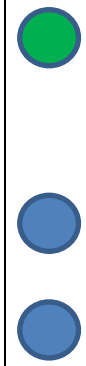
SUMMARY OF CURRENT POSITION IN RELATION TO CQC WARNING NOTICES & CONDITIONS

CQC letter content (summarised)	QIP Action Plan position	QIP RAG
Section 1 of Section 29A Warning Notice – Received 26th August 2015 **You are not ensuring the systems to assess, monitor, and mitigate risks to people receiving the care as inpatients and outpatients are operated effectively**		
Risk management system (1.1): ▪ Lack of clarity about escalation and reporting systems. ▪ Risk management policy used different wording for the risk committee to the most recent governance structure chart. ▪ Risk (management) committee reports to the trust management board but could not clarify whether risks are then escalated to the trust board of directors or its committees. Governance support unit staff told us patient safety risks should go through your clinical quality and governance committee, which reports to both the trust management board and the quality committee. A non-executive director told us some items are escalated directly to the quality committee, and there is a risk of duplication.	Clearly defined Risk Tolerance (escalation and delegation) section 7.3 in Risk Management Policy and Reporting (section 7.4.5) Risk Management Policy consistent with Governance structure – Board Risk Committee Board Risk Committee reports to Board – no longer a reporting process through TMB. • Risks scored over 15 reported to Board & relevant Oversight Committee • Risks over 10 reportable to Board Risk Committee • Risks 8 to 12 - Divisional/ Departmental oversight • Risks 1 to 6 - Specialty/Service oversight. Patient safety risks are considered at Patient Safety & Quality Board and subsequently to Board Quality Committee and if appropriate to	  

	Board of Directors.	
Potential suicide risks - Newark: (1.2 to 1.4) ▪ Found curtain rails in the Newark MIU were non-collapsible. ▪ Previous risk assessment had identified this but no actions and suggested it did not regularly see or treat patients at risk of deliberate self-harm or suicide. In fact they regularly treat patients at risk of self-harm and some are regular attendees. ▪ The unit's mental health link, a role for which there was no role description or training for, did not understand what a ligature risk was. ▪ Three members of staff were unable to find ligature cutters and confirmed that the unit did not have any. ▪ Three nurses in the Newark Hospital minor injuries unit were not aware of two incidents in the trust since March 2014 when patients used ligatures to commit suicide by hanging and they were not aware of the risks to patients from ligature points.	Installation of collapsible rails at Newark complete. Risk assessments undertaken in all high-risk areas across the Trust. Environmental works to reduce risks agreed with Skanska/CNH. Works commencing July 16. Ligature training completed for 780 staff (Dec 15). Now included in induction for new RCN/HCA/ODP/Midwives. Spot audits indicate 100% compliance	 
Call bells in Kings Mill Emergency Department (1.5 & 1.6) ▪ There were no call bells or alternative facilities in cubicles 14 to 22 in the 'majors' area. ▪ The clinical director thought that an orange button was the patient call button. However, the nurse in charge confirmed that this button was the cardiac arrest reset button. ▪ There had been no previous risk assessment of this. A risk assessment was undertaken with mitigating actions but on subsequent visit CQC did not see evidence that these mitigating factors were in operation.	Installation completed November 2015	

Patients at risk of self-harm (1.7 & 1.8) ▪ In March 2014, a patient took their own life by hanging whilst in the trust. One of the investigation's recommendations was to develop a trust policy for the management of patients who present with self-harming behaviour. Such a policy had not been developed and staff confirmed that they knew of no such policy. ▪ No one CQC spoke with had been informed of the March 2014 incident and a further incident prior to inspection and did not know how to identify and mitigate potential risks. ▪ The investigation of the March 2014 incident concluded in July 2014 found that staff identified the patient's history of self-harm but were not trained to care for patients with such complex psychological needs. A further recommendation from the incident in March 2014 was for staff to receive training from the local mental healthcare trust regarding the care of patients who are at risk of self-harm. This had not been actioned by the time of the visit.	Significant training in Mental Health Awareness and Self-Harm undertaken. Self-harm policy reviewed and communicated. Support secured from Mental Health Trust and provided significant training in Mental Health Awareness and Self-Harm. Policy for Assessment and Management of Patients at risk of self-harm developed and communicated.	  
Outpatient appointment backlog (1.9 & 1.10) ▪ In January 2015 you identified 19000 patients for whom there was no record of them attending an outpatient appointment or for whom there was no record of the outcome of their appointment or who were overdue a follow-up appointment. This meant there was a high risk of patients not receiving treatment and/or their condition deteriorating while waiting for an appointment.	We have cleaned and re-built the PTL which included validating 58,000 records. The NHSI Intensive Support Team was invited to review our progress and our processes and have 'signed off' the Trust. All appropriate administrative staff in RTT and significant numbers of clinical staff have been trained reconciliation. We have revised and implemented our Access, Choice, and Booking	All 

▪ You did not report this as a serious incident until March 2015, following the Clinical Commissioning Group seeking assurance about incomplete patient pathway performance as part of ongoing monitoring. ▪ You set up an investigation and incident management group in March 2015 and established an outpatient improvement programme in April 2015. The outpatient improvement programme consistently failed to meet your targets for completion. ▪ Ophthalmology was the highest risk group of patients, where 2,467 were overdue appointments. By June 2015 less than a third of these 2,467 patients had appointments booked. Your response to the backlog of unreconciled patients was not progressed in a timely way to ensure patients were reviewed and their follow up appointments booked. You fell behind the planned trajectory for this work to be completed and there have been further delays from original target dates.	policy. Processes for managing outpatients and RTT have improved resulting in: • Cancelled and rebooking of patients has improved from approximately 1100 to 110 a month. • The number of booking concerns raised by patients has reduced from 132 per month to 16 per month. • There are very low rates of missing case-notes in outpatients (at or below 1%). Sustained improvement work with clinical departments has seen a continuous improvement in the number of patients without recorded outcomes or who are overdue their follow up appointment. The Trust total for overdue follow up outpatient appointments at 23rd June is 2277. Ophthalmology has reduced their follow up outpatient overdue list to 886 of which the longest wait is 9 weeks. We have renewed our contract with an external Ophthalmology provider to maintain capacity prior to the merger. We have approximately 600 outpatient outcomes a day. At 29th June our systems were showing 901 unreconciled and missing outcomes of which 114 were over 6 days and none over 10 days. Ophthalmology (including pre-op assessment) is showing that there are 190 unreconciled and missing outcomes of which 11 are over 6 days and none over 10 days.	

Section 2 of Section 29A Warning Notice **You are not ensuring the systems to assess, monitor, and improve the quality and safety of the services you provide to people attending your hospitals as inpatients and outpatients are operated effectively.**		
Trust Board receives conflicting and inaccurate evidence of assurance about the quality and safety of health care delivered. (2.1) ▪ The Quality and Safety report presented to the June 2015 trust board claimed that performance for the number of falls was "significantly improving." The data actually showed that performance was about the same performance for the same period in 2013, with the performance in May 2015 worse than the performance in June, July, August, September and October 2014. ▪ We examined the minutes of the board meeting from May 2015 where a patient's story was heard. The story related to a serious incident where a patient had fallen and had subsequently died. The minutes report, "An update was given on falls prevention and falls recorded in April 2015 had been the lowest for the last 6 months and proactive work was being undertaken." When we compared this to the falls data presented in the other reports to the same trust board meeting, it was clear this statement did not present a true picture of the falls performance and was giving false assurance to the trust board. Your Quality Account for 2014/15 confirms there was no significant improvement in falls reduction.	Escalation processes to Board clarified. Board Assurance Framework revised and processes strengthened. Operational Risk Registers totally refreshed and from June significant risks reported to Board (if not on BAF). Single Fully Integrated Performance report aligning Quality, Performance, Finance and Workforce. Consistency of information reported to Board, Quality Committee and Quality Account significantly improved.	

Concerns raised by Health Education East Midlands (HEEM) (2.2 to 2.4) ▪ HEEM visited the trust in October 2014 and identified concerns in trauma and orthopaedics, as well as for foundation second year (FY2) trainees in a number of clinical areas. These concerns included poor communication within and between departments, unclear decision making, lack of senior clinical support, poor staffing levels at night and lack of opportunities for trainees to get experience. ▪ HEEM follow up visits to both trauma and orthopaedics and FY2 trainees in February 2015 found that issues for the FY2 trainees had escalated rather than been resolved, in relation to lack of leadership out of hours in the emergency department, a disconnect between the emergency department and the rest of the hospital, inappropriate referrals from the emergency department, lack of senior review of patients particularly in the areas of Medicine, Surgery, Obstetrics and Gynaecology and Urology, difficulty with the blood test reporting IT system, poor management of out of hours rota, lack of opportunity to attend mandatory training and undermining and inappropriate behaviours. In trauma and orthopaedics there remained a lack of senior support in some cases and trainees raised concerns about inappropriate patient care in the emergency department, such as where patients had had an interventional procedure in the emergency department for fractures but had then not had an x-ray. Trainees felt that the patients were not always properly assessed and were being sent to Trauma and Orthopaedics to 'rule out' a fracture. ▪ The trust's improvement plan to the trust board in April 2015, showed improved relationships between trauma and	All HEEM related issues have been fully resolved and confirmed by HEEM. In particular: - Improved communication with T & O junior doctors and senior support improved ; - New ED & T & O pathway protocols established and improved communication and decision-making between the two; - Consent training conducted and consent audit shows high compliance with regular audits undertaken; - Improved supervision of junior doctors; - Improved support at night from Hospital at Night team; - Increased training operating lists for T & O trainees; - Improved rota management and mandatory training; - Improved blood test reporting; - Ophthalmology trainee concerns addressed; - Junior doctor forums regularly held and working well. - Lack of leadership out of hours in ED addressed; - Senior review arrangements in cardiology and urology improved;	All  

orthopaedics and the emergency department as on track for completion by a target date of 31 March 2015. However, on further visits in May 2015, HEEM found that concerns remained about the quality of referrals and behaviours from the emergency department staff; FY2 trainees also reported similar concerns about the emergency department. ▪ In May 2015 HEEM visited ophthalmology where trainees raised virtually identical issues to those raised and ongoing since October 2014 in trauma and orthopaedics. The Director of Medical Education and Deputy Director of Training and Development were unable to provide an explanation as to why the learning from experiences of trainees in trauma and orthopaedics were not considered in relation to other departments such as ophthalmology so that these risks to quality and safety could be reduced or avoided.		
Lack of progress in special measures action plan ▪ You are failing to make significant progress in improving the quality and safety of health care delivered. 18 point action plan commenced in September 2014 with initial target completion dates from October 2014 to March 2015. – Only one action had been completed by May 2015; – 8 had no revised deadline; – 9 had been put back and had revised dates in February, March and April 2015 (already passed). – 8 were rated as "progress being made or overdue." – 9 were rated as "action on track to complete in line with the completion date" which was not possible as the dates were either missing or had already passed.	QIP governance is robust and can clearly demonstrate excellent progress. 24 June position of total 287 actions; Embedded actions - 56 Embedded subject to CQC confirmation - 73 Completed/on track - 149 Off-track - 2	

Section 3 of Section 29A Warning Notice **You are not ensuring that there are proper processes to enable you to make the robust assessments required by the Fit and Proper Persons Requirement (3.1 to 3.4)**	**Warning Notice lifted following CQC Review**	
Section 31 Imposition of Conditions – Received 7th August 2015 The registered provider must ensure that there is an effective system in place to deliver effective sepsis management, in line with the relevant national clinical guidelines, so as to identify patients with sepsis, stratify sepsis risk, determine appropriate levels of care and treatment and continue to provide appropriate care and treatment for patients with sepsis. This applies to King's Mill Hospital Emergency Department, Emergency Assessment Unit and all medical and surgical adult wards; and Newark Hospital Minor Injuries Unit and Urgent Care Centre and all adult surgical and medical wards. The registered provider shall submit a report to the Care Quality Commission each week commencing on Friday 14 August 2015.	**Conditions removed by CQC on 31st May 2016**	
Section 10 – Offence to carry out a regulated activity relating to the assessment or medical treatment for persons detained under the Mental Health Act 1983 without registration – Received 29th January 2016	**Registration applied for in February 2016** **CQC review of application – 15th July 2016**	