlotte & Chelsea Hospital

- Review the staffing levels and take action to ensure they are in line with national guidance.
- Review the capacity of the maternity and neonatal units to ensure the services meet demands.
- Review the divisional risk register to ensure that historical risks are addressed and resolved in a timely manner.

Action the hospital SHOULD take to improve

St Mary's Hospital

- Ensure that there is a single source of up-to-date guidelines for A&E staff.
- Improve ambulance turnaround time.
- Seek ways of improving patient flow, including analysing the rate of re-attendances within seven days.
- Improve links with primary care services to help keep people out of A&E.
- Ensure that all patients who undergo non-urgent emergency surgery are not left without food and fluids for excessively long periods.
- Review the literature available to patients to ensure it is available in languages other than English in order to reflect diversity of the local community.
- Ensure same-sex accommodation on Witherow Ward to ensure patients' privacy and dignity are maintained.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Develop a standardised approach to mortality review which includes reporting to the divisional boards and to the executive committee.
- Review patients' readmission and length of stay rates to identify issues which might lead to worse-than-average results.
- Review the processes for ensuring compliance with statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust-wide records.
- Review the double-checking process for medication to ensure that staff are compliant with trust policies and procedures.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Consider the children and young people's service having representation at board level.
- Review the provision of adolescent services and facilities to ensure the current provision is able to meet the needs of patients.
- Ensure that there is sufficient capacity to accommodate parents/carers while their child receives intensive care support.

Charing Cross Hospital

- Take sufficient steps to ensure the 'Five steps to safer surgery' checklist was embedded in practice at Charing Cross Hospital.
- Implement the trust-wide plans to reduce the backlog of more than 3,500 patients awaiting surgical intervention would be tackled.
- Ensure that all patients who undergo non-urgent emergency surgery are not without food and fluids for excessively long periods.
- Increase the capacity in the outpatients department to address the increased demand and adequately respond to people's needs.
- Assign sole responsibility for the outpatients department to one division so that quality and risk issues could be managed more effectively.
- Meet its target of sending out appointment letters to patients within 10 working days of receiving the GPs referral letter.
- Ensure outpatient letters to GPs occur within its target time of 10 days following clinics.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Reduce the backlog of patients who are awaiting elective surgery.
- Increase capacity to ensure patients admitted to the surgical services can be seen promptly and receive the right level of care.
- Avoid cancelling outpatient clinics at short notice.
- Minimise number of out-of-hours transfers and discharges from the medical wards.

Hammersmith Hospital

- Improve patient transport from the outpatients department so that patients are not waiting many hours to be taken home.
- Improve the management of medicines on the medical wards.
- Ensure patients' records are always appropriately completed.

Outstanding practice and areas for improvement

- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Ensure cleaning of equipment is always carried out.
- Improve access to the one pain clinic that is available in the trust.
- Reduce the high number of out-of-hours transfers and discharges.
- Monitor the clinical impact of cancellations and delays in surgery.
- Ensure that surgical patients are not cared for in inappropriate areas such as in the theatre overnight.
- Improve the responsiveness of the outpatients department with regards to clearing the backlog of GP letters from the gastroenterology clinic and reducing the waiting times for patients to get an initial appointment.
- Avoid cancelling outpatient clinics at short notice.
- Ensure there is accurate performance information from the outpatients department.
- Ensure that quality and risk issues in the outpatients department are managed effectively.
- Consider reviewing the processes for the capturing of information to help the service to better understand and to measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the provision of children's outpatient services to ensure there is parity across the hospital campus.
- Consider reviewing the operating times of the David Harvey Unit to ensure the service is accessible to the local population to which it serves, at the right time of day.

Queen Charlotte & Chelsea Hospital

- Review the current training matrix for statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust-wide records.
- Ensure that the risk management process within the neonatal division is suitably robust and fit for purpose to ensure risks are assessed, investigated and resolved in a timely manner.
- Explore how staff can learn from minor incidents and near misses to avoid similar incidents occurring.
- Consider the neonatal service having a representation at board level.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there were not sufficient numbers of nursing staff on the neonatal intensive care unit, maternity wards at Queen Charlotte & Chelsea Hospital. Also at Hammersmith Hospital there were not sufficient numbers of nursing staff and healthcare assistants on the medical wards. Regulation 22

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because the problems associated with the administration of appointments for the outpatients department were leading to unnecessary delays and inconvenience to patients at Hammersmith Hospital, Charing Cross Hospital and St Mary's Hospital. Regulation 9 (1) (a)(b)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Compliance actions

People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there was a significant backlog of patients who were awaiting elective surgery in the surgical department at Hammersmith Hospital

Regulation 9 (1) (a)(b)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there were not sufficient numbers of nursing staff and healthcare assistants in some medical wards; and insufficient medical staff for out of hours ICU and level two beds at Charing Cross Hospital. Regulation 22

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider did not have suitable arrangements to protect patients against the risk of unsafe equipment at St Mary's Hospital • An anaesthetic machine had been out of order for six days. • An examination lamp head in one cubicle was significantly dented with resultant sharp edges. There was no light bulb so the equipment was unusable. • There was a number of items of broken equipment, held together with tape, for example a drip stand and a patient monitor in one cubicle. • The brake on one of the patient trolleys did not work. • There were insufficient wheelchairs which led to patients missing their appointments, for example for radiology. • The floor in the resuscitation area was lifting in the gap between door and floor.

This section is primarily information for the provider

Compliance actions

- The psychiatric holding room had two movable chairs rather than seating fixed to the floor.

Regulation 16 (1) (a) Health and Social Care Act

2008(Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 (1) (a) (b) (c), (2) (a) (c) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010. Cleanliness and infection control (1) The registered person must, so far as reasonably practicable, ensure that- (a) service users; (b) persons employed for the purpose of the carrying on of the regulated activity, and (c) others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2) 2) The means referred to in paragraph (1) are- (a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection, (c) the maintenance of appropriate standards of cleanliness and hygiene in relation to- (i) premises occupied for the purpose of carrying on the regulated activity. (ii) equipment and reusable medical devices used for the purpose of carrying on the regulated activity. We saw unbagged soiled linen on the floor next to two linen bags that were full, one was outside the treatment room and the other was near the porters' room. On two consecutive days we observed the floor in the triage room of the paediatric area to be dirty. There was also dirt along the back of the fixed seating in the waiting room.

This section is primarily information for the provider

Enforcement actions

The cupboards and drawers in the treatment room in the A&E department were dirty.

The floor of the psychiatric holding room was dirty.

The curtains of bays L and J had brown stains on them and these had had last been changed in February 2014..

A portable X-ray machine in a corridor that was labelled “clinically clean” was thick with dust in the lower part.

A laryngoscope in the adult resuscitation area which was not clean and had had the blade prepared for re-use.

Not all nursing staff washed their hands before and after attending to patients. Several hand hygiene handrub dispensers for use by ambulance staff delivering patients to the department were empty.

The theatre, which was regularly being used by the A&E department as a treatment room, did not contain any liquid soap for hand washing. As a result, clinical staff were unable to observe thorough hand washing principles in this area.

There was no built-in hand washing sink in the sluice room for staff to wash their hands after handling dirty equipment and body fluids.

There were no disposable plastic aprons in the paediatric isolation room for clinical staff to use in order to minimise the spread of infection.

18 cubicles in the A&E department had sharps bins that were more than three-quarters full and still open for use. Therefore there was the risk a staff member sustaining a needle stick injury.

Regulation 12 (1) (a) (b) (c), (2) (a) (c) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010.

Imperial College Healthcare NHS
NHS Trust

Trust Board - Public

Agenda Item	4.1
Title	CQC Chief Inspector of Hospitals' Inspection – follow up and action plan
Report for	Monitoring
Report Author	Dr Senga Steel, Deputy Director of Nursing
Responsible Executive Director	Professor Janice Sigsworth, Director of Nursing

Executive Summary:

The purpose of this report is to update the Trust Board on the outcomes of the CQC inspection. This includes delivery of the CQC action plan as a result of the outcomes of the inspection.

The attached CQC action plan was approved by the Executive Committee on 13th January 2015 and ratified by the Quality Committee on 14th January 2015. The action plan was submitted to the CQC on 19th January 2015. We are awaiting feedback.

Recommendation to the Board:

The Board is asked to note the report.

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered effectively and with compassion.

CQC CIH Inspection Update

1 Background

The CQC carried out an inspection of the Trust in September 2014. The inspection assessed whether our services were:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well led

By services, the CQC defines the eight 'core' services it has identified for NHS acute trusts as:

- Urgent and emergency services
- Medicine (including older peoples' care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

2 Inspection

Four hospital sites and the eight core services were inspected between 2 – 5 September 2014 as part of the announced component of the inspection. Unannounced visits took place between 1st and 11 September 2014; five of the eight unannounced visits took place out of hours.

3 Responding to Initial Feedback

Following the conclusion of the announced component of the inspection, on 5 September 2014 the CQC delivered brief, high level feedback. Four areas of concern were highlighted:

- Inconsistent monitoring of the temperatures of fridges where medicines are stored
- Incomplete or missing documentation which is required in relation to Do Not Attempt CPR orders
- A backlog of letters for patients and GPs with medical secretaries in Gastroenterology
- Cleanliness and infection control in the A&E department at St. Mary's Hospital

Action plans were immediately put in place to address these concerns. The Executive Committee monitored the performance in these areas to ensure these improvements were sustained.

The CQC served the Trust with a Warning Notice in September 2014 which related to aspects of cleanliness and infection control in the A&E department at St. Mary's Hospital. An action plan to address these concerns has now been fully executed. The Chief Executive wrote to the CQC in October 2014 to confirm that all of the actions in this plan had been completed.

The A&E Department has been subsequently re-inspected by the CQC and an updated CQC report for St Mary's for urgent and emergency services was published on the 7 January 2015. The re-inspection looked at the safe domain, which improved from 'inadequate' to 'requires improvement'. The overall rating for this service at St Mary's has not changed.

4 Inspection Report and Final Outcome

The final report of the September inspection was published on 16 December 2014 with an updated version published on 7 January. The updated report included actions that undertaken by the Trust to improve the Emergency Department issues found during the inspection.

The Trust overall received a 'requires improvement' rating; a rating of 'good' was received for caring and effective, safe, responsive and well-led received a rating of 'requires improvement'. Each hospital site was rated. Charing Cross, Hammersmith and St Mary's received 'requires improvement' and Queen Charlotte's and Chelsea was rated 'good'.

Of the services inspected Women and Children's and end of life care were rated as 'good'. The full report can be accessed on the CQC website http://www.cqc.org.uk/provider/RYJ

5 Areas of Outstanding Practice

Areas of outstanding practice were noted in the inspection reports. These are as follows:

- NIHR Biomedical Research Centre has a strong focus on translational research; hosting and leading national projects. An example of this is the evaluation of MRI to predict neurodevelopment impairment in pre-term infants
- The impact of the new CEO and senior leadership team and the evident optimism among staff
- The leadership programmes available to staff which aims to drive exceptional performance through engaged people
- Nationally leading outcomes in Trauma and Stroke services at Charing Cross

6 Quality Summit

Prior to the publication of the report, on December 12 2014 a Quality Summit was held to discuss the inspection findings with key stakeholders and the CQC with a particular focus on action planning. This was a positive event with offers of support made from all stakeholders to implement key actions. The action plan was then drawn up addressing all the identified actions and was submitted to the CQC on 19 January 2015. We are awaiting feedback.

7 Action Plan in Response to Inspection Findings

There has been much detailed work to develop and finalise the action plan. The Trust has actions in place and on-going work addressing many of the areas highlighted and further attention will be given to accelerating the pace of change to bring about the required improvements quickly.

A top priority for the Trust over the next year is to implement the CQC action plan. The plan will be monitored by exception and will form a key aspect of the new Quality Strategy during 2015/16. This will be driven forward by the Executive Committee and reported by exception to the Quality Committee and the Trust Board. The CQC will review the Trust's action plan and give formal sign off. Discussions are underway to agree how the CQC will monitor implementation of the plan and when we will be re-inspected.

8 Sharing the Outcomes of the Report

Staff briefing sessions were arranged following publication of the report which were led by the CEO on all the hospital sites, as well as divisional and 'back to the floor briefings' during December. Staff are now engaged refining the action plan.

9 Going Forward from the CQC Inspection

9.1 Improving Quality of Care

A framework will be developed to ensure that the Trust continues to meets the thirteen regulations set out as essential standards by the CQC. The framework will include activities and timelines for the year to ensure that assurance is provided that quality of services is good. The framework is likely to include:

- Review of compliance against the thirteen CQC regulations
- Core service reviews
- Divisional quality of care assessments
- Quality assurance exercise to test our assurance

The draft framework will be presented to the Executive Committee early February 2015. The framework will be embedded in the new Quality Strategy and be a key assurance mechanism of assurance. Internal audit and examples of good practice from other hospital trusts will be used to support this development.

Recommendation to the Board: The Board is asked to note the report.

Draft action plan in response to CQC inspection findings: January 2015

Actions that MUST be taken			
SAFE			
S1 Compliance Action: <u>In the A&E at St. Mary's Hospital</u>, equipment must be suitably maintained and checked by an appropriate person before use. *See page 118 in the SMH report.* Links to S12.			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
1.1 Clarify roles and responsibilities and improve processes to ensure equipment is always clean and maintained • Review Medical Devices Management Policy and Procedure (cleaning and decontamination of equipment) ○ Ratify changes through Executive Committee • Disseminate reviewed policy to divisional multi-disciplinary teams **Director Lead** Janice Sigsworth, Director of Nursing		Revised MDPP to be ratified by April 2015	• Extended Professional Practice Committee for nurses on 15 October addressed nursing responsibilities • Audit undertaken 25 October 2014 ○ Divisional action plans generated based on outcomes ○ Review of audit outcomes with Sodexo being arranged
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
1.2 One of two anaesthetic machines in the department not working for six days prior to the inspection	Anaesthetic machine to be replaced **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	Machine is due to be received by 31 Jan 2015	
1.3 An examination lamp head in one cubicle was significantly dented with resultant sharp edges. There was no light bulb so the equipment was unusable.	Lamp repaired and light bulb put in on 1 December **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	
1.4 There were a number of items of broken	Broken equipment identified for repair or	COMPLETE	From October 2014, weekly cleaning

equipment, held together with tape, for example a drip stand and a patient monitor in one cubicle.	replacement as appropriate. Reported to Executive Committee as part of weekly assurance report. **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine		and decontamination audits also identify whether any equipment is in need of repair or replacement. Audit outcomes are reported to the Executive Committee as part of the 'Emergency performance – recovering operational performance' action plan
1.5 One brake on one patient trolley did not work	Brakes on all patient trolleys were reviewed and repaired or replaced as required. **Divisional Leads** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	
1.6 There were insufficient wheelchairs which led to patients missing their appointments, for example for radiology.	Number of wheelchairs available reviewed in November and December 2014 **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	Next review of wheelchair numbers will be in Feb 2015. Spot checks will continue to be done during DDN visits to the department.
1.7 The floor in the resuscitation area was lifting in the gap between door and floor.	Flooring was replaced as part of the A&E refurbishment in October 2014 **Divisional Lead** Ian Taylor, General Manager, Medicine	COMPLETE	
1.8 There were two movable chairs in the psychiatric holding room	Fixed chairs have been ordered **Divisional Lead** Ian Taylor, General Manager, Medicine	Ordered w/c 16 Jan with 2 week delivery timeframe	The moveable chairs were removed from the room in December 2014. The Trust's mental health team consulted on the appropriate chairs to purchase.

S2 Compliance Action: The high vacancy rates for nursing staff and healthcare assistants on some **medical wards at Charing Cross Hospital** must be addressed. *See page 23 in the CXH report.*		
OVERALL ACTIONS BEING TAKEN	**DUE**	**PROGRESS**
2.1 In October 2014, the People and Organisational Development team was restructured to align with divisions, and additional administrative support was added. • Review vacancy management **Director Lead** Jayne Mee, Director of People and Organisational Development	Restructure COMPLETE Audit to be completed by Apr 2015	The restructure and new admin support have reduced the total time to hire from advert to start date • It has been agreed that Internal audit will carry out an audit of vacancy management for the Division of Medicine and Investigative saciences
2.2 Develop a new e-roster policy which includes key indicators through theQuEST quality improvement team • Provide 'masterclass' sessions for managers on principles and practice of good rostering (through QuEST and Allocate • Report KPIs through ○ the The QuEST programme board, which reports monthly at the Executive Committee ○ Divisional performance meetings and by continuing with the existing weekly Operational Resilience Report, which reports at the Executive Committee **Director Lead** Jayne Mee, Director of People and Organisational Development	Masterclasses will take place in Mar and Apr 2015 New policy with KPIs to be ratified Jan 2015	A lead had been assigned to the QuEST project and nursing support is currently being identified.
2.3 Align staffing with the Trust bed capacity plan for 2015 / 16 (part of the Trust's business plan) • A demand and capacity assessment will be factored into divisional business plans to ensure staffing establishments match bed capacity • The plan will be monitored via weekly Operational Resilience meetings **Director Lead** Steve McManus, COO	Trust board to sign off bed capacity plan May 2015	Establishments to be signed off no later than March 2015 by Nurse Director
2.4 Deputy Chief Nurse from NHS London to review recruitment plans for the Division of Medicine and provide feedback. **Director Lead**	April 2015	Meeting arranged with Deputy Director and Director of Nursing 13 January

Janice Sigsworth, Director of Nursing			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

2.5 High vacancy rates were on the divisional risk register but it was not clear what action was being taken to address them	• Review Vacancy levels for bands 2 to 6 at divisional performance reviews monthly using
	  ○ A performance trajectory with an end goal of 5% by December 2015
	  ○ More detailed workforce summaries (for example, by division by site)
	• Instigate monthly meetings between the Director of Nursing and Divisional Director of Nursing for Medicine to review vacancies
	  ○ Division of Medicine to present detailed action plan to reduce vacancy rate to 5%.
	  ○ Report and monitor to the performance management meeting monthly
	  ○ To align business planning with bed capacity and staffing requirements throughout the year
	  ○ Review staff establishment plans with COO and Divisional Director / Director of Nursing if changes are required
	  ○ Update the safe nursing and midwifery staffing policy to provide clarity around revised processes; particularly seasonal variation
	• Deputy Director of HR to ensure (bands 2-6) recruitment plans for Medicine
	• Division of Medicine to establish a Task and Finish Group to meet fortnightly to oversee the vacancy reduction plan
	
	Director Lead
	Jayne Mee, Director of People and Organisational Development
		A recruitment / vacancy reduction plan will be presented in Feb 2015	• First meeting with DDHR and DDN took place 7 January
			• General Managers in Medicine will begin meeting in February 2015
			• The Trust Risk Manager meets quarterly with the Executive Team and monthly with Divisional Governance Leads
			• Divisional, HR and the corporate risk registers were updated January 2015 to reflect the current vacancy situation and will be used to manage workforce risks going forward
			  ○ Divisional and HR risk registers are presented quarterly at the Executive Committee and monthly at the Quality Committee for assurance

	Divisional Leads Tim Orchard, Divisional Director, Medicine Sally Heywood, Divisional Director of Nursing, Medicine Gemma Glanville, HR Business Partner for Medicine		
2.6 High vacancy rates for nurses in the following specialties: ➢ Stroke (9N and 9W) ➢ Acute medicine (9S and 4S) ➢ Elderly medicine (8W and 8S) ➢ Oncology (Weston)	• Recruit to 5 % vacancy level for bands 2 to 6 • Attain bank fill of 90% by improving management of requests (receipt, booking, etc.) and developing a business case to address day rates **Director Lead** Jayne Mee, Director of People and Organisational Development **Divisional Leads** Tim Orchard, Divisional Director, Medicine Sally Heywood, Divisional Director of Nursing, Medicine	Existing vacancies will be filled by mid-March 2015 Bank fill to be reviewed between Jan and Mar 2015	• A nursing and midwifery vacancy plan is being developed • All current vacancies advertised • A schedule has been developed for the cycle of continuous recruitment, including events to target specialties ○ Will be presented at the divisional performance review in February ○ Event dates have been arranged and hiring managers advised
2.7 High vacancy rates for healthcare assistants in neurology	Same actions as for S2.6		

S3 Compliance Action: The level of medical staffing out of hours for ICU and level 2 beds in **Critical care at Charing Cross Hospital** must be addressed. *See pages 47 and 48 in the CXH report.*

This links to S10.

OVERALL ACTIONS BEING TAKEN	DUE	PROGRESS
3.1 As part of the Trust's 2015 / 16 business plan, the Critical Care Committee (which meets monthly) has carried out a strategic review which has recommended that critical care 'hubs' will be created on each site ○ External stakeholders across the Critical Care Network will be engaged in the redesign ○ Co-location of levels 2 and 3 beds (agreed at Quality Summit) ○ Reconfiguration of the service to increase capacity ○ Side by side management of HDUs and ICUs, including improvement of timely access to airway-trained staff **Director Lead** Steve McManus, COO With regard to the workforce issues below in addition and covering all the issue we have commissioned internal audit to review medical/nursing cover of critical care service	March 2016	Our latest assessment of critical care services found that we are complying with current critical care standards

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
3.2 A Registrar was not always available out of hours on the ICU so cover was sometimes provided by junior doctors (the most senior would be a CT2). At the time of the inspection, none of the junior doctors had ventilation training	• Review availability of registrar out of hours in the ICU (will be addressed under 3.1) • Junior doctors to have undertaken airway training in accordance with national curriculum • Develop an action plan to address the reconfiguration of CC services **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	Aug 2015	
3.3 The on-call consultant could take up to 30 minutes to arrive, which means immediate support is not always available.	Review the appropriateness of this and whether there are any alternatives **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	May 2015	

3.4 The consultant often stayed late (until midnight) due to the lack of a Registrar.	This will be addressed under S3.1		
3.5 Although there is a medical consultant for the HDU, there were no critical care medical staff dedicated to the HDU or other level 2 beds.	This will be addressed under S3.1		
3.6 There was support from Site Ops team but not all site practitioners were airway trained and were often preoccupied out of hours with bed management. Additionally, although there were two anaesthetists covering theatres out of hours, they were not ICU trained.	• Review scope of practice for Site Practitioners to determine whether the appropriate airway training is being met (all should be ALS trained –will be addressed under 3.1). • Ensure that staff have current details (contact information, procedure) for accessing airway support **Senior Management Lead** Nicola Grinstead, Director of Operational Performance	April 2015	Will be reviewed at the Quality Committee on 1 April 2015
3.7 Out of hours, there was a general medical registrar and two senior house officers, none of whom were airway trained.	This will also be addressed under S3.1 • Confirm that the Trust has sufficient numbers of airway-trained staff (all medical staff should be ALS trained) and that access out of hours is appropriate to meet patient needs • Ensure that staff are aware of who to call and what to do when they need airway support Undertake an audit of practice **Divisional Lead** Tim Orchard, Divisional Director, Medicine	COMPLETE Feb 2015 Mar 2015	According to the RCP curriculum, medical registrars and Site Practitioners are not required to manage complex intubated patients, although both are ALS-trained

S4 Compliance Action: The high number of vacant nursing and healthcare assistant posts on some **medical wards at Hammersmith Hospital** must be corrected. *See page 16 in the HH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
4.1 High vacancies were on the divisional risk register for Medicine	This will be addressed under S2		
4.2 Unfilled shifts were specifically mentioned on B1, Fraser Gamble, John Humphrey, De Wardener and Weston wards.	This will be addressed under S2		• B1 was closed in October 2014 • Weston has zero vacancies as of Jan 2015

S5 Compliance Action: The staffing levels in **Maternity and Neonatal Services at QCCH** must be reviewed and action taken in order to ensure they are in line with national guidance. *See pages 11 / 12 and page 24 in the QCCH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

5.1 Inadequate midwifery staffing levels were lower than the national average and did not meet the recommended ratio on postnatal wards.
 	
Pages 11 and 12
	Midwifery staffing plan being implemented from 1 April 2015 will bring midwife to patient ratio to 1:30
	
	• Monthly recruitment open days will be held on an on-going basis
	  ○ Centralised team with 'offer on the day' to improve process efficiency and reduce withdrawals between interview and offer.
	  ○ Candidates will be ready to start within eight weeks
	• Review recruitment plans and processes by the Deputy Chief Nurse for NHS London
	
	Director Lead
	Jayne Mee, Director of People and Organisational Development
		Recruitment began Jan 2015
		
		All posts filled with midwives ready to start Apr 2015
			• Business case for recruitment agreed September 2014
			• Recruitment campaigns are now underway for a total of approximately 60 midwifery, nursing and midwife support worker posts – recruitment has begun
			• Two recruitment open days (Feb and Mar 2015) have been arranged
			• The recruitment plan review by NHSL is currently being scoped and will align with an overall nursing and midwifery vacancy plan which is being developed
			• quarterly with the Executive Team and monthly with Divisional Governance Leads
			• Divisional, HR and the corporate risk registers were updated January 2015 to reflect the current vacancy situation and will be used to manage workforce risks going forward
			  ○ Divisional and HR risk registers are presented quarterly at the Executive Committee and monthly at the Quality Committee for assurance

5.2 Neonatal services did not have the	• Review 24 to 27 cot capacity as part of		• Current recruitment phase for

establishment recommended by the BAPM. *Page 24*	business planning in 2015 / 16 ○ Action plan to be developed in a paper for review by the W&C Divisional Management Team ○ Produce a business case to support recruitment of additional nurses to achieve BAPM standards (note - this is still under review by NHS England) ○ Monitor progress through directorate and divisional Quality and Safety Committees and Management Committees ○ Any increase staffing required will be addressed under S5.1 **Director Lead** Janice Sigsworth, Director of Nursing **Divisional Leads** Jacqueline Dunkley-Bent, Divisional Director of Nursing, W&C Natalie Dowey, HR Business Partner, W&C	Feb 2015	neonatal services concludes on 29 Jan • Progress is the same as set out in 5.1

S6 Must do: <u>In Surgery at St. Mary's Hospital</u>, the number of cases submitted to the audit programme for the WHO surgical safety checklist must be increased, in order to increase compliance with the 'Five steps to safer surgery'. *See page 46 in the SMH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

6.1 The low number of cases using the checklist means there is false assurance about the safety of surgical procedures.	Review the policy to clarify roles and responsibilities for the use and completion of the checklist
	
	Director Lead
	Chris Harrison, Medical Director
	
	• Launch communication programme on '5 steps to safer surgery'
	• Consolidate the practice of team brief prior to commencement of surgery
	• Introduce new moodle module for maternity which includes overall WHO checklist procedures
	• Review, streamline and centralize process for auditing use of WHO checklist and create and annual programme
	  ○ Informed by NHS England Task Force report (Feb 2014)
	• Audit compliance and report by division in the monthly quality report, for review at the Executive Committee and Quality Committee
	  ○ Results to also be available by individual surgeons / anaesthetists
	
	Director Lead
	Chris Harrison, Medical Director
	
	Divisional Leads
	Jamil Mayet, Divisional Director, SCCS
	Kikkeri Naresh, Divisional Director, ISCSS
		Policy to be reviewed by June 2015
		
		The comms prog will be launched Mar 2015
		
		The team brief will be re-introduced June 2015
		
		The new audits will commence June 2015
			• The WHO checklist is one of the Trust's objectives in its proposal for *Sign up to Safety*. A related paper which sets out next steps is being prepared for presentation at the Executive Committee and Quality Committee in Jan / Feb.
			• Roles and responsibilities have been added directly to the checklist for reference when it is being used
			• Working Group set up with representation from surgery, theatres and anaesthetists to address problems and support improvements
			  ○ Next meeting will be focused on setting a minimum number of cases to be audited monthly

6.2 The leadership team had not taken effective	Incorporate audit outcomes into annual PDRs	Audits will	Processes are now in place for

action to manage the associated risks	regarding compliance for individual surgeons and anaesthetists **Director Lead** Chris Harrison, Medical Director **Divisional Leads** Jamil Mayet, Divisional Director, SCCS Kikkeri Naresh, Divisional Director, ISCSS	start as above – will be incorporated into annual PDRs beginning 2015 / 16	addressing individual non-compliance at the time a checklist is identified as not fully completed.

S7 Must do: The level of anaesthetic consultant support / on-call availability in **Maternity at St. Mary's Hospital** must be in line with national recommended practice. *See page 70 in the SMH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
7.1 Anaesthetic consultant support or on-call availability was not in place 24 hours a day, which is not in line with national recommended practice.	• Review the level of anaesthetic consultant support on call and address gaps in cover • Put anaesthetists with obstetrics experience in place out of hours / on-call **Director Lead** Steve McManus, COO **Divisional Leads** Jamil Mayet, Divisional Director, SCCS Tg Teoh, Divisional Director, W&C	June 2015	• Lindo wing anaesthetists with obstetrics experience currently provide support if necessary (this is not a formal arrangement) • Meeting arrangements with the Division of Surgery are underway

S8 Must do: On **medical wards and across Outpatients services at St. Mary's Hospital**, arrangements for medicines storage must be reviewed and medicine management protocols must be adhered to. *See pages 31 and 110 in the SMH report.*

Director Lead
Janice Sigsworth, Director of Nursing

Senior Management Lead
Ann Mounsey, Chief Pharmacist

OVERALL ACTIONS BEING TAKEN	DUE	PROGRESS
8.1 Review policies and regulatory requirements relating to medicines management through the Trust's Medicine Optimisation Committee	COMPLETE	
8.2 Audit programme for medicines storage in Medicine and outpatients departments at SMH to be established by the Pharmacy team • Deliver education and training for staff to adhere to policies. To be delivered by: o Divisional Directors of Nursing for Medicine and ISCSS o Presentations at Back to the Floor Fridays (e.g. on the agenda every six months) o In response to audit outcomes • Report audit outcomes and subsequent improvement plans to the Medicines Optimisation Committee at their quarterly meetings	To begin Apr 2015	
8.3 TDA Pharmacist to review our plans with the Chief Pharmacist and confirm they are satisfactory	Mar 2015	

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
8.4 Medicines are not always stored securely (not locked, in outpatients and both on the ward and for patients' own) *Pages 31 and 110*	This will be addressed under S8.2		
8.5 Medicines are not always stored correctly (room too warm, fridge temperatures too warm / not monitored consistently on medical *Pages 31 and 110*	This will be addressed under S8.2		
8.6 There is limited evidence that ward managers took action in response to medication audits on	• Report audit outcomes and improvement plans at Divisional Quality and Safety Committees	This links to S8.2	

medical wards *Page 31*	where actions will be agreed • Audits and action plans will be overseen by the Medicines Optimisation Committee		
8.7 No staff spoken to on medical wards knew about the insulin passport *Page 31*	Review and re-launch insulin passport via the Trust's Diabetes Team **Divisional Leads** Sally Heywood, Divisional Director of Nursing, Medicine Francis Bowen, Chief of Service	Re-launch in April 2015	
8.8 Some staff spoken to on medical wards didn't know how to support self-medicating patients *Page 31*	• Review policy to ensure it is fit for purpose, including consultation with DDNs • Review and re-launch self-medication policy, to align with education to staff by DDNs	June 2015	
8.9 No staff spoken to in outpatients at SMH knew about the Trust policy on safe medicine storage *Page 110*	This will be addressed under S8.2		

S9 Must do: There must be adequate isolation facilities on **medical wards at St. Mary's Hospital** to minimize the risk of cross-contamination. *See pages 30 and 39 of the SMH report* This links to S11 and E2.			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
9.1 There were insufficient isolation facilities on medical wards which meant that on some occasions, patients with HCAIs were unable to be isolated. *Page30*	Review the Trust policy to ensure it is fit for purpose **Director Lead** Alison Holmes, Director of Infection Prevention and Control	COMPLETE	• Additional single rooms are already flagged to be part of any future site development or buildings (part of our current 3-5 year clinical strategy) – supported at Quality Summit • Patients are assessed and isolated in accordance with current Trust policy • Site team / infection control teams review isolation needs on a daily basis and provide reports to divisions, including delays to isolation • Cross infections are reported and reviewed monthly at the Medicine Infection Prevention and Control Committee • Risks are escalated to divisional Infection Prevention and Control Committee and the Medical Director
9.2 The lack of isolation facilities is on the trust risk register but there was no clear indication of what was being done to address the problem. *Page 39*	This will be addressed by S9.1		A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.

S10 Must do: Consultant cover in **Critical care at St. Mary's Hospital** must be sufficient, including that staff are supported where there are vacancies. *See page 61 of the SMH report.* This links to S3.			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
10.1 Critical care committee to review the provision of level two care at St Mary's This will be addressed under S3.1			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
10.2 Level 2 patients were seen by junior doctors only	This will be addressed under S3.2		
10.3 Medical staff covering the HDU were not always airway trained, which meant they relied on the outreach team or ICU staff.	This will be addressed under S3.7		

S11 Must do: The environment of the **Grand Union ward at St. Mary's Hospital** must be reviewed to ensure it is fit for purpose. *See page 82 in the SMH report.* This links to S9.			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
11.1 Cubicles could become cramped with staff and equipment in emergencies.	Review foot print to assess opportunity to improve current space utilisation **Director Lead** Chris O'Boyle, Director of Estates and Facilities	Jan 2015	A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.
11.2 Some immune-compromised patients were placed at risk due to the lack of en-suite facilities.	Review of Grand Union ward to address en suite facilities and keep risk register updated accordingly • Develop business plan to refurbish the area to ensure compliance with NHS England standards for neutropaenic patients **Director Lead** Steve McManus, COO **Divisional Lead** Tg Teoh, Divisional Director, W&C	Risk register has been updated Business plan will be developed for 2016 / 17	Estates actions are underway to review water piping and water testing • New showerheads installed and 3 x daily pipes flushes done to improve water flow and reduce the risk of *Pseudomonas sp.* • Water quality is monitored monthly If these interventions are unsuccessful, further works will be identified.
11.3 The negative air pressure system was faulty and had been temporarily replaced with portable HEPA filter machines. Repair of the negative air pressure system had been awaited for a month at the time of the inspection.	Repair the negative air pressure system **Director Lead** Chris O'Boyle, Director of Estates and Facilities	COMPLETE	Portable HEPA filter machines have been removed from the ward

S12 Warning Notice: Standards of cleanliness of premises and equipment, and infection control practices, in the **A&E department at St. Mary's Hospital** must be improved. *The warning notice and its related findings were set out in the original SMH report published 16 December 2014. Following re-inspection of the A&E on 25 November, an updated report was published on 7 January 2015 - see pages 16 to 18.* The CQC served a Warning Notice to the Trust on 19 September, with deadline for compliance of 17 October. This links to S1.		
OVERALL ACTIONS BEING TAKEN	**DUE**	**PROGRESS**
An action plan in response to the Warning Notice was overseen by the Executive Committee and is now complete. In addition to this plan: • Sodexo User Group to be set up • PLACE Steering Group to be established • Sodexo to carry out cleaning audits and issue monthly cleaning reports at ward level as part of their contract **Director Lead** Chris O'Boyle, Director of Estates and Facilities	June 2015	

EFFECTIVE			
E1 Must do: Staff in **Medicine and Surgery services at St. Mary's Hospital** must be up to date with mandatory training. *See pages 32, 43 and 46 in the SMH report.* **Director Lead** Jayne Mee, Director of People and Organisational Development			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
1.1 Measure and report only the core skills framework mandatory modules		COMPLETE	10 core modules identified (nationally recognized and in line with other trusts)
1.2 Implement Wired2 IT enhancement and evaluate effectiveness		Implementation Feb 2015 Evaluation July 2015	Implementation is on track
1.3 Compliance to be reviewed at divisional performance meetings • To be presented at the Executive Committee by exception for actions to agreed		From Mar 2015	Follows implementation of WIRED2
1.4 Target for compliance of 90%		June 2015	Initial campaign to target areas mentioned in the inspection reports to be completed by March 2015
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
1.5 Nurses and doctors in Medicine had low compliance *Page 32*	This will be addressed under E1.2	Mar 2015	
1.6 In Surgery, little evidence of training of senior managers in investigating incidents and complaints, or in having difficult conversations *Page 43*	SCCS to undertake review and make recommendations **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	Mar 2015	
1.7 In surgery, worse than average compliance among consultants but not being addressed *Page 46*	This will be addressed under E1.2	Mar 2015	

E2 Must do: The **paediatric intensive care environment at St. Mary's Hospital** must be reviewed to ensure it meets national standards. *See page 82 in the SMH*

report.			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
2.1 The environment was not compliant with the Paediatric Intensive Care Society recommendations on configuration and size	Complete works in accordance with the approved business case (see progress column) **Director Lead** Steve McManus, COO **Divisional Lead** Tg Teoh, Divisional Director, W&C	Two year build programme from autumn 2015 (Sept 2017)	• Refurbishment was carried out in 2013 to maximise the infection prevention and control that can be achieved in the current environment • The environment has been reviewed and a business case for re-development was approved by the Trust board in October 2014 • Application to the TDA for this spend was submitted Jan 2015
2.2 Bed spaces are 50% less than current Paediatric Intensive Care Society standards	This will be addressed under E2.1		Clinical risk issues are escalated to the divisional management team
2.3 Patients were not protected from cross-contamination due to the cramped space and only one designated isolation cubicle	This will be addressed under S9 and E2.1		• Cross infections are reported and reviewed monthly at the W&C Infection Prevention and Control Committee • Site team / infection control teams review isolation needs on a daily basis and provide reports to divisions, including delays to isolation • A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.

RESPONSIVE		
R1 Compliance action: <u>In Outpatients services across the Trust</u>, problems associated with the administration of appointments which were leading to unnecessary delays must be addressed. *Page numbers for each report are below.* Links to R3.		
OVERALL ACTIONS BEING TAKEN	**DUE**	**PROGRESS**

1.1 To consolidate OPD redesign and improvement programme, which will be set out in a project plan and accelerate its implementation. To include:
 	
Review management accountability of outpatient facilities to provide consistent leadership
Roll out centralized booking, scheduling and call Centre functions to streamline effectiveness of admin support to OPD
 	
Phase 1
• Expand technology support to OPD to improve check-in and booking function locally
• Appoint lead clinician (Chief of Service)
• Review nursing leadership
• Create dashboard and performance trajectories against plan
• Divisional General Managers oversee related action plans
 	
Phase 2
• Implement patients services centre project
• Outpatient and divisional scorecards will be generated, with exception-based reporting at the Executive Committee and Trust board
• Further external review will be commissioned to support implementation of the programme (agreed at Quality Summit)
  ○ CCGs and Healthwatch to help co-design outpatients and help obtain patient input (agreed at Quality Summit)
• Single point of access to be established for Outpatients
  ○ GP utilization of Choose and Book to be increased
  ○ Patient Service Centre to centralize telephone access (one number for all Outpatient services) with 8am-8pm opening hours
  ○ Options appraisal to be reviewed at Exco in March 2015
  ○ Full case to Trust board June 2015
  ○ Internal audit to undertake a review of CQC compliance and our plans for OPD in Sept 2015
	Feb 2015
	
	April 2015
	
	June 2015
		• The business case related to this programme will be signed off by the Trust Board in May 2015
		• A Darzi fellow has been appointed who will review the booking system
		• **QS** TDA to 'broker' a tri-partite approach to share learning and, potentially, initiatives

Director Lead: Steve McManus, COO			
Director Lead Steve McManus, COO **Divisional Lead** Kikkeri Naresh, Divisional Director, ISCSS		Feb 2015	
1.3 CQC to identify good practice in outpatients in other NHS trusts (agreed at Quality Summit) **Director Lead** Janice Sigsworth, Director of Nursing		COMPLETE	Met with Sue Walker and made request in writing 8 Jan
SPECIFIC FINDINGS **Director Lead for all specific findings below** Steve McManus	**ACTIONS**	**DUE**	**PROGRESS**
1.4 Performance in outpatient services was not monitored *See pages 113 to 116 in the SMH report, 68 to 71 in the CXH report, 68 to 70 in the HH report*	• Introduce a single OP improvement forum under executive leadership to drive and monitor all OPD improvement actions • Set/agree a single policy for clinical attendance and scheduled OP clinics to ensure timely service via consistent availability of clinical staff • Create and maintain divisional performance dashboards with improvement trajectories and report progress to the Executive Committee • Every clinic will have a named senior leader with responsibility for overseeing performance • KPIs will be developed for outpatients and incorporated into the Trust scorecard	Feb 2015 April 2015 June 2015 April 2015 April 2015	A Planned Care Board is co-chaired by a Trust consultant and an external GP, and is attended by GPs from Trust CCGs ○ Meets monthly to discuss outpatient pathway performance
1.5 Capacity has not been increased to meet increased demands, either in the number of clinics or the number of medical staff. Patients are waiting longer to be given an initial appointment.	A capacity and demand review is included in the 2015 / 16 business plan, including a review of the delivery of access targets against national standards	This will be addressed as part of 1.1	We currently meet or exceed national targets for access, but Cerner has caused reporting problems due to issue with data integrity in the system

See pages 108 and 111 to 114 in the SMH report, pages 67 and 69 in the CXH report, pages 66 and 67 in the HH report	• Continue Wait list monitoring by the Operational Performance team and divisional General Managers		
1.6 Trust targets for sending appointment letters to patients must be met. Some patients did not receive their letters or received them after their appointment had been scheduled to take place. *See pages 113 / 114 in the SMH report, page 69 in the CXH report, page 68 in the HH report*	Working group established for on-going monitoring and will be built in to the outpatient scorecard	This will be addressed as part of 1.1	
1.7 Trust targets for sending discharge summaries to GPs must be met. *See page 112 in the SMH report, page 67 in the CXH report, 67 and 68 in the HH report*	• Monitoring will be built in to the outpatient scorecard • Deliver improvements through CQUIN targets and metrics (new CQUIN for 2015)	This will be addressed as part of 1.1	
1.8 There is no process for ensuring appropriate clinical coverage for clinics. As a result, there could be long waits once patients arrived for clinics and clinics routinely overrun. *See pages 111 and 113 / 114 in the SMH report, pages 67 and 69 in the CXH report, pages 66 to 68 in the HH report*	This will be addressed as part of 1.1		
1.9 Doctors consistently turn up late for clinics with no warning or explanation *See pages 114 / 115 in the SMH report, page 68 in the CXH report, page 67 in the HH report*	This will be addressed as part of 1.1		
1.10 Clinics are cancelled at short notice and the reason(s) is not always given *See page 69 in the CXH report, page 67 in the HH report*	• Reduce clinic cancellations to less than 7% ○ Improve compliance with the Trust's current target for clinic cancellation (at least six weeks in advance) – Develop an SOP outlining expectations and	June 2015	

	processes ISCSS Medical Director to ensure team working to improve coverage of clinics when a doctor will be away		
1.11 Appointment cancellation rates are higher than the national average *See page 114 in the SMH report, page 69 and 70 in the CXH report, page 68 in the HH report*	This will be addressed as part of 1.1		A Darzi fellow has been appointed who will review urgent appointment access

R2 Compliance action: The significant delays for patients awaiting **elective surgery at Hammersmith Hospital** must be reduced (note that this does not apply to day surgery). *See pages 32, 51 and 52 of the HH report.*			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
2.1 CQC to identify good practice in the assessment and management of surgical wait lists, and in monitoring the clinical impact of surgical delays (agreed at Quality Summit) **Director Lead** Janice Sigsworth, Director of Nursing		COMPLETE	Met with Sue Walker and made request in writing 8 Jan
2.2 Audit of patient records to determine the impact of surgical delays on clinical outcomes to be incorporated into the Trust clinical effectiveness programme (this will be adopted from the same audit programme already in place for cancer care) **Director Leads** Steve McManus, COO Chris Harrison, Medical Director		To begin Apr 2015	
SPECIFIC FINDINGS **Director Lead for all specific findings below** Steve McManus, COO	**ACTIONS**	**DUE**	**PROGRESS**

2.3 Referral to treatment was often not being met
 	
Pages 51 and 52
	• RTT targets were being met with the exception of a few treatment functions, prior to the introduction of Cerner
	• Cerner is affecting data integrity
	  ○ An IT team has been established to address this
	  ○ Data quality KPIs have been established and are assessed weekly in the Operational Resilience Report which is presented at the Executive Committee
		May 2015	• An RTT remedial action plan is already in place for the three / four areas which have not consistently met RTT targets
			  ○ NHS England has now set new targets and we expect to be meeting these by the end of the activity year
			• This will also be addressed within the demand and capacity assessment (S2.3)
			• The Cerner plan started six months ago and the current phase is due to conclude in Jan 2015. We will then move on to the next phase of

			'business as usual' Cerner implementation.
2.5 Cancellation of surgical procedures is higher than national average. This is linked to problems with pre-operative assessments. *Page 32*	• Establish Elective Access Waiting Group • Ensure sign-off of all cancellations • • Develop pre-operative assessment improvement plan that ensures consistency and best practice for pre-op care.	May 2015	• An Elective Access Waiting Group has been established and meets weekly to ensure re-booking takes place within 28 days • The Site Operations team signs off cancellations (started six months ago) to coordinate bed availability • A Darzi fellow has been appointed who will focus on surgical pathways, including pre-operative assessments • This will also be addressed within the demand and capacity assessment (S2.3)

R3 Must do: Systems and processes must be implemented to reduce the rate of patients who do not attend **outpatient appointments and surgical procedures at St. Mary's Hospital.** *See pages 53 and 114 of the SMH report.*

Director Lead
Steve McManus, COO

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS

3.1 In outpatients, the reason(s) for this is unknown due to lack of performance monitoring
 	
See page 114 of the SMH report
	• Implement 8am-8pm opening hours for outpatient call centre and admissions office to improve patient access
	• Implement text reminders and increase Choose and Book utilization by GPs
	• DNA rates to be monitored and reviewed monthly
	  ○ Oversight by new Chief of Service with exception reporting at the Executive Committee
	  ○ North West London sector dashboard, on which action plans are created
	  ○ Performance Contracting Executive (commissioner-chaired)
		This will be addressed under 1.1	

3.2 In surgery, this was linked to problems with pre-operative assessments *See page 53 of the SMH report*	This will be addressed in part under R3.1. Additionally, a pilot for preoperative same day 'see and assess model' has been introduced to reduce rate of cancellations / DNAs on the day.	This will be addressed under 1.1	

R4 Must do: The capacity of the **maternity and neonatal units at QCCH** must be reviewed to ensure they meet service demands. *See pages 11 / 12 and 29 in the QCCH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
4.1 Lack of sufficient nursing staff numbers has led to reduction in number of available beds, resulting in patients being refused.	This will be addressed under S5		

WELL-LED			
W1 Must do: Divisional risk registers for **Services for children and young people at St. Mary's Hospital, and Maternity and Neonatal services at QCCH**, must be reviewed to ensure risks are resolved in a timely manner. *Page numbers in each report are below.* **Director Lead** Steve McManus, COO			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
SMH **1.1** Seven risks had been on the risk register for five years. **1.2** Lack of inpatient facilities for adolescents had been on the risk register since 2009. *See page of 85 and 93-95 of the SMH report*	• A standardized approach to managing the risk register will be developed, including a review of the risk management policy • Divisional governance lead and risk manager to review risk register to ensure it is up to date and accurate • Board representation of the service to be established	April 2015	• Divisional review of risk register completed December 2014 • The risk manager will attend an upcoming W&C divisional quality and safety meeting to discuss risk management
QCCH **1.3** The failure to meet BAPM recommendations for staffing establishments had been on the risk register since 2011. **1.4** Inability to meet NICE guideline 137: Epilepsy due to the lack of a neuropsychologist had been on the risk register since 2006. *See pages 24, 29 and 30 of the QCCH report*	This will be addressed in part under S5. Additionally: • A new SLA with CNWL will include neuro-psychology support and epilepsy management. • A dedicated clinical risk and audit nurse will support NICU during Q1 of 2015 / 16 and focus on risk management • Divisional governance lead and risk manager to review risk register to ensure it is up to date and accurate • Board representation of the service to be established	June 2015	• Divisional review of risk register completed December 2014 • NICU risk register to go to the next W&C performance review (Feb) for executive oversight • The risk manager will attend an upcoming W&C divisional quality and safety meeting to discuss risk management
Actions that SHOULD be taken			

SAFE			
A: <u>On the Grand Union Ward at SMH</u>, the Trust should ensure that staff adhere to the Trust's policies and procedures for the double-checking process for medication. *See page 83 of the SMH report.* **Director Lead** Janice Sigsworth, Director of Nursing			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
The service operated 'double check' processes whereby two nurses independently checked medication to ensure it had been prescribed, prepared and administered correctly. However, the approach to double checking was informal and did not provide assurance that the double-check process was suitably robust to safeguard children.	• Head of Nursing for Paediatrics will review the double checking process (which is for oral medication only) and amend as appropriate • Staff will be educated about the updated process • Audit compliance and ensure actions are put in place to address non compliance	June 2015	Head of Nursing for pediatrics tasked with leading this review and changes in practice. Deputy Chief Nurse to provide professional advice and support on evidenced based practice in this area.

B: The availability of case notes / medical records in **<u>Outpatient services at St. Mary's Hospital</u>** should be monitored and action taken in a timely manner where necessary *See page numbers below* **Director Lead** Steve McManus, COO **Divisional Lead** Naresh Kikkeri, Divisional Director, ISCSS			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
This cannot be located in the SMH report, but it appears in the CXH and HH reports *See page 66 in the CXH report and page 65 of the HH report*	This will be addressed in part within the Cerner plan (R2.3). Additionally, case note availability audits are regularly carried out by the health records team with support from the Medical Director's office. Improvement plans will be developed as a result of audit findings and reported through to Executive Committee via the OP performance dashboard	COMPLETE	

C: A standardized approach to mortality review in **Medicine and Surgery at St. Mary's Hospital** should be developed, including reporting to divisional boards and the executive committee. *See pages 29, 35 and 43 in the SMH report*

Director Lead
Chris Harrison, Medical director

Divisional Leads
Tim Orchard, Divisional Director, Medicine
Jamil Mayet, Divisional Director, SCCS

FINDINGS	ACTIONS	DUE	PROGRESS

• In Medicine, divisional mortality and morbidity meetings took place at specialty level and issues or concerns were reported through the directorate committee meetings. There was no standardised approach to mortality reviews or standard written records from those meetings. *Pages 29 and 35*
 	
• In Surgery, mortality and morbidity meetings were varied in quality and frequency. Meetings took place at a specialty level, with reporting to the quality and safety committee by exception. Actions and lessons arose from these meetings but no action plans produced. *Page 43*
	• Develop terms of reference for formal mortality reviews and review SOP
	• Develop standardized methods for collecting mortality and morbidity data across the Trust
	  ○ To be approved at the Executive Committee
	  ○ To be audited for effectiveness
	• Establish standardised approaches for
	  ○ Reporting mortality and morbidity data and analyses
	  ○ Monitoring action plans which result
	• Establish a process for disseminating information and sharing lessons learnt from mortality and morbidity reports
	• Implement a process for recording mortality and morbidity discussions in patient notes
		Sept 2015	• Darzi fellow currently in place who is leading the review of morbidity and mortality meetings
			• Support has been offered by London NTDA to review our morbidity and mortality plan

D: The current matrix for statutory and mandatory training in **Surgery and Services for children and young people at St. Mary's Hospital, and in Neonatal services at QCCH,** should be reviewed in order to improve the recording system, to ensure that local (ward) and Trust-wide records are consistent

FINDING	ACTIONS	DUE	PROGRESS
	This will be addressed under Must-do E1		

E: Ensure the WHO checklist is embedded in practice in **Surgery at Charing Cross Hospital**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do S6		

F: How staff in **Neonatal services at QCCH** can learn from minor incidents and near misses should be explored in order to avoid similar incidents occurring. *See pages 21 and 30 in the QCCH report*

Director Lead
Chris Harrison, Medical Director

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
	• Will be covered within the 2015 / 16 Quality Strategy • A dedicated clinical risk and audit nurse will support NICU during Q1 of 2015 / 16 and will focus on ways to share learning	June 2015	Reviews of low level incidents and near misses are currently undertaken • Discussed at local risk meetings • Actions arising are discussed at directorate Quality and Safety meetings, and by exception to the divisional Q&S Committee • Reported in monthly newsletters (Children's Indicator and maternity's Risky Business)

G: Ensure that patient records **across the Trust** are always appropriately completed. *See page numbers below.*

Director Lead
Chris Harrison, Medical Director

FINDINGS	ACTIONS	DUE	PROGRESS
• DNACPR forms were not consistently completed *See page100 in the SMH report,55 and 57 /58 in the CXH report, page 54 of the HH report* • On the Christopher Booth ward, monitoring forms such as stool and fluid charts were not completed for one patient and NEWS charts were not completed for another. Additionally, risk assessments were not fully completed for a number of patients. *See pages 14 / 15 and 15 of the HH report*	• Review Trust-wide record keeping policy and standard ○ Trust-wide documentation assurance audit programme to be commenced as part of the overall audit and improvement programme • Disseminate expectations of good clinical record keeping • Commence regular DNACPR audits • Develop improvement plans for areas of non-compliance with the standard	Policy to be reviewed by June 2015 and related comms to follow Audit programme begins Q1 2015	

H: Ensure learning from investigations of patient falls and pressure ulcers is proactively shared **Trust-wide.** *See page numbers below.*

Director Lead
Janice Sigsworth, Director of Nursing

FINDING	ACTIONS	DUE	PROGRESS
See page 43 of the SMH report, pages 21 and 31 of the CXH report and page 25 of the HH report	Review mechanism for learning and sharing across ICHT via the nursing patient safety and improvement committee	May 2015	

I: Ensure cleaning of equipment is always carried out **in <u>Critical care at Hammersmith Hospital</u>**

Director Lead
Ian Garlington, Director of Strategy

Divisional Lead
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
	This links to Must-do S1 and S12	COMPLETE	Revised cleaning and decontamination schedule formally launched across the Trust in December 2014

EFFECTIVE

J: Ensure that there is a single source of up to date guidelines in the **<u>A&E department at St. Mary's Hospital</u>**. *See page 21 of the SMH report.*

Director Lead
Chris Harrison, Medical Director

FINDING	ACTIONS	DUE	PROGRESS
Trust policies were based on up-to-date guidelines available on 'The Source'. However, the A&E department had some systems of its own outside this system. Trainee doctors used a USB storage drive containing separate guidelines written by A&E seniors; those guidelines on the USB storage drive were different to those on the intranet and some were out of date. An audit of USB drive use did not include use of the guidelines accessible from this drive. A third set of guidelines was located in the A&E manual. Paper printouts were found filed in the handover room. We noted that there was often more than one protocol for a given condition and guidelines contained different referral routes. This presented a risk that patients might receive treatment which did not reflect current best practice.	• Collate guidance into a single comprehensive document which contains the most up to date information • Ensure out of date guidelines are removed from all Trust documentation, including the Intranet and hard copies held by staff	Sept 2015	Clinical guideline and policy review across the Trust is one of the Trust's objectives in its proposal for *Sign up to Safety*.

K: Patients who undergo non-urgent emergency **surgery at St. Mary's and Charing Cross hospitals** should not be left without food or fluids for excessively long periods. *See page numbers below*

Director Lead
Janice Sigsworth, Director of Nursing

Divisional Lead
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
See page 49 of the SMH report and page 37 of the CXH report.	• Review 'nil by mouth' policy • Provide education and training for staff about policy requirements • Audit practice and develop improvement plans against audit results	June 2015	

L: Patient readmission and length of stay rates in **A&E, Medicine, Surgery and Critical care at St. Mary's Hospital** should be reviewed in order to identify issues which may lead to worse than average results. *See pages 21, 39, 50, 52 and 64 of the SMH report.*

Director Lead
Steve McManus, COO

Divisional Leads
Claire Braithewaite, Divisional Director of Operations, Medicine
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
	Develop a standardized, structured process for review of data at divisional performance reviews which ensures action is taken where needed	To begin by June 2015	Appropriate data is already provided at Trust and division level

CARING			
M: The handover area for ambulances in the **A&E department at St. Mary's Hospital** should be improved in order to preserve patient dignity and confidentiality. *See page 23 of the SMH report.* **Director Lead** Steve McManus, COO **Divisional Lead** Tim Orchard, Divisional Director, Medicine			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	• The UCC is relocating and will be operational mid-February 2015, which will release some space • Review the process for patient movement based on the additional space to determine whether using alternate route into A&E will address this	June 2015	• A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee

RESPONSIVE			
N: Improve links with primary care to keep people out of the **A&E department at St. Mary's Hospital.** *See page 24 of the SMH report*. **Director Lead** Steve McManus, COO **Divisional Lead** Claire Braithewaite, Divisional Director of Operations, Medicine			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
• Different responsiveness of the five boroughs the Trust works with • Lack of clinical engagement with CCGs • Arrangements not yet in place with GPs for frequent A&E attenders	• Six week programme is underway (Jan 2015) to review emergency pathways, including the interface with primary care • Adopt improvements to integrated care made available by the community independent service contract recently awarded to the Trust (this is in partnership with a number of GP confederations)	COMPLETE	• Review workstreams agreed early Jan 2015 • A System Resilience Group is in place with representatives from CCGs and primary care • An Urgent Care Board is in place which is co-chaired by a CCG and the Trust's Deputy Medical Director

	QS NHS England, CCGs and Heathwatch to work with the Trust to create a systematic approach to integrated care practice • To reduce admissions • To minimize delayed discharges		• We have an existing relationship with our ECIST for external support

O: Reduce the backlog of patients awaiting **elective surgery at Hammersmith Hospital**.			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R2		

P: Consider reviewing the current arrangements to ensure there is parity in **children's Outpatient services across Hammersmith Hospital**.			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed in part under Must-do R1. Additionally, a review of current space will assess capacity and condition of the estates and facilities.	June 2015	

Q: Improve flow from the **A&E at St. Mary's Hospital,** including analysis of re-attendance within seven days. *See page 22 of the SMH report.* **Director Lead** Steve McManus, COO **Divisional Lead** Claire Braithwaite, Divisional Director of Operations, Medicine			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	Six week programme is underway (Jan 2015) to review emergency pathways	Review to be completed by March 2015	Review workstreams agreed early Jan 2015

R: Clear the backlog of letters and reduce the waiting times for patients to have an initial appointment in **Gastroenterology at Hammersmith Hospital.** *See page of the 67 of the HH report*

Director Lead
Steve McManus, COO

FINDING	ACTIONS	DUE	PROGRESS
	Clear the backlog of letters	COMPLETE	

S: Monitor the clinical impact of **surgical delays at Hammersmith Hospital.** *See page 31 of the HH report.*

FINDINGS	ACTIONS	DUE	PROGRESS
• Patients who wait a long time for surgical procedures must be clinically managed. • There is no designated emergency theater at HH, which could lead to delays.	This will be addressed in part under Must-do R2		

T: Ensure **adolescent services and facilities at St. Mary's Hospital** meet patient needs. *See pages 92 and 93 of the SMH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
A lack of dedicated space for adolescents / young people in children's outpatients at SMH, limited inpatient facilities for adolescents – no dedicated unit – had been on the risk register since 2009.	Review current space to assess capacity and condition of estates and update risk register	June 2015	• A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee • Links to current clinical and estates strategies

U: Ensure same sex accommodation is available on the **Witherow ward at St. Mary's Hospital**. *See page of the 38 SMH report.*

Director Lead
Steve McManus, COO

FINDING	ACTIONS	DUE	PROGRESS
	• Review EMSA policy • Assess layout and service delivery on the ward	COMPLETE	

V: Reduce number of out of hours transfers and discharges in **Medicine at Charing Cross and Hammersmith Hospitals**. *See page 27 of the CXH report and page 19 of the HH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Claire Braithewaite, Divisional Director of Operations, Medicine

FINDINGS	ACTIONS	DUE	PROGRESS
• CXH transfers are from gastroenterology and medical oncology • HH transfers are from cardiology, nephrology, gastro • CXH discharges are from endocrinology, gastroenterology and medical oncology • HH discharges are from cardiology, clinical haematology and nephrology	This will be addressed by the following: • Demand and capacity assessment (Must-do S2.3) • A review of emergency pathways is underway (Jan 2015)	May 2015	• Managed during daily Site Operations team meetings • Reported weekly at the Executive Committee via the Operational Resilience Report

W: Ensure that patients are not cared for in inappropriate areas overnight such as **recovery at Hammersmith Hospital**. *See page 31 of the HH report*

Director Lead
Steve McManus, COO

Divisional Lead
Kikkeri Naresh, Divisional Director, ISCSS

FINDING	ACTIONS	DUE	PROGRESS
	Identify related incidents and create action plan	COMPLETE	No incidents in past 12 months

X: Ensure parents and carers can be accommodated when children are being treated in the **PICU, NICU and Great Western ward at St. Mary's Hospital**.
See page 80 and 93 of the SMH report.

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
	Undertake a review of space for children's services at SMH as part of the clinical strategy in 2015 / 16, including a need for patient / carer accommodation • Continue to use local hotel accommodation (paid for by charity and NHS) in the interim.	Review to be completed by June 2015	• By the bed side accommodation for parents and carers is already provided on Great Western. • A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee

Y: Across the Trust, patient information (literature, menus) should be available in languages other than English. *See page numbers below.* **Director Lead** Michelle Dixon, Director of Communications			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
See page 36 of the SMH report and page 50 of the HH report	Complete current patient information stock-take and agree action plan (this includes access to information in languages other than English)	Action plan to be agreed by Feb 2015 Phase 1 to be delivered by Sept 2015	

Z: Increase capacity to meet demand in **Outpatient services at Charing Cross Hospital.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

AA: Ensure that targets for sending appointment letters to patients from **Outpatients services at Charing Cross Hospital are met.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

BB: Ensure that targets for sending discharge summaries to GPs from **Outpatients services at Charing Cross Hospital** are met.			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

CC: Increase capacity in **Surgery across the Trust** so patients admitted are seen promptly and receive the right level of care. *See page numbers in reports below.*			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

• Difficulty accessing an appropriate bed in SMH, CXH surgery – cared for in non-surgical wards *See page 53 of the SMH report and page 40 of the CXH report* • High cancellations in surgery in May 2014 and inability to accept patients from other hospitals for vascular surgery *See page 53 of the SMH report* • Lack of surgical beds CXH and HH – led to being cared for on non-surgical wards and long delays in recovery (delays in recovery were on the divisional and Trust risk registers) *See pages 39 and 40 of the CXH report and page 32 of the HH report*	This will be addressed under Must-do S2.3		

DD: Avoid cancelling **Outpatients clinics at Charing Cross Hospital** at short notice**.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

EE: Improve patient transport from **Outpatient services at Hammersmith Hospital** so the wait to go home is reduced.

Director Lead
Ian Garlington, Director of Strategy

FINDING	ACTIONS	DUE	PROGRESS
This is particularly an issue for vulnerable patients. *See pages 64, 67 and 69 of the HH report.*	Review patient transport policies and practice with particular reference to prioritizing vulnerable patients to ensure a more responsive service	Sept 2015	

FF: Improve the management of medicines on **medical wards at Hammersmith Hospital.**

FINDING	ACTIONS	DUE	PROGRESS
	This will be addressed under Must-do S8		

GG: Improve access to specialist pain treatment and support **at the Trust.** *See page 111 of the SMH report.*

FINDING	ACTIONS	DUE	PROGRESS
Patients could not always access the pain clinic when they needed it because only one clinic in the Trust (which is at CXH).	This will be addressed under Must-do R1		

HH: The operating times of the **David Harvey Unit at Hammersmith Hospital** should be reviewed to ensure the service is accessible (i.e. opening hours) to the population it serves. *See page 49 of the HH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
Staff estimate that the peak time of need is approximately 7 PM but the unit closes at 5 PM.	• Review paediatric pathways • Review the mandate for the unit and determine if it is being fulfilled • Assess paediatric UCC attendance rates between 5 and 9 PM	June 2015	

II: Ensure there is accurate performance information from the **Outpatients department at Hammersmith Hospital**.			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

WELL-LED			
JJ: Coherent governance arrangements are needed in **Outpatients services at Charing Cross and Hammersmith Hospitals** in order to manage performance and risk more effectively. *See page 71 of the CXH report, and pages 69 and 70 of the HH report*			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
Assign responsibility to effectively manage quality and risk in outpatients – it is currently dispersed among the other services (different leaders for each specialty or managed by an outpatient team).	This will be addressed under Must-do R1		

KK: Robust and fit for purpose risk management is needed in the **NICU at QCCH**.			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
See pages 24, 29 and 30 of the QCCH report	This will be addressed under Must-do W1		

LL: Services for children and young people and Neonatal services should be represented at Board level. *See page 96 of the SMH report and page 31 of the QCCH report.*			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do W1		

Health, Social Care and Social Inclusion Policy and Accountability Committee

Work Programme 2014/2015
22 July 2014
Imperial College Healthcare NHS Trust: Cancer Services Update Shaping a Healthier Future: Update on programme and decisions to date. Healthwatch: Presentation on its Role and Work Care Act: Update
7 October 2014
Hammersmith & Fulham Foodbank Imperial College Healthcare NHS Trust: (i) update following closure of Hammersmith Hospital Accident & Emergency Department (ii) update on outline business case for clinical services across the three main hospital sites, following Trust Board meeting Medium Term Financial Strategy (Update)
17 November 2014
Adult Social Care Information and Signposting Website – People First Call for Evidence: Engaging Home Care Service Users, their Families and Carers Independence, Personalisation and Prevention in Adult Social Care and Health Safeguarding Adults: Annual Report
3 December 2014
Healthwatch Adult Social Care Customer Feedback: Annual Report 2013/2014 Customer Journey: Improving Front-line Health & Social Care Services Meals on Wheels Under Fives Flu Vaccination Programme in Hammersmith & Fulham
20 January 2015
Imperial College Healthcare NHS Trust: Accident & Emergency Waiting Times 2105 Medium Term Financial Strategy Abolition of Charging for Home Care Services Overview of Public Health Services for the Three Boroughs Under Fives Flu Vaccination Programme in Hammersmith & Fulham
4 February 2015
Imperial College Healthcare NHS Trust: CQC Report and Action Plan Imperial College Healthcare NHS Trust: Accident & Emergency Performance

Shaping a Healthier Future: Update
March 2015: to be agreed
Care Act : Go Live implications Central London Community Healthcare NHS Trust: Five Year Strategy and Foundation Trust Status Update Individual Budget Changes/Self Directed Support/Personalisation Overview of Public Health Services for the Three Boroughs Transition from Children's to Adult Social Care
13 April 2015
Equality and Diversity Programmes and Support for Vulnerable Groups GP Networks and Enhanced Opening Hours H&F CCG: Performance Report Review of Learning Disabilities Day Services
2015/2016 Meetings
Customer Journey: Update Customer Satisfaction Digital Inclusion Strategy H&F Foodbank Imperial College Healthcare NHS Trust: Actions in response to the CQC report and the Francis Inquiry recommendations Integration of Healthcare, social care and public health Meals on Wheels: Future Arrangements Safeguarding Adults: H&F Report