PLYMOUTH CITY COUNCIL

Subject:	Progress Update on CQC Action Plan
Committee:	Health and Adult Social Care Overview and Scrutiny Committee
Date:	23 January 2019
Cabinet Member:	Councillor Tuffin (Cabinet Member for Health and Adult Social Care)
CMT Member:	Carole Burgoyne (Strategic Director for People)
Author:	Julie Morgan, Head of Audit, Assurance and Effectiveness
Contact details	Kevin Baber, Chief Operating Officer email: kevinbaber@nhs.net
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

The purpose of this report is to provide an update on the action being taken by University Hospitals Plymouth NHS Trust in response to the 2018 Care Quality Commission (CQC) inspection report and Section 29A Warning Notices for Pharmacy and Diagnostic Imaging.

Corporate Plan

This report supports the City vision, values, objectives and outcomes described in the Caring Plymouth section of the Corporate Plan.

This report supports the following Strategic Outcome in the Plymouth Plan : People in Plymouth live in happy, healthy, safe and aspiring communities, where social, economic and environmental conditions and services enable choices that add quality years to life and reduce the gap in health and wellbeing between communities.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

None for Plymouth City Council - This report has been produced by University Hospitals Plymouth NHS Trust; any financial and resource implications will be relevant to the Trust rather than to the Council.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

Failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 results in the provision of services to patients that fails to meet essential standards of quality and safety. This may result in the issuing of a warning notice, imposition of a condition of registration, suspension or cancellation of registration, or under criminal law, a caution or prosecution.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:

It is recommended that the Committee takes assurance from the progress that we have made whilst recognising that the outcome of the current re-inspection by the CQC is awaited.

Alternative options considered and rejected:

Not applicable.

Published work / information:

Not applicable.

Background papers:

Not applicable.

Sign off:

Approved by: Greg Dix, Chief Nurse and Kevin Baber, Chief Operating Officer University Hospitals Plymouth NHS Trust.

Fin		Leg		Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Not Applicable													
Has the Cabinet Member(s) agreed the contents of the report? Not Applicable													

1.0 Introduction

1.1 University Hospitals Plymouth NHS Trust was inspected by the CQC in April – May 2018. In addition to the Inspection Report which contained a number of Requirement Notices, the Trust received two Warning Notices, one for Pharmacy and one for Diagnostic Imaging. The Trust was required to make the significant improvements identified in the Warning Notices by 26th October 2018.

1.2 An Action Plan was developed in response to the report and the Warning Notices with delivery of this plan subject to a process of internal and external monitoring and reporting. Progress is being overseen by a CQC Post Inspection Project Group which meets monthly and has a forward plan of work. Ongoing assurance is also reported internally to Safety and Quality Committee at each meeting and externally to the CQC, NEW Devon Clinical Commissioning Group and to NHS Improvement; this will continue until completion or re-inspection.

1.3 Any concerns with lack of delivery of actions or lack of desired impact of the actions will be escalated to Trust Management Executive and Trust Board as required.

2.0 Warning Notices

2.1 **Warning Notice (Pharmacy)**: The Warning Notice states that *"Significant improvement is required to ensure that systems and processes for safely managing medicines are operating correctly both within the pharmacy services and across the Trust, and are effectively governed so that people are given the medicines they need, when they need them and in a safe way"*.

2.2 Good progress has been made in supporting a positive cultural shift and with the recruitment to current vacancies. Ongoing work remains to ensure that all systems are robust and sustainable. The current concern relates to pace of change which is being adversely impacted by the lack of capacity at a senior Pharmacy leadership level. Steps are currently being taken to address this.

2.3 **Warning Notice (Diagnostic Imaging):** The Warning Notice states that *"Significant improvement is required to ensure that patients suspected of having cancer have timely access to initial assessment, test results and diagnosis in diagnostic imaging"*.

2.4 Good progress has been made with delivery of the action plan although improving the culture and wellbeing of staff will take time.

2.5 The one area that has been a long standing challenge for Diagnostic Imaging has been in progressing the e-referral system implementation to reduce risks to patient safety, particularly around unnecessary exposure, and incorrect referrals. One of the key issues has been to find a way forward for the management of Emergency Department (ED) requests. Progress is now being made with a four week pilot in Ultrasound and MRI which commenced in ED on 26 November. This will be extended to CT on 9 January, and if that is successful, to Plain Film. Initial feedback has been positive.

2.6 A summary of our assessment of our progress in addressing the Warning Notices is appended at Annex 1. Please note that the RAG rated assessment is purely subjective and designed to give an indicator of progress in delivery of the actions.

2.7 It is also important to note that our progress is currently being reviewed by the CQC. This process commenced on 11 December 2018 and we are expecting a draft report in February. The action plans for these two services will be refreshed on receipt of the inspection report.

3.0 CQC Quality Report

3.1 An Action Plan has been developed in response to the Quality Report which addresses the 'Must Do' and the 'Should Do' areas for improvement. A copy of the Performance Report is appended at Annex 2. 43% of the actions have now been completed. The following is a summary of the content:

- **Urgent and Emergency (pages 3-14)**: All actions are progressing in accordance with agreed timescales. The most significant issue relates to the redesign of the Emergency Department for which the Trust has been awarded £30m for a strategic rebuild.
- **Medical Care (pages 4 - 21):** All actions are progressing. The most significant issues relate to nurse staffing, scrutiny of mortality data and training.
- **Surgery (pages 22 – 29):** All actions are progressing in accordance with agreed timescales. The most significant issues relate to waiting times for treatment and training. Whilst 'Project Persist' continues with the aim to ensure that all available theatre time is optimised to an 85% opportunity, this continues to be compromised by the non-elective admissions to the hospital which is contributing to the cancellation of elective procedures.
- **Maternity (pages 30 - 36):** A number of actions are now complete. There has been minor slippage with some actions but these are being addressed. The most significant issues relate to training and competency, document control and medicines management.
- **Outpatients (pages 37 - 39):** All actions are progressing in accordance with agreed timescales. The most significant issue relates to mandatory training – this needs to be addressed by service lines so has been merged into the Trustwide actions for training.
- **Trustwide (pages 40 – 60):** Most actions are progressing in accordance with agreed timescales. The most significant issue relates to achievement of operational standards for which ongoing pressures, staffing issues and endoscopy remain the key challenges. One of the action timelines that has slipped relates to the management of equipment. This is a concern given that this was an issue that was highlighted in the last CQC report.
- **Use of Resources (pages 61 – 64):** All actions are progressing in accordance with agreed timescales. The most significant issues relate to readmissions and non-elective pre-procedure bed days which are both ongoing workstreams.
- **Mandatory Training (page 51):** There are nine separate 'Must Do' Requirement Notices or 'Should Do' recommendations related to mandatory training. Whilst initial actions had originally been identified, on reflection, a piece of work has now been initiated by the Quality Managers to develop a unified and pragmatic way forward to address these. This has commenced with identifying the causes of non attendance at training, their individual repercussions and the controls in place at that point in the chain of events. A number of further actions have been identified together with a confidence rating which has helped to identify the likely success this will give against different staff groups. The revised actions are in the process of development and agreement and will be reflected in future updates on delivery of the action plan.

4.0 Conclusion

4.1 Progress in delivery of the CQC action plan will continue to be monitored internally and reported externally.

4.2 The outcome of the current re-inspection by the CQC of how we have addressed the Warning Notices for Pharmacy and Diagnostic Imaging is awaited. The Action Plan will be reviewed in light of the report once received.

Annex I

Pharmacy Summary of Progress

	Pharmacy CQC - Areas for Improvement	Status Jan'19
Must Do's		
1	Address and resolve the issue of unrecognised or unaddressed risks in the pharmacy teams connected with patient safety, staff pressures, performance, and governance failings. - Completed Gap Analysis against the Royal Pharmaceutical Society's Professional Standards (RPS) for Hospital Pharmacy. Detailed action plan now needs to be formulated. - In the short term, an action plan has been formulated based on the detail of the Warning Notice. - Risk Register has been reviewed and is subject to ongoing review at Pharmacy Board.	60%
2	Address and resolve the cultural, wellbeing, staffing, resource, and workload issues within the pharmacy service and as they affect both the service and the wider trust. - Implemented a series of leadership and team development days planned to support staff. - Recruited to current vacancies as identified in establishment review with the exception of the Medication Safety Officer and Formulary Pharmacist posts. - Cardiology Pharmacist is not in the current establishment and will form part of the stakeholder review and business development process. - Plan to conduct a workforce review in line with the planned pharmacy integration with Livewell.	55%
3	Urgently produce standard operating procedures to ensure patients leave the hospital with critical medicines, and attend or are made aware of any critical follow-up appointments. -Standard Operating Procedure for return of critical medicines to Pharmacy implemented; any that are returned are escalated back to the ward. - Improved TTA monitoring process on the wards has been trialled successfully on two wards. An implementation plan is now being agreed.	55%
4	Ensure effective governance within the pharmacy service to provide a high quality and safe service. - Revised governance framework has been agreed. - The focus is now on improving 'quality management systems' (QMS) meetings relating to internal pharmacy processes and on reviewing the reports submitted to Pharmacy Board related to quality and safety. - Controlled Drug and Antimicrobial Surveillance audits re-established following recruitment and on-boarding of new pharmacists.	60%
Should Do's		
1	Improve documentation of when liquid medicines are opened to ensure they are not administered when they have expired. - Medicines Management Policy is on the agenda for January Medicines Utilisation and Assurance Committee. - Review of Audit programme underway as informed by RPS Standards Gap Analysis.	55%

Diagnostic Imaging Summary of Progress

	Imaging CQC - Areas for Improvement	Status Jan'19
Must Do's		
1	Replace equipment which is beyond its 'end of life'. Develop and act upon the imaging equipment replacement programme - Equipment was prioritised for the replacment programme by the Imaging Equipment Project Manager and the Care Group Manager on 02/01/19. The Trustwide prioritisation will take place later this month with the capital programme finalised Feb/March. The prioritisation was assessed on the basis of age, risk to failure and impact of failure.	90%
2	Improve the management of risk - All risks have been reviewed and updated and the Risk Register and action plans will be reviewed by the Imaging Governance Lead and escalated as appropriate. The Imaging Governance Committee will report to the Imaging Board.	85%
3	Substantially improve waiting times including the 7 & 10 day targets for 2ww and the 6 week diagnostic target - Performance against the 6 week target for diagnostics continues to improve. Scanning performance has stayed on trajectory and the reporting backlog has reduced significantly. Performance against the cancer standards (7 day scanning and 2 day reporting) is inconsistent. An intensive support project with the booking team is due to commence on 9 January. - Performance will continue to be monitored through the weekly modality performance meeting.	80%
4	Ensure all patients of child bearing age have appropriate pregnancy checks recorded - Standard Operating Procedure was reviewed but did not need to be changed. - Compliance was audited and found to be inconsistent. Further work has been done on education and communication with a re-audit planned in January.	60%
5	Ensure leaders have the capacity to lead - The Service Line have addressed some of these issues in the managerial team and in the booking department. In addition there is a proposal to address capacity to lead across the radiographer workforce. This has been circulated and generally well received, however, no additional investment has been committed to support the workforce.	60%
6	Support and improve the culture & wellbeing of staff - Reinstated HR Leadership Meetings fortnightly with Clinical Leads. - Implemented Communication Boards. - Regular senior management walkabouts. - Implemented 'SCORE' safety culture survey in Interventional Radiology. - Musculoskeletal risks are on the Risk Register and are being adequately managed. - The Service Line have identified some concerns relating to the leadership in one department and have met with the staff to discuss those concerns. - Further 'Your Voice' sessions are planned in February 2019. - Responsibility for the management of the rota, which has been the cause of some concern from staff will transfer to the Service Line Office with effect from February 2019. - First formal meeting of Imaging Board 18 January 2019.	55%

	Imaging CQC - Areas for Improvement	Status 1 Jan'19
7	Progress the e-referral system implementation to reduce the risk to patient safety - Went live with e-requesting of Ultrasound and MRI on 26 November 2018. CT to go live on 9 January 2019 with Plain film to follow.	55%
Should Do's		
1	Achieve compliance with Mandatory Training standards - Current compliance level 90% (target 95%).	90%
2	Complete all staff appraisals and job plans - Current compliance level 98% (target 95%).	98%
3	Improve privacy and dignity for patients - All actions requiring completion before the end of December have been completed.	75%
4	Ensure that targets are achievable, realistic and encourage the service to improve - CT complete. Performance meeting standards. - Ultrasound - undertaking some data quality work before publishing performance. - MRI will need to set different standards for some examinations to reflect the complexity of the service	70%
5	Improve compliance with audits e.g. hip fracture & trauma - Trauma audit action plan reviewed. Main recommendation addressed. - Hip fracture service to be re-audited early 2019.	65%

Key:

- >80%
- 51-79%
- <50%