Stronger Together

London North West Healthcare NHS Trust

Care Quality Commission

Compliance Improvement Plan

(Working Document)

Locations covered – Northwick Park, St. Mark's and Central Middlesex Hospitals

Version	Date	Author	Amendment / Change
1.0	4th Oct 2014	C Thorne, Director of Governance	First Version
1.2	17th October	C Thorne, Director of Governance	Status updates to compliance plan
1.3	21st October	C Flowers, Chief Nurse	Status updates to compliance plan
1.4	19thDecember	C Flowers, Chief Nurse	Status updates to compliance plan and removal of duplication actions.
1.5			

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Section 1 – Hospital Inspection Ratings

As part of their hospital inspection regime the Care Quality Commission (CQC) looks at the quality and safety of the care provided based on the things that matter to people. They look at services to ensure they are;

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

Following inspection prior to merger with Ealing ICO NHS Trust, North West London Hospitals underwent inspection of its three main hospital sites. The CQC published a report and ratings for each hospital inspected, as well as an overall North West London Hospitals Trust rating.

CQC Overall ratings for the NWLH Trust		
Overall rating for NWLHT	Requires Improvement	🟡
Are services at this Trust safe?	Requires Improvement	🟡
Are services at this Trust effective?	Requires Improvement	🟡
Are services at this Trust caring?	Requires Improvement	🟡
Are services at this Trust responsive?	Requires Improvement	🟡
Are services at this Trust well led?	Requires Improvement	🟡
CQC Overall ratings for three hospitals		
Central Middlesex Hospital (CMH)	Good	🟢
Northwick Park Hospital (NPH)	Requires Improvement	🟡
St Mark's Hospital (SMH)	Requires Improvement	🟡
		🟡

Section 2 – Areas for Improvement

As part of the findings from the inspection of our hospitals the CQC produced a list of recommendations. These actions are grouped into actions that **MUST** be taken and those that **SHOULD** be taken to improve.

Action that MUST be taken to improve:

- The Trust must ensure that there are appropriate numbers of staff to meet the needs of patients in the A&E department, surgical areas and critical care (NPH and SMH)
- The Trust must ensure there are systems in place to assess and monitor the quality of service provided in A&E, critical care, surgery and maternity, to ensure services are safe and benchmarked against national standards (NPH).
- The Trust must ensure that the environment is safe and suitable in Paediatric services (NPH)
- The Trust must ensure that equipment is available, safe and suitable within the Paediatric service (NPH)

Action that SHOULD be taken to improve

- The staff should review medical and nursing levels particularly in areas which directly impact on care provided to patients such as SMH
- The Trust should ensure all staff are aware of escalation procedures and that these are followed
- The Trust should ensure all policies, procedures and protocols are based on national guidance and are in date.
- The Trust should ensure improvements are made to the Maternity service to ensure a cohesive, safe and effective service is provided to women
- The Trust should review and improve multi-disciplinary working within Maternity services
- The Trust should improve appraisal rates for staff
- The Trust should take steps to improve its Friends and Family test rating
- The Trust should take steps to ensure staff receive feedback on incidents reported
- The Trust should improve visibility of the leadership and communication with staff, particularly at CMH to develop a sense of cohesion for the organisation.

Section 3 – Actions the Trust MUST take to improve

This section lists the compliance actions that the Trust MUST take to improve.

The progress status of each action is indicated by the colour code below

Milestone Rating key :	
Completion Status	
	Delivered
	On Track
	Issues – Narrative description
	Not on track to deliver

The compliance action plan is overseen by the Clinical Performance and Patient Experience committee of the Trust Board.

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
Actions the Trust MUST take to improve – Mission Critical Key Actions							
REGULATION: Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. **KEY RISK:**People who use services and others were not protected against the risks associated with ineffective decision-making in order to protect their health, welfare or safety.							
1.	Very little information was systematically collected on the safety and quality of care and treatment provided within critical care.	ICNARC license application required - May 2014 Confirmed joining – June 5, 2014. Clinical Lead role made explicit. Recruitment to Audit Nurse Post	Medical Director Clinical Director Divisional General Manager / General Manager	July 2014 August 2014 September 2014 Review December 2014	Joined – June 5, 2014. Data collection in place with NWL *Critical Care Network Quality measures uploaded* for first quarter of 2014/15& ongoing. Dedicated 1PA for development, leadership and overseeing of quality measure return. ICNARC – Audit Manager appointed. Audit Nurse appointed. The ICS, ICNARC and ACUBASE systems collate necessary data. Info flows between systems to be confirmed to reduce double entry. The ICS standard for data is a risk register and associated audit calendar which the CIRG is undertaking. ICU governance will become a platform for dissemination of learning points of incidents raised and	Complete July 2014 & ongoing Complete July 2014 Complete Sept 2014 Ongoing.	Delivered

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
					investigated. This will also inform the clinical dashboard.		
2.	Ensure adequate numbers of medical staff with the right skills are in place to ensure safe staffing in Critical Care.	Continue to actively recruit to this staff group.	Medical Director Divisional General Manager / General Manager	December 2014	**November 2014 update:** **SHOs -** all 9 in post at present; one consultant (ACC) with direct responsibility for SHO recruitment. Additionally, we are in advanced talks about getting ICM trainees to replace some of our current Clinical Fellow posts in August 2015 **Middle Grades** –6 posts, 3 in post, one due to start in 2015. 2 posts re-advertised. **Consultants** - job description recently received from Regional Advisor. To be revised before plans for advert.	On-going Review December 2014	On Track
3.	There was a lack of up-to-date protocols and guidelines for staff to work from within surgery.	Programme of update for guidelines and protocols in line with best evidence based practice. To include: • Sedation • Renal replacement • Management of septic patient • Deteriorating patient	Medical Director Divisional Clinical Director Head of Nursing Divisional General manager (DGM)	December 2014.	**Protocols :-** Sedation – Completed Renal replacement – Completed. **Other progress includes:** Analysis of complaints and incident data will be displayed on the Quality Board. It will also include actions taken and changes to practice that have been implemented. Clinical Governance meetings in place. Dedicated ICU Clinical Governance Day for Friday 5th December. Clinical Incident Review Group monitors risk register and reported incidents. **Evidence available.**	October 2014. Ongoing	On Track

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
4.	The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway.	• Ensure clear display of Trust posters and information on: 'Listening, responding and improving your experience' • Audit compliance.	Chief Nurse, Head of Patient Experience Head of Midwifery Head of Patient Experience Head of Midwifery.	September 2014 September 2014 January 2015	• Posters in place. • Women's Feedback Plan devised and being implemented. **Evidence available.** Audit of information available Re-audit of information available	July 2014 September 2014 September 2014	Delivered On track
		• Staff engagement workshop	Chief Nurse HR Business Partner Head of Midwifery DGM and Clinical Director for Women's and Children's services.	September 2014 √ December 2014	First one undertaken. Plan for next steps devised for ongoing work. **Evidence available.**	September 2014	On track
		• Develop Complaints management improvement plan.	Chief Nurse. Head of Patient Relations Head of Midwifery DGM and Clinical Director for Women's and Children's services.	September 2014	Complaints management improvement plan **Evidence available.**	September 2014	Delivered.

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
	above…seeking and acting on feedback…	• Recruit designated maternity Patient Experience & Quality Improvement Lead. (appoint interim)	Chief Nurse. Head of Midwifery DGM and Clinical Director for Women's and Children's services	October 2014	Job description developed. Interim in place. **Evidence available.**	September 2014 October 2014.	Delivered.
				December 2014	Post advertised interviews planned.	December 2014	On Track
		• Continue to implement the Women's Improvement action plan.	Chief Nurse. Head of Midwifery DGM and Clinical Director for Women's and Children's services.	December 2014	Women's experience improvement plan, reviewed and updated on feedback received. **Evidence available.**	November 2014.	Delivered. & Ongoing
	Continued from	• Explore mechanisms for real time patient feedback	Chief Nurse. Head of Patient Experience Head of Midwifery DGM and Clinical Director for Women's and Children's services	September 2014	Women's Feedback Plan devised and being implemented. Includes electronic real time feedback, equipment has arrived. **Evidence available.**	September 2014. & ongoing	Delivered. & Ongoing

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
	above…seeking and acting on feedback…	• Develop women's feedback plan on maternity pathway, to include: ➢ Improve response rate of F&F test. ➢ Themes and trends from on call supervisor of midwives and bleep holder ➢ Repeat of national survey	Chief Nurse. Head of Patient Experience Head of Midwifery DGM and Clinical Director for Women's and Children's services	Sept 2014 January 2015	Women's Feedback Plan devised and being implemented. **Evidence available.** National survey planned.	September 2014	Delivered. On track
		Improve feedback, learning and change through being incorporated into: ➢ Divisional Monthly Clinical Governance meetings.	Chief Nurse. Head of Midwifery DGM and Clinical Director for Women's and Children's services	October 2014	Women's Governance Board Meeting Agenda and minutes. **Evidence available.**	October 2014	Delivered.

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
5	The lack of escalation processes in maternity.	Re-launch Maternity Early warning Signs MEOWS assessment and escalation tool	Chief Nurse & Medical Director Head of Midwifery and Clinical Director for Women's Services.	Re-launch in Sept 2014	Tool re-launched. **Evidence available.**	September 2014	Delivered.
				Audit of compliance November 2014.	Tool in place **Evidence available.** Summary report being complied.		On Track
		Review bed management escalation protocol and re-launch Review clinical escalation protocol and re-launch. Audit / test	Chief Nurse & Medical Director Head of Midwifery and Clinical Director for Women's Services.	Review and re-launch Sept 2014 Review and re-launch Nov 2014 Audit of compliance December 2014	Bed management escalation protocol reviewed ad re-launched. **Evidence available**	September 2014	Delivered.
					Clinical escalation protocol reviewed ad re-launched. **Evidence available**	November 2014	Delivered.
					Tool in place Summary report being complied. **Evidence available.**		On track
		Establish joint midwifery and obstetrician handover	Chief Nurse & Medical Director Head of Midwifery and Clinical Director for Women's Services.	Establish October 2014 Audit of compliance January 2015	Joint midwifery and obstetrician handover in place **Evidence available**	October 2014	Delivered.
					Tool in place Summary report being complied. **Evidence available.**		On track

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
Actions the Trust MUST take to improve – Mission Critical Key Actions							
REGULATION: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare **KEY RISK:** Women who use maternity services at Northwick Park Hospital were not protected against the risks of receiving care or treatment that is inappropriate or unsafe							
6.	Women not having their individual needs met as comfort checks on the postnatal ward were not regular	Comfort Rounds in place requires aprocess review and audit to ensure outcome of regular checks is established. Audit in November/ December 2014	Chief Nurse. Deputy Chief Nurse. Head of Midwifery	September 2014	Comfort round guidance re-launched. **Evidence available**	September 2014	Delivered.
				in November/ December 2014	Audit undertaken, summary report being complied.		On Track
7.	Women may not have their safety and welfare ensured because behaviour and attitudes of some midwives towards women fell below expectations.	Provide ongoing customer care training. Review training compliance.	Chief Nurse. Head of Midwifery Head of Patient Experience	September 2014 Review training compliance Dec 2014	New Trust wide Customer care training commissioned. Customer care policy devised Local 'customer care' positive attitude, resilience training in place. **Evidence available**	September 2014	Delivered On track
		Re-launch Maternity services staff attitude and behaviour charter & card.		October 2014	Trust 'Working together in partnership: A charter for patients, visitors and colleagues' Maternity services staff attitude and behavior Charter **Evidence available**	October 2014	Delivered

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
		Launch 'See something say something campaign' for staff to raise concerns	Chief Nurse Head of Patient Experience	Nov 2014	'See something say something campaign' for staff to raise concerns- launched. **Evidence available**	October 2014	Delivered.
		Undertake observational audits to assess patient safety and welfare standards.	Chief Nurse Head of Midwifery	(September 2014) October 2014. Await December 2014 update.	Timescale slipped to Oct 2014 due to availability of additional resource but has commenced. Await summary report. **Evidence available**		On Track
		Implementation of midwifery consultation paper to ensure right staff, right skills right place.	Chief Nurse Divisional General Manager Head of Midwifery	Consultation started Feb2014 and completed March 2014. Implementation started 1st April 2014, staged programme of completion for March 2015.	Final approved midwifery staffing service model **Evidence available**	Ongoing between April 2014 to March 2015.	On Track

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
Actions the Trust MUST take to improve – Mission Critical Key Actions							
REGULATION: Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises. **KEY RISK:** People who use services and others were not protected against the risks associated with the safety and suitability of premises							
8	**Jack's Place:** The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward. The ward appeared clean, but it was cluttered which meant thorough cleaning could not be achieved.	Review of ward configuration to be undertaken with options for changes being scoped and costed.	Director of Estates and Facilities Paeds management team	May 2015	Meetings taken place and provisional plans proposed. **Evidence available.** Await funding approval.		On track
		Implement weekly monitoring of ward using PLACE template	Chief Nurse & Director of Estates and Facilities Ward manager	May 2014	Monitoring in place. **Evidence available**	Complete May 2014	Delivered.
9	**Jack's Place:** The treatment room and store room doors on the ward were left open, potentially allowing access to children.	Door now remains locked with ongoing spot checks	Chief Nurse Ward manager	May 2014	Door now remains locked with ongoing spot checks **Evidence available**	Complete May 2014	Delivered

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
Actions the Trust MUST take to improve – Mission Critical Key Actions							
REGULATION: Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. **KEY RISK:** People who use services and others were not protected against the risks associated with the safety and suitability of equipment							
10	**Jack's place** Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked.	Asset register completed with service schedule update	Director of Estates and Facilities Head of Estates Ward manager	May 2014	All equipment on asset register **Evidence available**	May 2014	Delivered
11	**Jack's place** Some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward 24% of equipment had passed their due date for servicing.	Devices register and maintenance status corrected and updated	Director of Estates and Facilities Head of Estates Ward manager	May 2014	Maintenance completed **Evidence available**	May 2014	Delivered
12	**Neonatal unit** We noted that a fridge in the neonatal unit was iced up and there were gaps in the temperature recording.	Fridge defrosted with out of samples disposed of. HCA to add to rota of temperature recordings	Chief Nurse Unit manager	May 2014	Immediate action taken on day **Evidence available**	May 2014	Delivered

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
Actions the Trust MUST take to improve – Mission Critical Key Actions							
REGULATION: Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. **KEY RISK:** People who use services did not always have their health and welfare needs met by sufficient numbers of appropriate staff							
13	There were inadequate staffing levels to provide safe care to patients within the major's treatment area in the A&E department.	Additional staffing will become available post CMH A&E closure.	Chief Operating Officer (COO) DGM Emergency division Clinical Director Head of Nursing	Sept 2014	CMH A&E Department closed on 10th September 2014. Medical and nursing capacity has been transferred to NPH A&E rota's, increasing medical workforce and reducing nursing vacancies that were being held.	Sept 2014	Delivered
		Review of rota will take place	COO DGM Emergency division Clinical Director	Oct 2014	Full rota review underway to better match capacity to demand peaks and support new ways of working in our new A&E department, which is due to open at NPH this winter.		Delivered
		Appointment of new clinical leads	COO DGM Emergency division Clinical Director	September 2014	Additional Clinical Director capacity has also been introduced to support the Emergency Pathway.	Complete	Delivered

No	Recommendation	Key action	Responsible Exec / Manager	Date for review / completion	Progress	Date completed	RAG status
14	Increase bed capacity.	Beds/4 hour performance – Estates Strategy, Carroll Ward, Treat &Transfer CMH, Modular Units (up to100 additional beds by Oct 2015).	Chief Operating Officer Director of Operations. DGM Emergency division	September 2014	Carroll Ward opened on 10th September 2014, 20 new acute assessment beds at NPH.	September 2014	Delivered
					A treat and transfer system to utilize CMH bed capacity.	September 2014	Delivered & Ongoing
				Review December 2014	The estates strategy currently overseeing redevelopment of Jenner Ward day care (8 additional beds) in place and Fletcher Ward (22 additional beds).	November 2014	Delivered
		Full Business case (FBC)submitted for additional beds submitted to TDA Approval of the Modular ward plan.		February 2015 October 2015	The Trust Board has approved the FBC. The TDA to consider the final FBC for approval in February 2015.		On track
		Full implementation of the modular ward plan.	Director of Estates and Facilities	October 2015			On track
15.	There were low numbers of middle grade doctors in general surgery.	Review middle grade staffing numbers and allocation.	Medical Director DGM Surgery Clinical Director	Oct 2014.	Middle grade staff review undertaken.		Delivered
		Move to Consultant delivered service with associated recruitment plan as required		Review December 2014	Plans to progress to Consultant delivered service in progress.		On track