Imperial College Healthcare 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) o 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 o Divisional action plans generated based on outcomes o 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 o the The QuEST programme board, which reports monthly at the Executive Committee o 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
	  o A performance trajectory with an end goal of 5% by December 2015
	  o 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
	  o Division of Medicine to present detailed action plan to reduce vacancy rate to 5%.
	  o Report and monitor to the performance management meeting monthly
	  o To align business planning with bed capacity and staffing requirements throughout the year
	  o Review staff establishment plans with COO and Divisional Director / Director of Nursing if changes are required
	  o 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
			  o 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 o Will be presented at the divisional performance review in February o 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 o External stakeholders across the Critical Care Network will be engaged in the redesign o Co-location of levels 2 and 3 beds (agreed at Quality Summit) o Reconfiguration of the service to increase capacity o 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
	  o Centralised team with 'offer on the day' to improve process efficiency and reduce withdrawals between interview and offer.
	  o 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
			  o 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 o Action plan to be developed in a paper for review by the W&C Divisional Management Team o Produce a business case to support recruitment of additional nurses to achieve BAPM standards (note - this is still under review by NHS England) o Monitor progress through directorate and divisional Quality and Safety Committees and Management Committees o 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
	  o 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
	  o 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
			  o 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) o 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 o GP utilization of Choose and Book to be increased o Patient Service Centre to centralize telephone access (one number for all Outpatient services) with 8am-8pm opening hours o Options appraisal to be reviewed at Exco in March 2015 o Full case to Trust board June 2015 o 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 o 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% o 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
	  o An IT team has been established to address this
	  o 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
			  o 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 o Oversight by new Chief of Service with exception reporting at the Executive Committee o North West London sector dashboard, on which action plans are created o 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 o To be approved at the Executive Committee o To be audited for effectiveness • Establish standardised approaches for o Reporting mortality and morbidity data and analyses o 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 **<u>across the Trust</u>** 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 o 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 **T<u>rust-wide</u>.** *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: <u>Across the Trust</u>, 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 **<u>Outpatient services at Charing Cross Hospital</u>.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

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

CC: Increase capacity in **<u>Surgery across the Trust</u>** 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 **<u>Outpatients clinics at Charing Cross Hospital</u>** 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		