

CQC post inspection action plan**September 2016 – updated March 2017 and further updated September 2017**

TOPIC	Division/Corporate Area	Issue/Concern	Action to date	Time frame for delivery	Executive Lead
Delirium Policy	Clinical Services	The management team should ensure that the policy for managing delirium is updated	The policy has been updated and training on the policy is in progress	September 2017 Completed	Director of Nursing and Quality
End of Life	Clinical Services	The Trust should ensure that plans in place are implemented to ensure all staff have access to specific training needs in end of life to deliver effective and	EOL Training A new set of learning modules for end of life care have been agreed and implemented. In addition three full end of life training days have been set up.	September 2017 Completed	Director of Nursing and Quality

		<p>high quality care to all</p> <p>The Trust should ensure that there are specific medication guidelines in place for patients at the end of their lives who are being cared for in the intensive care environment</p>	<p>The EOL Clinical Lead is now employed 0.4 hours. She has started to attend the Consultant Intensivist Ward Round on Mondays when she is present in LHCH. This has improved communication and speedier referrals for EOL support. Whilst a specific EOL policy for Critical Care was identified as not being required, the existing policy is</p>		
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			<p>due for further review and will include an appendix relating to variance of EOL medications within the critical care environment.</p>		
		<p>The end of life dashboard was not always updated and therefore could be inaccurate</p>	<p>The dashboard is not in operation currently as there are improvement works required to ensure it is fit for purpose</p>		
		<p>Not all staff were aware of the end of life strategy</p>	<p>The end of life strategy has been approved and has been circulated widely trustwide and is available on the trusts intranet.</p>		

Mandatory and Safeguarding training	Corporate	The Trust should ensure that staff attendance at mandatory and safeguarding Training is improved. The Trust should ensure that medical staff attendance at safeguarding training sessions is documented to determine compliance.	Mandatory training is currently at 95% and safeguarding at 97%.	September 2017 Completed	Director of HR and OD
Human factors training	Corporate	The Trust should ensure that medical trainees can access human factors training, simulation training and formalise	The Trust has a strategy for developing awareness and building capability trust wide for human factors. This encompasses offering awareness	Completed	Director of Nursing and Quality

		cardiac training opportunities.	training to all groups of staff which is in place currently. Human factors awareness is available for medical trainees and has been embedded onto the trust induction, preceptorship and the care certificate training.		
WHO Checklist	Medicine and surgical Divisions	The Trust should continue to improve the WHO checklist completion by staff	Good progress has been made across both divisions with completion of the WHO checklist. Both the surgery and medicine divisions are working with the EPR Team to ensure the checklist information is	September 2017 April 2018	Medical Director

			<p>robust and is written correctly for the purposes of audit. The Trusts focus in on the qualitative aspects of the checklist. This is monitored through the Quality committee.</p> <p>March 2017</p> <p>LHCH monitor the WHO safe surgery checklist on a monthly basis. The WHO checklist is carried out for all patients and is therefore at 100%. The assurance target for the WHO checklist is set at 90% within theatres (quality of each</p>		
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			<p>element being completed). In January 2017 compliance was at 92.1% and February 92%. The compliance rate for Cath Labs for February 2017 was 98.13%.</p> <p>September 2017</p> <p>The WHO checklist remains compliant across theatres and Cath labs. The standard was observed in the recent mock inspection and found that there were small omissions in the completion of the</p>		
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			checklist in Cath Labs. This was further assessed during the unannounced mock inspection and the standard of completion was good.		
Resuscitation equipment	Clinical services	The Trust should take steps to ensure that resuscitation equipment is checked in line with trust policy, expiration dates are monitored and all emergency equipment is available for use	<p>All Resuscitation Trolleys are checked daily. The Leads in Outpatients and Diagnostics need to ensure this is carried out thoroughly.</p> <p>March 2017 A Trustwide monitoring audit on resuscitation checklists was carried out in February 2017. The</p>	September 2017 April 2018	Director of Nursing and Quality

			<p>audit showed that all the resuscitation trolleys were checked. sealed and there was clear documentary evidence that the contents were checked weekly. The main deficiencies found were overstocking of equipment on some trolleys and in one area an old check-list was in use.</p> <p>September 2017</p> <p>The Trust wide mock inspection found that were a couple of resuscitation trollies that were not checked</p>		
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			<p>thoroughly. The main issue for the clinical areas was the complexity of the checklist. This has now been reviewed and a more comprehensive but shortened version of the checklist has been introduced into the clinical areas. Monitoring of compliance with this is carried out by the Resuscitation officer through regular audits and weekly by the ward matrons.</p>		
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Mixed sex Breaches	Clinical services	The management team had struggled to manage mixed sex breaches in the POCCU areas of the unit in accordance with the Department of Health standard	March 2017 Up until Feb 2017, there had been a marked improvement in the MSA breaches within Critical Care. Unfortunately during February there have been some MSA breaches. Each breach has been due to ward bed capacity or the unavailability of enhanced levels of care provision in the ward environment. Each case was escalated to a Head of Nursing and a risk assessment on an individual basis and when	Completed	Director of Strategic Partnerships and Chief Operating Officer
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			<p>deemed in the patient's best interest with regard to safety, patients remained on critical care. Where possible, patients were moved to a side room on ITU to eliminate further breaches. To aid further delayed discharges, patient flow and MSA breaches, extra ward bed capacity has been achieved, with Cedar ward opening an extra 4 beds.</p> <p>September 2017</p> <p>Progress with compliance with MSA breaches has</p>		
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			been good with one breach recorded over the past 6 months.		
Delayed discharges critical care	Clinical Services	Approximately 35% of all discharges from the unit had been delayed by over 4 hours between April 2015 and May 2016. This was higher than similar units nationwide	Significant improvements have been made to delayed discharges and this is work on-going There has been an increase in our discharges within 4 hours of patients being medically discharged, a decrease in the number of patients being discharged between 4 – 24 hours and the Trust has practically eliminated delayed discharges over 24 hours. This information is for	September 2017 Completed	Director of Strategic Partnerships and Chief Operating Officer

			<p>Q1- Q3 (i.e. up until the end of January 2017)</p> <p>August 2017</p> <p>Good progress in compliance with delayed discharge target which is also a Cquinn. Patient flow projects are in place in both surgery and medicine to improve patient flow.</p> <p>Over performance on CQuin for delayed discharges last year so we have a maintenance target this year. Current position is just 20% against a 60% target</p>		
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Handwashing critical care	Clinical Services	We observed some occasions where staff did not wash their hands in between treating patients which meant that there was a risk of infection being transmitted between patients.	March 2017 Increased Surveillance in critical care and this will be monitored through the infection prevention committee. Adhoc checks continue to be made, ITU action team in place, February hand hygiene audits show 100% compliance for ITU/POCCU.	Completed	Medical Director
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Storage of cleaning chemicals	Medicine Division	Cleaning chemicals had been left out in an unlocked room on Maple Suite and the dirty utility room was left unlocked which presented a risk to people	This has been addressed	Completed	Medical Director
Leadership in medical areas	Medicine Division	It was identified that improvements could be made in the leadership /culture in a couple of isolated areas in medical services	The trust has undertaken a trust wide culture Survey in 2014 and each individual area has an action plan. The plan is in place to repeat this Survey in spring 2017. The medical areas have action plans and are involved in Listening into action Workshops	Completed	Director of Nursing and Quality

			<p>The Head of Nursing is working with the managers in medical services to further develop an open and transparent Culture</p> <p>September 2017</p> <p>The Trust wide safety culture results show that the Trust has improved in all areas and remained static in one area. The results are pleasing and demonstrate improvements in the safety culture trust wide. All areas have received their individual feedback and are addressing</p>		
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			the areas highlighted for improvement.		
Store room unlocked	Medicine Division	There was a store room unlocked. This posed a risk as it contained essential fluids and equipment and there was direct access to an area.	This has been addressed	Completed	Director of Nursing and Quality
Incident Reporting Outpatients and Diagnostics	Clinical Services	Staff knew how to report incidents and received feedback but there was inconsistency in the types of incidents reported.	Information has been circulated trust wide regarding examples of types of incidents that staff should report March 2017 Incident reporting awareness raising continues. Training continues on induction and ad hoc on request. The laminated copy	Completed	Director of Research and Informatics

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			of definitions of incidents was recirculated in February 2017 to wards and department areas incident reporting is underway		
Medications storage	Trust wide	Medications storage is not in line with policy in some area due to lack of storage space in some clinical areas	A review of medications storage has been carried out trust wide and capacity for storage addressed. Staff have also been reminded of the need to ensure all medicines are locked away and medicines trollies locked in placed when not in use.	Completed	Director of Nursing and Quality
Staff knowledge of key information unsatisfactory	Trustwide	Staff knowledge of key issues e.g. end of life contacts, ECS,	Learning and sharing held fortnightly with all leads trust wide.	April 2018	Director of Nursing and Quality

in some areas		care partner, line management structures, HALT and key risks	Sharing and learning of key information and five Key lines of enquiry. Trust booklet shared with all staff containing key information.		
DNA rates – outpatients and diagnostics	Clinical Services	The Trust had a number of patients who failed to attend for their appointments and the did not attend (DNA) rate was higher than the England average. A DNA policy was in place however this had been scheduled for review in March 2016. 44% of	<p>March 17</p> <p>The SMS Text Project has been placed on hold whilst a full Trust wide admin review takes place. It is planned that this will be Completed by October 17.</p> <p>A trial on undertaking reminder phone calls was completed but was</p>	<p>September 2017</p> <p>April 2018</p>	Director of Strategic Partnerships and Chief Operating Officer

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		<p>clinics started late and 41% of patients waited over 30 minutes to see a clinician</p>	<p>found to demonstrate no benefit in reducing DNAS.</p> <p>The second phase will involve an Initial trial being conducted on a selection of specific clinics, with higher than average DNA rates.</p> <p>A review of administration functions within the Trust is currently underway. All administrative policies and processes are being reviewed with an expected completion date for</p>		
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			<p>March 2017. The draft Access and administration Policy has been submitted to NHS Improvement. Further review is required by CCGs and Trust Divisions</p> <p>August 2017</p> <p>Analysis of DNAS has shown that the Trust main OPD DNA rates are in line with the national average. Community and diagnostics are above the national average both at 20%. A comprehensive</p>		
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			action plan is in place to address the areas for improvement.		
Late Starts In outpatients	Clinical Services	It was noted that there were a number of late starts in clinic	<p>March 17 Changes to the previous data collection have been made to collate more meaningful information. The information is currently being collated and will be shared with the Divisions for action by the end of April 2017.</p> <p>September 2017 A 3 tier shift pattern has been implemented within the Outpatient Department; this</p>	<p>September 2017 April 2018</p>	Director of Strategic Partnerships and Chief Operating Officer

			<p>means that patients arrive earlier to their morning appointments. The OPD has engaged with both the Medicine and Surgical Division to introduce minimum data sets.</p> <p>OPD are working with the Pulmonary Function/Diagnostic Leads to open their Departments at 7.45am and work is on-going with the Division SLM's to streamline and create new outpatient letters to encompass earlier arrival for tests.</p>		
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Waiting times	Surgery Division	<p>The national referral to treatment data target fell below both the England average and referral to treatment standard. The 18 week RTT times for elective cardiac surgery were an issue as demand outstripped supply. The Trust had focused on improving the delivery of RTT 18 week waiting times during 2016/16. The backlog of patients waiting</p>	<p>On-going monitoring in place to ensure the Trust meets the 18 week RTT standard.</p> <p>March 2017 The trust has been compliant with RTT. A robust action is in place to ensure continuous improvement.</p> <p>September 2017 The trust has remained compliant overall against the RTT standard other than for one month in May 2017. The surgical division has completed all actions described in the last update including the recruitment of three</p>	<p>September 2017 April 2018</p>	<p>Director of Strategic Partnerships and Chief Operating Officer</p>
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		<p>over 18 weeks had significantly reduced and plans were in place for 2016/17 to reduce the backlog further. Service developments had also improved patients access to treatment A revised action plan is in place to reduce the backlog by 50% to 70 at the end of 2016/17 and a plan to become service line compliant at the end of November 2017.</p>	<p>additional consultant posts (locums at present) and introduced two dedicated consultant rotas one that deals with urgent inpatients and operating and the other than reviews all surgical inpatients daily. In line with the national picture referring organisations are struggling with outpatient capacity and thus LHCH has received a significant increase in the number of patients that are referred to us late. At the beginning of October this made up 25% of the</p>		
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		<p>Substantive consultant to be appointed in January and an additional locum to be recruited for a February 2017 start. Additional urgent capacity implemented so the impact on the elective service should be minimal.</p>	<p>patients that are currently waiting longer than 18 weeks for treatment. The Executive Team are writing to the units who persistently send late referrals escalating the issue to them. The surgical division continues to proactively manage patients through the RTT pathway and to reduce long waiting times as a priority. The issue with regards to late referrals has also been escalated to NHS Spec Comm through the trust RTT meetings with them.</p>		
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