LNWUH Composite Trust CQC Action Plan 21/01/2019

Overall Trust Rating	Safe	Effective	Caring	Responsive	Well Led
Requires Improvement (RI)	RI	RI	Good	RI	RI

Progress Ratings	Total	Complete	On Track	Delayed
'Must Do' requirements	39	23 (59%)	15 (36%)	1 (5%)

The Trust was inspected by the CQC in June 2018 and rated as "Requires Improvement". The Trust received 4 section 29a enforcement notices and 1 section 31 decision notice which was dealt with and removed by the CQC in July 2018. Immediate actions were taken to respond to the warning notices and a comprehensive action plan was put in place in August 2018.
This document reports progress for the Trust against the CQC Action Plan providing RAG ratings by each action, outstanding actions and expected completion date

Following actions are not progressing as expected and need plans:	
Following actions are progressing but need revised date as expected missed	1.01,3.01,8.01,11.01,

Must do	CQC Recommendation	Trust Actions	Remaining actions/Escalation	Expected completion Date and RAG Status
1	**Medical Care at Ealing hospital- Warning notice**			
1.01	• Assess the risks to the health of service users on medical wards.	Task and Finish Group chaired by the Chief Nurse or their deputy Established 18th July 2018, The Terms of Reference were agreed. Key work streams; • Safer Staffing, Documentation, Safe Medicine Management Documentation - Review the admission booklet with cross divisional representation - Commenced - **Update 10/09/18** - Feedback obtained - used to inform discussion in regard to re-organisation and content of booklet prior to a controlled trial.	needs plan and revised expected as expected completeion date 30/12/18 is likely to be missed	**31/12/18**
1.02	• Have staff following policies and procedures about managing medicines on medical wards.	1. Expiry Dates: Each trolley and medicine cupboard, IV fluid stores but excluding Controlled Drugs across the entire Trust was thoroughly checked and all expired, patients own and medicines dispensed to patients' who are no longer on the ward removed and returned to pharmacy for destruction **COMPLETED** 2. Follow up Actions following Audit: Review stock lists on those wards identified in the audit as requiring review. 3. Follow up Actions following Audit: Develop a feedback form for ward/department nurse manager regarding findings from stock expiry checks. 4. Ongoing actions following audit: Monthly stock checks to be undertaken 5. Task and Finish Group to oversee the audit results and improve systems to support monthly checks of expiry dates 6. Oral liquid Controlled Drug expiry dates audit undertaken 5 July 2018 across the entire Trust. Pharmacy Department have amended the Standard Operating Procedure so that the date of issue is taken to be the date opened and an expiry date assigned accordingly by the Pharmacy. This will mitigate the risk as nursing staff will have an in use expiry date assigned.**COMPLETED** 7. Follow up actions following the audit: CD Quarterly audits to include 2 questions on oral liquid CDs to provide assurance of compliance 8. Expiry dates of all Controlled Drugs including expiry date checks to be completed. All medical wards on the Ealing site to be completed on 5 July 2018 and the rest of the entire Trust to be completed by 17 July 2018.**COMPLETED** 9. Immediate Action 'Fridge Temperatures: Pharmacy Department to audit all areas Trust wide with refrigerators every week to monitor compliance with the following standard. " 100% of refrigerators in clinical areas storing medicines have been checked for any temperature excursions within the last 28 days and any remedial action has been taken if excursions have occurred". When the clinical area has 100% compliance on 4 consecutive weeks, the audit will revert to monthly. When the clinical area has 100% compliance on 3 consecutive months, this audit will cease for these areas. Ongoing compliance will then be audited within the Quarterly temperature monitoring audit. COMPLETED	Develop Business Case for level 2 Care in designated area (EH) (no6). Due date changed from 30/11/2018 to 01/03/2019	**Overdue 01/03/2019**
1.03	• Have the sufficient numbers of suitably qualified, competent skilled and experienced persons deployed within the medical wards	1. Established a weekly escalation meeting to ensure early escalation of uncovered medical shifts 2. Introducing a handover log on 12 July at the Professional Awareness Day 3. Nursing have a robust daily safety brief. The Bank attend the safety Huddle 4. Immediate Action: Completed a nursing establishment review for 4 South **COMPLETED** (03/07/2018) 5. Develop a standard operating procedure (SOP) to ensure staffing levels is enhanced to deliver 24 hour Level 2 care if and when required. 6. Medium Term Action: Develop a business case for the expansion of ITU to deliver Level 2 care at Ealing Hospital 7. Weekly recruitment meetings chaired by Heads of Nursing and supported by HR to continue until vacancy rate drops below 12%. Deliver incremental improvements through the recruitment and retention strategy. 8. Immediate action: Recruitment strategy developed which include the following; Launch a targeted advertising campaign including social networking. Rolling recruitment interview days are now established 3 times per week Launched an open day in August, September and October Establish rotational education and development pathways	Develop Business Case for level 2 Care in designated area (EH) (no6) Establish rotational education and development pathways	**31/03/19**
2	**Urgent and Emergency Care at Ealing hospital – Warning notice**			
2.01	• Ensure that in the accident and emergency (A&E) department at Ealing hospital	1. Paediatric checks completed weekly by Resus nurse. This includes all equipment and grab bag. 2. Simulation trainings done forth nightly with ED reg/ Consultant, Nursing staff, PDN.		**completed 30/07/18**
2.02	• Support the provision of safe care and treatment and must demonstrate that there	1. Email send to staff from pharmacy, with ongoing pharmacy support to address changes. (see attached). 2. Changes made have been discussed with nursing staff during daily communications.	3 month governance assurance to carried out February 2019	**completed 16/07/18**
3	**Maternity at Northwick Park Hospital – Warning Notice**			

3.01	• Ensure robust systems are in place to ensure that the correct staff are bleeped on an ongoing basis including a system of regular checks of the bleep system to ensure that the correct staff are bleeped at all times.	Bleep system has been re-programmed. The emergency bleep list has been reviewed by the Clinical Director and confirmed that correct staff groups are enlisted. this has been triangulated with Obstetric guidelines including that for shoulder dystocia. PROMPT training incorporates obstetric emergencies which includes summoning for assistance.		**completed 30/08/18**
		Switchboard undertakes daily bleep testing and records outcomes.Exception reports provided to Head of Unified Communications who feedbacks into maternity .	• Awaiting for assurance of real times escalation of non-responders before action can be closed	**30/08/18**
		Process and governance map produced and communicated across the Directorate		**completed 30/09/18**
		• Bleep testing procedure has been compared to other Trusts and has been found to be similar standards. Bleep testing exception reports remains a standing agenda item at local risk management meetings in maternity for a minimum of 6 months	• Awaiting for assurance of real times escalation of non-responders before action can be closed	**31/03/219**
		This item is shared with staff in the risk management monthly newsletter in order to raise staff awareness .		**completed 31/10/18**
3.02	• Ensure robust systems are in place to ensure unauthorised persons cannot gain access to theatres via use of the staff/ theatre lift.	12/07/18 Temporary doors were installed which block any public access from the lift. SOP in place and circulated among staff . NHSI and CCG visit confirmed that public access had been blocked.		01/10/18
		02/10/18 Temporary doors removed. Override key of public lifts are with coordinator in the event of staff lift failure and the need to use public lift. If this happens security guard sits outside theatres		30/09/18
		Monthly Risk newsletter is sent to all staff. Security guards are available 7pm-7am OOH in main access area. Active monitoring and data reviews systems are in place.		30/06/18
		Tailgaiting signs have been put up with active monitoring		30/06/18
3.03	• Ensure the doors to the delivery suite from theatres are by secure access only.	Staff ID Swipe access has been installed, weekly security reports are submitted to DGM for review		25/07/18
3.04	• Ensure the main doors to the maternity unit cannot be forced open at any time of the day or night.	Locking Bolts activated on the doors to restrict risk of forced opening . There is a Buzzer system in situ at maternity entrance with CCTV link into Delivery Suite reception and Trust Security Control centre. Out of hours delivery suite administrator manages buzzer system and access into the maternity unit, in hours there is a receptionist located at the maternity entrance . OOH security presence reinstated since 17/09/18.	• An options paper for the longer term security in maternity has been drafted for longer term security planning	30/06/18
		Replacement doors that cannot be forced open have been installed		31/10/18
		Security patrols are undertaken 4 times in each 24 hour period covering in hours and out of hours.		30/09/18
		security has designated slot at senior midwives and nurses meeting and is providing training	All staff to remain security aware. Assurance through CQ & R meeting	31/03/19
		Tailgaiting signs have been put up and remain in situ.NHSI and CCG visit confirmed visibility of tailgating notices		30/06/18
4	**Urgent and Emergency Care at Ealing hospital –Notice of Decision**			
4.01	• Stop treating children (individual aged under 16) in the Ealing Urgent and Emergency Department which is an emergency department for adults only except for clinically stabilising the child before transferring to an appropriate facility	Evidence to show the communication of the paediatric policy to all staff members are attached. Datix and the resulting shared learning are communicated to all staff in the Emergency Department as well as at the following meetings: (EPIG Meetings, Joint ED and UCC ops meeting, clinical governance, Performance Meeting) 2.11.18 - Updated Paediatric attendances audit attached.	Ongoing monitoring of paeds attendance and awaiting more current audits for resus and simulation 3 month governance assurance to carried out February 2019	**completed 20/07/18**
4.02	• Develop a clear policy on the management of children who present to or are brought to the Ealing Urgent and Emergency Department stating in clear terms the extent to which staff in the Urgent and Emergency Department stating can be involved in the management and care of children	The policy for ratification is embedded in evidence as well as the ongoing audit for paediatric patients to display ongoing shared learning of paediatric cases.	Ongoing monitoring, require more current data for paeds grab bag audit and checklist. 3 month Governance assurance to carried out February 2019	**completed 20/07/18**

4.03	• Place visible signs in the Ealing Urgent and Emergency Department informing members of the public that the department is not a paediatric emergency department.	1. Signage in place.		**completed 18/07/18**
4.04	• Following actions taken by the trust and the submission of an ongoing action plan, CQC notified the trust that it had discontinued the notice of decision subject to the improvements set out by the trust's actions and action plans being sustained.	notice discontinued	3 month governance assurance to carried out February 2019	**Notice Discontinued**
5	**Urgent and Emergency care- at Northwick Park Hospital Requirement notice**			
5.01	• Review the processes, implementation and recording of observations of mental health patients in the ED department.	Mental health processes within the Emergency Department reviewed Ensured that the documentation of observation is up to date in a timely manner, available on the patients records. (requires ongoing monitoring)	3 month governance assurance to carried out February 2019	**Completed 03/07/18**
5.02	• Ensure that there are effective systems in place for learning from incidents.	Monthly cross site Clinical Governance meetings in place ensuring shared learning across the Trust. Agenda includes learning from serious incidents, complaints and the risk register. Minutes of these meetings are available and provided for all staff to read in the clinical governance folder. (Please see evidence). Feedback is provided to clinical team, through the staff newsletter and Divisional board slides. Updates on SI's, complaints and the risk register are provided by the clinical governance team at the Divisional Board meeting. Top 3 risks are updated and displayed for staff in the Emergency Department. Complaints champion has been nominated within the nursing team to work with the Clinical Governance team. The champion will disseminate feedback and action plans from complaints to all members of the team. Appointment of a cross-site governance lead consultant has been undertaken Process in place-plan for monthly assurance report for three months until Feb 2019	Awaiting more current clinical governance assurance in the form of minutes and Newsletters 3 month governance assurance to carried out February 2019	**In Progress 28/02/2019**
6	**Critical Care at Northwick Park Hospital- Warning Notice**			
6.01	• Have beds appropriately located within critical care to perform emergency lifesaving care and treatment.	As per the warning notice the changes to the Level 5 Critical Care area has been completed. Two beds have been removed and the remaining furniture has been repositioned to deliver the required layout for optimal care and emergency management of patients.	ongoing monitoring	**Completed and closed 10.8.18**
6.02	• Have sufficient hand washing facilities to mitigate the risk of cross-contamination.	As per the warning notice changes have been made to ensure compliance with sufficient hand washing facility provision and this is now completed. There are now sufficient hand washing facilities within Edison level 5 Critical Care Unit. Two extra wash basins have been installed into the ITU area and two extra wash basins have been installed into the HDU area of Edison level 5 Critical Care Unit.		**Completed and closed 10.8.18**
7	**Children and Young People Services at Ealing hospital – Requirement Notice**			
7.01	• Improve compliance with mandatory training especially for medical staff.	Data on ELMS were cleansed, Improved monitoring and compliance systems have been put in place at divisional and Executive level. • Jan 2018 Over 85% of staff have had appraisals and are compliant with MAST (Appraisals at 91.7% and MAST at 87.1%)	ongoing monitoring	31/10/18
		Ensuring Medical staff are compliant - work with clinical leads and supervisors, introduction of iPDF for pre-commencement completion of on-line mandatory training		31/10/18
7.02	• Provide nursing staff with training in the recognition and management of children with sepsis.	All registered nursing staff working within acute in patients children's ward and day care at Ealing have been trained by the ward sister in the recognition and management of children with sepsis. Any new staff who join the department will have this training as part of staff induction by ward sister		30/09/18
7.03	• Provide nursing staff with clinical and safeguarding supervision.	Supervision framework and guideline have been developed A formalised supervision framework is embedded and cascaded across children's services		31/12/18
		The Gibbs Reflective Practice cycle is used for reflection/supervision with the nursing lead at Ealing . Clinical supervision is provided by Senior Nurse. Monthly report is produced to evidence clinical supervision.		31/03/19
7.04	• Ensure a protocol is easily accessible and available for staff to follow if a child or young person became unwell unit.	SOP has been revised and circulated.Paedetric anesthetic cover at Ealing Hospial is on risk register Risk 909.		30/09/18

7.05	• Have clear oversight of young people admitted to adult wards.	The Head of Nursing for paediatrics based at Ealing Hospital attends the daily bed meeting at Ealing site. She offers advice if there is a paediatric or safeguarding concerning A log is kept of all cases		30/09/18
7.06	• Improve staffing levels including staffing establishment on the children's outpatients and day care unit.	RCN guidance for staffing a low risk daycare is agreed by local arrangments. We see on average 3.5 patients per day, and to support that we have 2 RN's (band 6) plus HCA support. Senior support increased by allocating the paediatric day care sister (band 7) one day a week. This change is effective from the 10th September 2018. We also evidence staffing on our safer staffing tool which was recently amended to reflect activity. Daily reporting of staffing activity completed		30/09/18
7.07	• Ensure there are effective systems in place for sharing the learning from incidents	All SIs and datix are reported into quarterly Clinical governance meetings. Staff governance newsletter has been introduced and these incidences are shared with the staff through newsletter. The DHON holds meetings with nursing staff and those who cannot attend have emailed notes sent to them for information .		30/11/18
8	**Children and Young People Services at Northwick Park Hospital– Requirement Notice**			
8.01	• Ensure robust safeguarding systems and procedures are put in to place to ensure children are protected from harm and abuse.	Children Protection Information System(CPIS) implementation will be completed by 28/02/19. This allows transferring information to symphony (ED system) for safeguarding concerns on admission. This ensures CAS card is showing correct information on printing. Safeguarding checks are made by the paediatrician on clerking patient . Safeguarding named nurse attends the unit when there is a safeguarding issue and in her absence the Head of Safeguarding lead nurse provides required support.		28/02/19
8.02	• Ensure that nutrition and hydration assessments are routinely carried out and consistently reviewed.	Weekly audits are undertaken by ward sister, who reports to matron. This is reported to DHON at monthly meeting with an action plans if required.	further assurance and monitoring with support from nutrition and hydration working group	30/11/18
		Audit are undertaken monthly and reviewed by the DHON		30/11/18
9	**Surgery at Northwick Park Hospital – Requirement Notice**			
9.01	• Improve medicines management to include regular, documented checks of the temperature in storage areas including refrigerators.	Spot audit with Pharmacy was taken in real time after the Requirement Notice. We have increased surveillance from the Pharmacy Team to have more focus on this from the ward staff. The data-log from the fridges are in situ to help with this as well as helping where fridges are stored in areas that are higher ambient temperatures. The use of Omicell medication safety cabinet use is being explored - for areas that low air flow and high ambient temperatures as well as the use of high cost drug areas.	Ongoing spot checks and monitoring to continue. Outcome of Omnicell exploration to be established with the pharmacy team.	10/08/18
9.02	• Address the low levels of compliance with mandatory training amongst the medical team. We identified this as an area for the trust to improve in our last inspection in October 2015.	Correspondence to the relevant persons in the Division (along with the areas they are non-compliant in) has been sent (via email) from the DGM to indicate the absolute requirement in this regard and how failure to comply will affect both appraisal success and pay-progression and result in meetings with relevant operational or clinical supervisors 16.01.19 Discussion about MAST training and Junior doctors. IPDF roll out with an app is in progress. 31 Drs to join in feb and for this to be started with them. Allows sharing of past and current training from previous Trusts. Face to face training to be completed on first day of induction. On Risk Register	December 2018 update: appraisal compliance 87%, MAST 84.3% Ongoing monitoring	31/01/19
9.03	• Ensure sufficient nursing staff have up to date training in basic and immediate life support.	The main challenge here is the availability of these sessions - work has commenced with the RESUS team to look at setting up area specific training and maximising the utilisation of their time and resource as well as those who need to undertake this training	December 2018 update: Cleansing of BLS and ILS data as some staff were listed incorrectly for ILS Additional BLS sessions provided on site	31/01/19
9.04	• Implement a system to ensure all equipment is regularly inspected, safe and fit for purpose.	EBME are doing this - alerts sent and shared with colleagues to note the need to ensure that all new equipment is PAT inspected	To understand the process EBME have in place and to establish if this includes routine servicing and calibration. To gain assurances on what audits are being undertaken to monitor this. New equipment, regular serving and fault reporting.	10/08/18
10	**Surgery at Ealing Hospital – Requirement Notice**			
10.01	• Ensure patients are cared for in areas that are appropriate, meet all of their needs and have sufficient space to accommodate the potential number of people using the service at any one time.	The Trust has an escalation process which will when in escalation result in needing to allocate, against a known discharge, an additional patient to a ward (in line with locally agreed risk assessment) - this arriving patient is placed in the acute setting with the discharge planned patient moved to an appropriate area on the ward for their ongoing care and management (until discharge). The Ward teams have been reminded of the need to follow this Policy but challenge when concerned about the risk - bearing in mind the shared risk in ED where there may also be need to management and mitigation. Ward 3 North Day Care Unit is also used for escalation.	December 2018: Ward 3 North used for escalation regularly as instructed and authorised by the COO. Need to seek assurances from DHoN and HoN that individual risk assessments for each area have been completed.	10/08/18
10.02	• Ensure proper and safe management of medicines. This includes avoiding practices that compromise safe medicines management including the use of pre-prepared medication in theatres.	This issue has been discussed with staff and a reminder sent to colleagues to follow the agreed process for medicines management accordingly.	Ongoing spot checks. Spot audit and	10/08/18

10.03	• Ensure there are sufficient staffing levels on orthopaedic wards.	The orthopaedic ward vacancy has reduced from 47% to 24% which has allowed for consistent and competent staffing of these areas. The creation and appointment of a Practice Development Nurse has been implemented to help with development and training to assist with retention. Practice Development Nurse appointed to Ward 7 South Ealing and now in post. Trust recruitment campaigns: overseas, skype interviews, national recruitment events, on-going adverts on NHS jobs. 16.01.19 - The Division report that all staffing was reviewed in budget setting meeting on 16/01/19 with the finance team. High Turnover of nursing staff identified at Ealing Hospital with new starters moving to NPH when opportunities arise.	Ongoing Trust recruitment campaigns: overseas, skype interviews, national recruitment events, on-going adverts on NHS jobs. December 2018 update: Resources still being identified. Ward instructed to increase staffing at night by a Bank HCA when required to accommodate increased acuity due to patient mix of trauma and medicine Action was originally due for completion 30/11/18; however has been extended to 31/01/2019	31/01/19
10.04	• Work to improve access and flow within surgical services.	Review of OP clinic capacity and type. A weekly review of the RTT position is in place with oversight from the COO - actions for all SMs to work with the clinicians and look how to maximise lists and not waste operating time.	Seek assurances work is in progress. Review progress made on this.	31/03/19
10.05	• Work to improve mandatory training completion rates for medical staff.	Reminders provided by DGM and DCD. Link between appraisal, revalidation and statutory mandatory training established. 16.01.19 Discussion about MAST training and Junior doctors. IPDF roll out with an app is in progress. 31 Drs to join in feb and for this to be started with them. Allows sharing of past and current training from previous Trusts. Face to face training to be completed on first day of induction. On Risk Register	Divisional Data cleansed. Compliance is 82% at 06/11/18 (up from 75% 2 months ago). The main concerns are Junior Doctors – assistance requested from the Medical Director. Discussion to check the actions and courses attended at Induction Week are being recorded is being undertaken via audit with Learning & Development Appraisals have, in the same time, achieved 86% (compliant)	31/01/18
10.06	• Ensure staff on the Ealing site are engaged in planning and delivery of services.	Implementing fortnightly joint meetings with Clinical Leads for Ealing and NPH to discuss business matters. Establish monthly Ealing-business meeting. CQC Summit held in Ealing Hospital November. 16.01.19 Transformation team have appointed improvement fellows from within the staff to carry out specific improvement initiatives. Perioperative Matron to lead on Improvement pathway in day surgery and perioperative assessment.	November 2018 update: the CQC Summit was held in Ealing with all CCG and other Health Economy Stakeholders and as part of the ICU works they are very much involved to reflect the vision of this statement Update on continued engagement of staff required. Assurances of information cascade to all staff levels	31/01/18
10.07	• Improve theatre utilisation and efficiencies related to start and finish times.	Recruit additional scheduling staff. Review POA process to avoid OTD - this is part of a wider Transformation Work Stream looking at the whole pathway and focussing on the known pinch points to reduce the time scale but also improve quality in contact and delivery of services	November 2018 update: Dashboard in place with improvements in flow and utilization showing Continue to monitor.	30/10/18
10.08	• Improve referral to treatment times in surgery.	WLI lists. Review of Consultant Job plans. Transfer of elective lists from NPH to Ealing to improve access to inpatient work and improve the admitted position for the Trust January 2019: A weekly review of the RTT position is in place with oversight from the COO - actions for all SMs to work with the clinicians and look how to maximise lists and not waste operating time.	November 2018: remains a real challenge and is one that has daily challenge and scrutiny with attention from the COO and NHSI	01/02/19
11	**Community Inpatient**			
11.01	The trust must ensure that mental health needs of its patients are met. The trust must ensure adequate security arrangements are in place on the premises to support staff when supporting agitated patients.	Psychology input to address patient psychological needs- Clinical Psychologist 8A is now providing, 0.5 WTE support to the Wards at Willesden including Robertson Ward. Clayponds cover is currently provided by Dr. Sara Banks while awaiting for Band 8a 0.5 WTE recruitment -Robust screening process for admission introduced with Matron and consultant reviewing patients for suitability to mitigate risks where current service provision may be insufficient to meet existing mental health needs		31/12/18
		Develop Psychiatry Pathway to support Patient need-On risk register 811	Pathway in place at Clayponds via the Single Point of Access for crisis team to assess patient at CPH. There are currently no plans for psychiatrist at Willesden. SOP to be agreed in a meeting with Triumvirate and Dr. Sara Banks	31/12/18
		Develop SOP to meet Security needs of the service -Security risk assessment has been completed by HoN and Matron -HoN,DGM met with Head of security on 10/01/19-zero tolerance posters now displayed on the unit to deter security incidences, police engagement through safer neighbourhood planned through local inspector, weekly security awareness training sessions are planned for staff to empower them and make aware of different pathways such as calling security and police on need basis, data on conflict resolution training awaited, on risk register 894	Challenges around 24 hours security cover are highlighted in Divisional CQ&R meeting on 16/01/19	31/12/18