Proposed Plans to address Warning Notices

Issued by

Care Quality Commission and Monitor Enforcement Actions

1.1 Introduction

The Care Quality Commission has visited the Trust on two occasions in the last twelve months. In May 2013, the CQC identified that the Trust was failing to meet expected standards in a number of areas, therefore attracting Compliance actions and a major failing in monitoring systems that attracted a Warning Notice. The concerns raised by the CQC included lapses in care caused by a lack of capacity within the Accident and Emergency Department and the bed stock within the hospital, evidence of breaches in infection control, medicines management, privacy and dignity of patients and respecting and involving those who use services.

The Trust developed plans to address the issues and shared these with Monitor, CCGs, and other stakeholders, including the Local Authority Overview and Scrutiny Committees. The Trust established a weekly Quality Programme Board, chaired by the Chief Executive, reporting into the Healthcare Governance Committee (a Board sub-committee) to oversee and drive forward delivery of the plans. A number of these actions have been completed and an ongoing assurance mechanism in place to ensure that they are embedded into the Trust's systems and processes. The completed actions are summarised in ***table 1*** below.

The CQC identified failings in the assessment and monitoring of services as it would be expected that the Trust's assurance systems would have identified all the issues to the Trust. The Trust commissioned support from PwC to review certain areas of operational governance and to develop ward based performance dashboards, this work is on-going.

1.2 October CQC Inspection and Action

In October 2013, the CQC visited the Trust for a second time. The report was received in January 2014. This report highlights a number of improvements, particularly in the previous lapses found related to capacity and found those areas "significantly improved". They also found positive improvements in "a number of wards" and found these areas were "well led and well managed". Previous shortcomings in medicines management had been corrected and the Trust now meets the required standards. However, although there is improvement, the inspection continued to find lapses in care in some specific areas, identified some new issues and continued to identify failings in matters where the Trust had not yet completed work to address issues from the May 2013 inspection. The CQC has served the Trust with 7 warning notices. It found failures to meet the following 8 essential standards:

- Outcome 1 - respecting and involving people who use services;
- Outcome 4 - the care and welfare of those who use services;
- Outcome 8 - cleanliness and infection control;
- Outcome 10 - safety and suitability of premises;
- Outcome 11 - safety, availability and suitability of equipment;

- Outcome 14 – staffing;
- Outcome 16 - assessing and monitoring the quality of service provision ; and
- Outcome 21 - records.

Of the failures to meet essential standards, 4 were judged by CQC to have a major impact on patients and 4 were judged to have a moderate impact.

1.3 Monitor's Requirements

The issuing of further warning notices and compliance actions by the CQC also 'triggers' the need for Monitor to take additional enforcement action, under the terms of the Trust's provider licence[1] and Monitor's Risk Assessment Framework. In response, Monitor has again issued the Trust with Enforcement Undertakings under Section 106 of the Health & Social Care Act. This requires the Trust to submit a responsive action plan to Monitor, the CQC, NHS England and the relevant CCGs by 11th January 2014 that includes the following:

- A review of clinical and ward governance;
- Action to identify and address those aspects of staff culture at the Licensee which are contributing to the licence breaches, including in particular those in general surgery and maternity;
- Proposals for how the Licensee will demonstrate whether those cultural issues are being addressed effectively.

The revised Enforcement Undertakings also ask the Trust to work with an Improvement Director appointed by Monitor who will provide Monitor with external assurance as to the delivery of the Trust's action plan and the general improvements in the Trust's governance arrangements and quality of care.

1.4 Trust's Action

The Trust Board has reviewed all outstanding CQC actions and developed a unified Action Plan which is outlined in ***table 2***. A programme management function has also been established to oversee and co-ordinate the implementation of plans.

This plan includes the Trust's response to the proposed enforcement undertakings as follows:-

- A summary of the key actions that the Trust has achieved to date together with the assurance mechanism being used to monitor ongoing delivery;
- A high level timescale for the implementation of the response to the warning notices;
- A high level action plan to respond to each of the warning notices with a nominated executive lead; and
- An illustrative project plan.

The Trust recognises that the timescales for implementation are challenging and has brought in additional resource to help implement the action plan. A number of experienced project managers are now in post to

[1] In particular, compliance with the Licensee's duty to ensure compliance with health care standards binding on the Licensee and with applicable legal requirements.

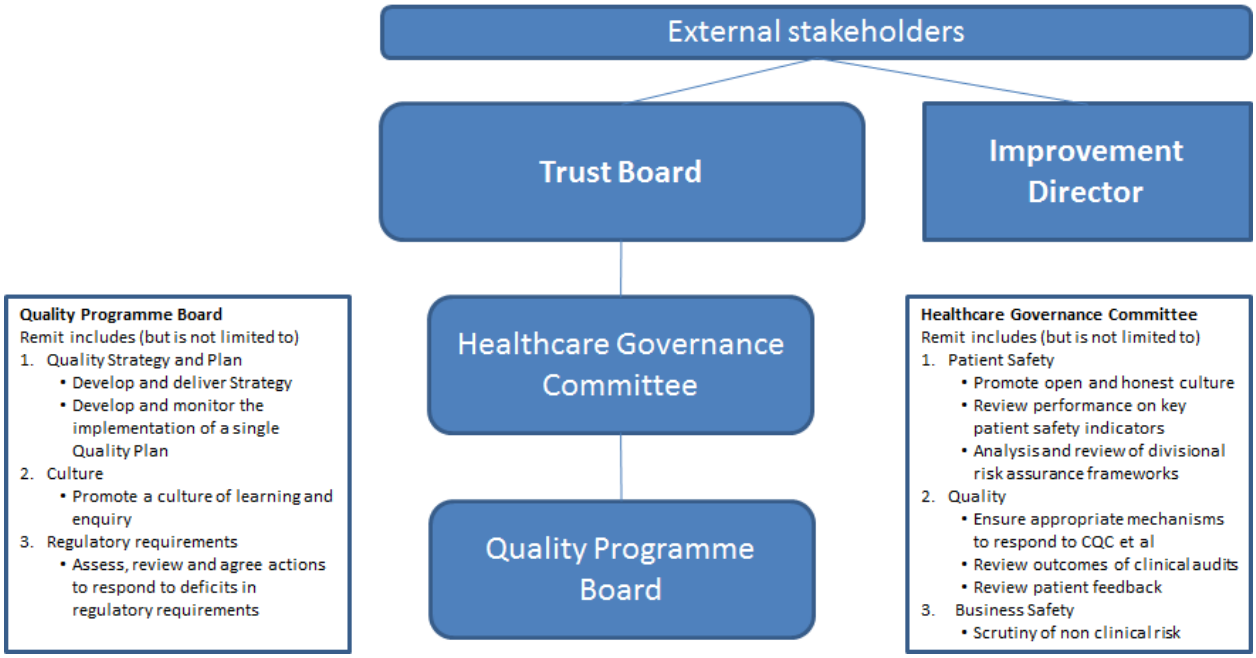
support members of the Executive Team. Progress will be monitored by a programme management office lead who will report to the Chief Executive. The weekly Quality Programme Board will continue to operate, chaired by the Chief Executive. Together with the Improvement Director appointed by Monitor, this forum will hold the Executive Team to account for delivery of the actions. The governance mechanism is shown below.

1.5 Overview of the Governance Framework

The Trust's Quality Programme Board ('QPB') is responsible for monitoring the Action Plans arising from the various CQC reports. The weekly meeting is chaired by the Chief Executive and attended by all members of the Executive Team together with divisional chairs.

The QPB reports to the Healthcare Governance Committee which includes non-executive members. This meets on a monthly basis. Minutes of the Healthcare Governance Committee are reported to the Board.

Figure 1- Governance Framework



2.0 Actions completed from May CQC Inspection

Table 1

The Trust has already made progress on implementing actions in response to the CQC reports. We outline below those actions that have been completed together with the forum in place for ensuring that the changes are embedded and continue to operate effectively.

Completed actions	Ongoing assurance mechanism(s)
1. Respecting and involving people who use services The Trust has re-designed the A&E department and completed significant capital works to increase bed capacity. A new rapid assessment entrance has been created to accommodate all ambulance arrivals to maintain privacy and dignity in the resuscitation area. The capital works were completed on 23 December 2013. The use of the Medical Investigations Day Unit (MIDU), rehab/physio and discharge lounge areas ceased in line with the plan. These areas are only used in accordance with the Surge Escalation Policy. The Trust has purchased new gowns to enhance patient privacy and dignity.	*Emergency Care Programme Board* *Ward level dashboards* *Monitoring of the escalation policy controls.*
2. Care and welfare of people who use services The Trust developed a capacity plan to meet non-elective and elective activity demands. This was approved by the Board in October 2013. 56 new beds have been established with a further 28 due for completion in February 2014. Coupled with the re-design of the A&E, a new rapid assessment and treatment system for 'major' patients commenced in early September. This has led to an improvement in the flow of patients in A&E. A Surge Escalation Policy is in place that prioritises the use of escalation areas on a risk assessed basis. The use of the Medical Investigations Day Unit (MIDU), rehab/physio and discharge lounge areas ceased in line with the plan. These areas are only used in accordance with the Surge Escalation Policy. Escalation areas are no longer used as core capacity. A review of call bells was completed to ensure that any defective or broken bells were identified and rectified. All rectifications are complete. Any issues with call bells are flagged with the estates help desk facility which is available 24 hours a day, 7 days a week. Wards have a standardised system for establishing who is in charge and individuals have a name badge clearly showing they are in this role.	*Emergency Care Programme Board* *Ward level dashboards* *KPIs on dementia assessments for all patients >75 within 72 hours of admission* *Monitoring of operational KPIs eg. RTT, cancelled on the day etc.* *Ward compliance checks* Ward compliance checks

Completed actions	Ongoing assurance mechanism(s)
3. *Cleanliness and infection control* Infection control audits are scheduled and the results and associated action plans are reported to the Infection Control Committee and Healthcare Governance Committee. An infection control dashboard has been developed and is reported to the Trust Board. An enhanced cleaning schedule has also been disseminated to all ward matrons and lead nurses and is displayed in the ward areas. Training on hand hygiene has taken place and a process is in place to address areas of low compliance. There are further new actions to address concerns from the October inspection.	*Reporting to Infection Control Committee, Patient Safety Group and Healthcare Governance Committee* *Ward level dashboards* *Ward level governance compliance process.*
4. Management of medicines An audit of all lockers used to store patients own drugs was undertaken and any lockers requiring repair were rectified. Ward fridges were also reviewed to ensure that they were lockable and had thermometers in place to check the temperature of the drugs. Repairs and replacements were made where necessary and an additional stock was ordered to facilitate swift replacement if needed. The Director of Nursing has written to all nursing staff reminding them of the Trust Policy, NMC standards and the NMC Code of Conduct regarding medicines management. A revised policy for Medicines Management with Standard Operating Procedures is in place.	*Site audits undertaken by facilities managers* *Ward level governance mechanism* *The CQC determined the Trust to be compliant with this standard in the October inspection*
5. Assessing and monitoring the quality of service provision A Surge Escalation Policy is in place and areas previously used for escalation (rehab, MIDU etc) are now closed. Infection control audits are routinely reported to the Infection Control Committee, Healthcare Governance Committee and the Board. An escalation process is now in place for concerns around infection control, fire safety and pharmacy.	*Monitoring of the Surge Escalation Policy* *Board reporting.* *Evidenced with revised policies.*

3.0 High level Action Plan to return Trust to compliance with CQC Standards **Table 2**

NB. It should be noted that detailed project plans behind each action will be developed through January. In some cases, the initial action will be to commission an external piece of work which, in most cases, will lead to recommendations. Implementation of these recommendations may take longer.

Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
1. Respecting and involving people who use services			
1.1 A technology enabled programme to continuously monitor patient satisfaction, with the intention of capturing feedback and using it to play it back to medical and nursing staff to identify their training needs and foster a greater understanding of the patient's needs.	DoN	PMO	February
1.2 Commission a customer care programme for all patient facing staff	DCEO	External	January
1.3 Implement changes to a number of ward layouts to improve bed flexibility for patients whilst achieving single gender accommodation.	DoN / DoEF	Contract Estate	January
1.4 Implement a rolling programe of education for nurse leaders to ensure a sound knowledge of care standards that can be cascaded to others.	DoN	PWC	January
1.5 Set some common stanards to enhance patient experience.	DoN/MD	PMO	January
1.6 Raise staff engagement through joining the next "listening into action" programme	DCEO	PMO	January
1.7 Ensure that "Always"and "Never" events are engrained in staff through a programme of communication with staff	DCEO	PMO	January
1.8 Complete a programme of improving discharge planning.	COO	PMO	February

Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
1.9 Continue engagement with Sodexo to improve the food service.	DCEO	Dir Facilities	February
1.10Complete a rapid desktop review of MHPS cases	MD	NHS England	January
1.11 Develop proxy indicators for measuring cultural change.	CEO / DCEO	Internal	January
2. Care and welfare of people who use services			
2.1 Develop and implement a plan to drive higher standards on wards 4, 7, 8, to incorporate KPI's to demonstrate improvement.	DoN	Elaine Strachan-Hall	February
2.2 Make changes to nursing leadership roles in appropriate areas.	DoN	DoN	Complete
2.3 Implementation of ward dashboard to highlight issues.	COO	PWC	January
2.4 Increase the number of staff trained to deliver intentional rounding and patient observations.	DoN	External training firm	March
2.5 Complete and evaluate pilot programme on open visiting, relatives are enabled to assist in providing appropriate care as (e.g. meal times)	DoN	PMO	February
3. Cleanliness and infection control			
3.1 Recruit a Hotel Services Director position to drive improvement	DCEO	DCEO	Complete
3.2 Commission a review of cleanliness from an appropriate organisation.	DCEO / DoEF	Dir Facilities/Green and Kasaab	Complete
3.3 Implement recommendations from the cleanliness review	DoEF		June
3.4 Complete a "deep clean" of the Trust	DoEF	ISS Mediclean	January

Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
3.5 Replace equipment that is identified asa significantbarrier to achieving a clean and infection free hospital.	COO /DoEF	Estates	January
3.6 Improve education of Hibiscrub use.	MD	Infection Control Team	January
4. Safety and suitability of premises			
4.1 5 year prioritised plan to address £37m of estate issues identified in a 6 facet survey has been agreed with DH.	DoEF	Internal	As per plan agreed with DoH
4.2 Plan to address short term issues, such as toilet and shower facilities in ward 18 are being implemented.	DoEF	Estates	January
4.3 Infection Control signage is being installed.	DoEF	Estates	January
4.4 Trust internal signage plan to be completed.	DoEF	External Supplier	July
4.5 Implementation of adequate lockable security solution to secure site.	DoEF / COO	Internal	March
5. Safety availability and suitability of equipment			
5.1 Accelerate and re- prioritise the equipment replacement programme to ensure that everything is fit for purpose – e.g. all macerators to be under 5 years old.	DoEF	Internal/PMO	January
5.2 Review the working condition of equipment (e.g. resuscitators).	DoEF	Internal/PMO	January
5.3 Review the need and availability of Hoists.	DoEF	Internal/PMO	January

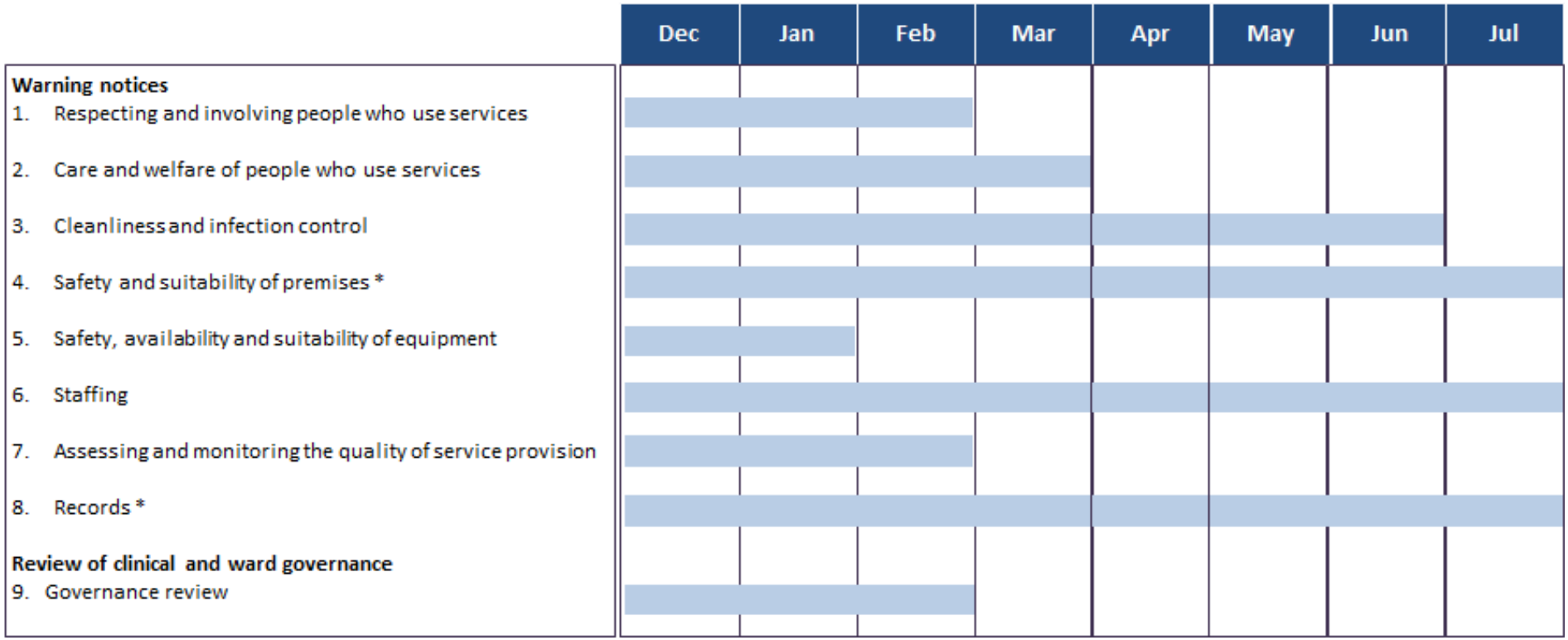
Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
6. Staffing			
6.1 Secure additional support to ensure that persistent workforce performance issues are resolved (e.g. General Surgery).	MD	Big 4 Firm	January
6.2 Complete implementation of ward staffing system to ensure that safe staffing levels can be monitored at Senior Management level.	DoN/CIO	Internal	January
6.3 Develop safe staffing metrics.	DCEO	DCEO	Complete
6.4 Programme to enable "realtime" understanding of staffing levels to include cleansing of ESR data .	DCEO/DoN/CIO	PMO/TVWLA	July
6.5 Ensure that all "non uk" health professionals receive adequate acclimatisation support during induction.	DCEO	External company	January
6.6 Organisational Development review to include leadership development.	CEO	NHS England/FRA	June
6.7 Conclude an agreement with a "big 4" firm to enable a short term increase in senior management capacity to underpin the delivery of these and other organisational priorities.	CEO	DQIPP	Complete

Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
7. Assessing and monitoring the quality of service provision			
7.1 External review maternity cluster of incidents	MD	NHS England / Royal College of Obstetricians	December
7.2 External review of Maternity Services	COO		January
7.3 External review of safeguarding with support to receive assurance	DoN	NHS England	January
7.4 External review of falls.	DoN	NHS England	December
7.5 Complete the implementation of a ward dashboard to drive continuous improvement and reporting up through the Trust	COO	Internal/PMO	February
7.6 Complete implementation of ward quality rounds (with matron assessments peer reviewed against independent perspectives)	DoN	PMO	February
7.7 Ensure that approaches that have yielded improvement on wards 1,3, 5,17,18 are shared to enable a broad based change across the Trust	DoN	PMO	January
8. Records			
8.1 Programme to review clinical records process prior to automation	DoCA	External	July
8.2 Retrieval and storage of records via funded EDM project	CIO	Internal	From July
8.3 Review of nursing documentation complete and embedded	DoN	PMO	January
8.4 Continue to reinforce and "police" need for correct documentation	DoN/MD	Internal	January
9. Governance review			
9.1 Agree terms of reference with Monitor	DoCA	Internal	January
9.2 Commission a governance review	DoCA	Internal	January

Warning notices and Monitor undertakings with associated actions	Accountable Exec Lead	Identified Resource	Completion Date
9.3 Review findings of the governance review and develop action plan	DoCA	Internal	February
10. Other (not subject to warning notices)			
10.1 Establish and disseminate a single policy on the sharing of patient information with relatives.	DCEO	Internal	February
10.2 Review staff training for individuals with learning disabilities.	DoN	PMO	January
10.3 Implement a system for marking equipment as clean and ready for use.	DCEO	PMO	January
10.4 Determine whether first aid kits are required on wards. Ensure that all first aid kits are removed where they are not required.	MD	PMO	January
10.5 Implement 8-8 working hours for staff on the reception desk.	DCEO	PMO	January
10.6 Review the policy on injectable medicines to determine whether one or two nurses are required. Update the policy as required.	DoN	PMO	January
10.7 Review the usage of current red mark scorecards on the wards and provide clarity on what is being measured and why.	DoN	PMO	January
10.8 Re-issue Datix passwords to all ward managers, lead nurses and clinical leads.	DoCA	Internal	January
10.9 Implement a system to identify and disseminate newly produced professional clinical guidelines (other than NICE)	MD	Internal	February
10.10 Establish an assurance process to ensure that intentional ward rounding and care plans are in place.	MD	PMO	January

4.0High level timeline to address the CQC warning notices and Monitor undertakings

Figure 2 – High level timeline



**** Actions in respect of the safety and suitability of premises and records will extend beyond July 2014The Trust recognises the importance of implementing the actions to address the shortcomings identified but considers that it would be impossible to deliver all of the actions by the end of January 2013. The Trust has prioritised actions on a risk assessed basis which reflects what is achievable in the timescales required. The Trust is, however, assured that progress will be made in most areas by 31 January 2013 and that a plan will be in place to deliver the actions thereafter.***

5.0 Tools and templates

The dedicated support that the Trust has engaged to help deliver the above plans is using standardised project management tools and templates. Each of the above warning notices is split into detailed workstreams with a nominated Executive lead and timescale for implementation. The project managers have worked with the nominated Executive lead to develop a detailed project plan with associated milestones for delivery. This will then be monitored by the PMO lead who will report progress to the Chief Executive on a weekly basis. Further external assurance will be provided by the Improvement Director appointed by Monitor. An illustrative project plan is shown below.

Figure 3- Illustrative Project Plan

Project Milestone Tracker

Please document all key project milestones and the weeks they fall due. Using the key below, update milestones to show progress against plan.

Project Name	Operation workstream
Accountable / Sponsoring Director	Lisa Glynn
Project Manager	ZhiQian Huang

Heatherwood and Wexham Park Hospitals NHS
NHS Foundation Trust

O	Original milestone due date, not yet due. This is the starting position for all milestones
OC	Original milestone, Completed on time.
OM	Original milestone, target date for completion missed

Workstream Relates to key milestones in project brief (specific milestones can be grouped into key milestone workstreams)	**Milestone Owner**	Milestone Description The date which the milestone is to be completed in (week commencing)	Jan-14				Feb-14				Mar-14				Apr-14					May-	
			06-Jan-14	13-Jan-14	20-Jan-14	27-Jan-14	03-Feb-14	10-Feb-14	17-Feb-14	24-Feb-14	03-Mar-14	10-Mar-14	17-Mar-14	24-Mar-14	31-Mar-14	07-Apr-14	14-Apr-14	21-Apr-14	28-Apr-14	05-May-14	12-May-14
Enhance Direct Nursing leadership/management in EDDU	Angela Ballard	Monitor standards of nursing care on EDDU via the ward level governance compliance process and ward dashboards				O															
	Emily Montgomery	Monitor local action plan	OC																		
	Angela Ballard	Start recruitment core team into EDDU				O															
Review and establish the required staffing to meet the demand in A&E	Angela Ballard	Identify required level of staffing in A&E	OC																		
	Angela Ballard	Ongoing recruitment of vacant posts	OC																		
	Helen Crick	Monitor improvements on delays to assessment and treatment (breach analysis)		O																	
	Angela Ballard	Compliance checks ensure appropriate care can be provided in A&E (3 times a week by lead nurse and once a week to Matron)	OC																		
	Angela Ballard	Monitor improvements to staffing level to ensure appropriate care can be provided	OC																		
	Andy Howlett	Document reasons for failed discharges to promote learning and process improvement	OC																		
	Andy Howlett	Ensure establishment of audit trail of all interactions with Local Authorities for each	OC																		

Milestones | Risks and Issues

Ready 80%