Agenda item 10

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for May 2021

EXCELLENCE STARTS HERE

Board of Directors (in Public)
6 July 2021

Summary

- The following slides display the progress of the 2021/22 IQIP against deadlines built into the IQIP's Forward Plan and include a RAG status and narrative update by exception.
- To date, 27 (33%) of the 2021/22 IQIP actions have been approved for closure as of Month 02. It is important to note that 20 of these actions are the completed Section 31 and 29A Warning Conditions transferred from the 2019/20 IQIP which have been closed internally, but remain open with the CQC.
- In May, 4 schemes were submitted to the Evidence Assurance Group in line with agreed completion dates:
  - 1 Must Do action was approved
  - 2 Should Do action were approved
  - 1 Should Do action was declined
- 12 Actions have been moved to At Risk and are currently RAG rated as Amber. These include 5 Radiology actions and 4 existing Must and Should Do actions. 1, 29A Warning Condition for Palliative Care Consultant Cover which incorporates 1 Must and 1 Should do action, have also moved to At Risk, as to date no applications have been received for this post. Mitigating actions are in place with support from NCHC.
- Following the findings of the Radiology Culture Assessment, a Radiology Improvement Plan incorporating the 5 'At Risk' actions, is being finalised with key milestones which will be monitored at the Quality Forum monthly from July.
- 1 Action has been moved to Behind Plan and RAG rated as Red following review at the May EAG.
- All At Risk and Behind Plan actions have clear recovery actions and or resubmission dates.
- Work continues with the Divisions to collate all required evidence to support the Trust's formal application to the CQC to request the lifting of all remaining 7, Section 31 Conditions in June 2021.
- Following the expansion of the EAG format to provide robust challenge and assurance against other material action plans in January 2021, the group continues to review Serious Incident Action Plans, to gain assurance and evidence of completion of all individual actions.
- The Monthly Clinical Review Programme continued in May with a visit to Same Day Emergency Care, Castleacre, Central Delivery Suite, Radiology, Shouldham Ward and West Newton Ward. This report details the high-level findings of these visits and next steps.

The Board of Directors is asked to note:

- Progress at Month 02
- 12 actions RAG rated as 'At Risk' with mitigation and recovery actions
- 1 action RAG which has moved to 'Behind Plan' with recovery actions and resubmission date
- The key findings from the May Clinical Review Visit
- Collation of evidence to support the Trust's application to request the lifting of the remaining S31 Conditions

Overall Programme Update

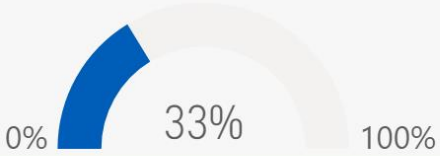
The new reporting numbers reflect 83 actions captured within the new 2021/22 IQIP with 56 open actions covering Conditions, Must and Should Do actions and structured accordingly

Status	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**5**	**13**	**7**	**2**	**27**
Clinical Support Services		1	2		**3**
Corporate	2			1	**3**
Medicine	2	2	2		**6**
Women & Children	1	10	3	1	**15**
Not Completed	**16**	**3**		**37**	**56**
Clinical Support Services	2			3	**5**
Corporate	11	3		25	**39**
Medicine	3			3	**6**
Surgery				3	**3**
Women & Children				3	**3**
Total	**21**	**16**	**7**	**39**	**83**

Overall Programme Status

Overall

Performance of Total



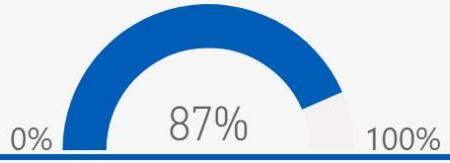
27
Total Complete

83
Total Planned

- Of the 83 total planned actions within the new IQIP, 20 are the completed CQC Conditions
- Three further conditions were approved in May with one Should Do action being declined, moving this action to 'Behind Plan'.
- The Fortnightly IQIP Monitoring meetings continue to track progress, escalate concerns relating to risks to delivery and where required, agree recovery actions.

CQC Conditions & Notices

Performance of Total



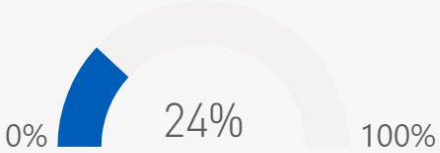
20
Total Complete

23
Total Planned

- 20 completed actions have been included within the 2021/22 IQIP, while they remain open with the CQC
- The three remaining open actions are 29A Warning Conditions.
- 1, 29A Warning Notice relating to Palliative Care Consultant cover has been moved to 'At Risk' and RAG rated Amber as the Trust has been unsuccessful in recruiting into post.

Must's

Performance of Total



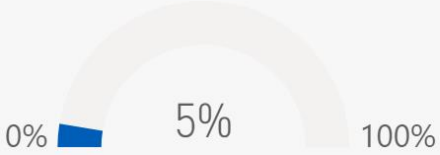
5
Total Complete

21
Total Planned

- One Must Do action relating to anaesthetics PROMPT Training compliance was approved for closure in May.
- The remaining 16 open actions continue to be reviewed at the fortnightly IQIP monitoring meetings to track progress, escalate concerns relating to risks to delivery and where required, agree recovery actions.

Should's

Performance of Total



2
Total Complete

39
Total Planned

- 2 Should Do actions relating to appropriate staffing levels and Midwifery Representation at CTG Meetings were approved at Mays Evidence Assurance Group for closure.
- The Should Do action relating to the development of a formalised strategy and vision within Surgery was declined. This is now 'Behind Plan' and RAG rated red. Recovery actions and resubmission date have been agreed with the Divisional Leadership Team for Surgery

Reporting Month (as at end)

May 2021

Forward plan for completion of actions

This table details a breakdown of all 83 actions within the IQIP which are included within the Forward Plan. There is a concentration of actions due for completion in September, so an additional Evidence Assurance Group (EAG) has been booked for 30th September to ensure sufficient time for all actions to be reviewed. The Trust Wide Fortnightly IQIP Review meeting monitors progress against agreed trajectories, escalates risks to delivery and agree recovery actions where required.

Main - Area	Completed & Signed off	Behind Plan	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Total
Clinical Support Services	**3**					**2**			**3**						**8**
Must									2						**2**
Section 29	1														**1**
Section 31	2														**2**
Should						2			1						**3**
Corporate	**3**		**2**	**5**	**1**	**16**	**6**	**4**		**3**			**2**		**42**
Must	2		1	2	1	4		2		1					**13**
Section 29				1		1				1					**3**
Should	1		1	2		11	6	2		1			2		**26**
Medicine	**6**		**2**			**2**	**2**								**12**
Must	2		1			1	1								**5**
Section 29	2														**2**
Section 31	2														**2**
Should			1			1	1								**3**
Surgery		**1**				**2**									**3**
Should		1				2									**3**
Women & Children	**15**			**1**			**1**		**1**						**18**
Must	1														**1**
Section 29	10														**10**
Section 31	3														**3**
Should	1			1			1		1						**4**
Total	**27**	**1**	**4**	**6**	**1**	**22**	**9**	**4**	**4**	**3**			**2**		**83**

Actions approved at the Evidence Assurance Group in May 2021

ID Ref	Main	Category	Description	Owner	Due	
008	Urgent & Emergency	Should	The service should ensure that staffing levels are maintained to ensure patients safety.	Chief Nurse	31/05/2021	24 May 2021
056	Maternity	Must	The trust must ensure that anaesthetists complete PROMPT (Practical Obstetric Multi- Professional Training) training.	DLT W&C	31/05/2021	10 June 2021
067	Maternity	Should	The service should ensure that there is midwifery representation at the Cardiotocography (CTG) meetings.	DLT W&C	31/05/2021	10 June 2021

Actions declined at the Evidence Assurance Group in May 2021

ID Ref	Main	Category	Description	Owner	Due	RAG
060	Surgery	Should	The service should develop and implement a clear vision and strategy.	DLT Surgery	31/05/2021	

The above action has been moved to 'Behind Plan'

060 – Vision and Strategy

This action was declined as the strategy needs final approval and a clear implementation plan, both of which have been delayed. The action was therefore moved to Behind Plan. The Division have been provided with guidance and support on the additional information required by the EAG. It was agreed with the DLT for Surgery that this action will be re-presented to the EAG in **September 2021,** allowing the Division time to launch their strategy and provide evidence of implementation, staff engagement and early testing of staff's awareness of the strategy.

RAG rated programme position as of May 2021

The following sets out the overall programme position.

- 1 Should Do action was declined for closure at the May Evidence Assurance Group. This action is now rated as 'Behind Plan' and recovery actions and a new submission date have been agreed
- The total number of Amber 'At Risk' actions has increased to 12. This includes the 5 Radiology actions moved to 'At Risk' in April and the 4 existing actions presented at the April Quality Committee. The 29A Warning Condition for Palliative Care Consultant Cover, which also incorporates 1 Must and 1 Should do action, has been moved to 'At Risk' following unsuccessful recruitment.

Main - Area	At Risk	Behind Plan	On Plan	Total
Clinical Support Services	**5**			**5**
Must	2			2
Should	3			3
Corporate	**5**		**34**	**39**
Must	3		8	11
Section 29	1		2	3
Should	1		24	25
Medicine	**1**		**5**	**6**
Must	1		2	3
Should			3	3
Surgery		**1**	**2**	**3**
Should		1	2	3
Women & Children	**1**		**2**	**3**
Should	1		2	3
Total	**12**	**1**	**43**	**56**

RED	Behind Plan
AMBER	At Risk
GREEN	On Track

Actions At Risk at the end of May 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
001	Corporate	Must	The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff.	Director of Patient Safety	30/09/2021	A
004	Corporate	29A Warning Notice Must / Should	There was a lack of palliative care consultant staffing compounded by a lack of ownership for end of life care by each speciality throughout the trust.	Medical Director	31/07/2021	A
051	Medicine	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	30/06/2021	A
065	Women & Children	Should	The service should ensure that there are enough maternity staff with the right qualifications, skills, training and experience to provide the service.	DLT Women & Children	31/10/2021	A

Narrative:

001 Learning from Incidents

- Progress has been made across the organisation to establish robust arrangements, both corporately and within the divisions, to share learning from incidents and audits, but there is inconsistent evidence of learning from complaints which has been impacted further by COVID. Under the Executive Lead of the Chief Nurse (CN), arrangements are in place which will incorporate the capture and sharing of learning. The 4 Divisional Leadership Teams have been asked to strengthened plans to ensure learning is effectively and consistently shared. This work will also be monitored through the Patient Experience and Carer Group Chaired by the CN.

004 Palliative Care Consultant Cover

- Following review of progress at the Trustwide Divisional fortnightly meetings it was agreed to move this action to 'At Risk'. The Trust has been unsuccessful in recruiting into the two Palliative Care Consultant posts (post advertised on NHS Jobs and BMJ). Mitigating actions are in place with support from NCHC and discussions on the potential of an alternative grade or Nurse Consultant role are in progress. This action also incorporates 1 x Must Do and 1 x Should Do Action.

051 Fluid Balance Charts

- An enormous amount of work has been undertaken to gain assurance of improvements in completing fluid balance charts. A training video has been made and placed on the Intranet. Perfect Ward questions have been reviewed and changed. New fluid balance charts have been trialled across some wards, these have been updated after each trial period following feedback from staff. The final chart has been passed at the R&R Forum, but is awaiting final review by the MDT documentation panel.

065 Staffing

- Diverse and robust recruitment plans addressing both short term and longer-term workforce needs in Maternity are in place and progressing well. System wide plans are also developing a blended learning approach to support all staff moving into CoC teams and are currently undertaking a training needs analysis. This is supported by a robust competency framework for newly qualified Band 5 Midwives moving into Band 6 roles and work is progressing to develop a similar framework for Band 6 Midwives moving into senior Midwifery roles. RAG rating discussion held with the Division and consideration given to move this action to Green. In view of the historical challenges with recruitment the decision was taken to keep this 'At Risk' and review progress against the plan again in July.

Actions At Risk at the end of May 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
003	Corporate	Must	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance.	Director of Patient Safety	30/06/2021	A

003 Duty of Candour

Significant improvements have been made in relation to Duty of Candour (DoC), including the accuracy of data. Although 3 Divisions demonstrated sustained improvement and compliance against this standard, the Division of Medicine were unable to consistently demonstrate compliance, thus delaying submission to EAG for closure. However, the recovery actions are demonstrating sustained improvement against this standard. Recovery actions include the substantive appointment of a Divisional Risk & Governance Manager who is responsible for ensuring Phase 1 and 2 DoC is monitored and completed, alongside notifications from the Patient Safety Team on Day 5 and Day 8 of the 10 day standard where DoC s still required. The Medical Director will also meet with any Consultant who fails to complete DoC.

Whilst this action is due to be presented to the EAG in June it has been agreed with the DLT for Medicine to delay submission by 2 months to August. This will allow evidence demonstrating improved performance has been sustained. This action will therefore move to a RAG status of Red 'Behind Plan' for the July report, but close monitoring and recovery actions will remain in place.

Month Fin Year 2019/20	+/- Incidents in Month	PH1 completed	PH1 Count completed with 10 WD's	PH1 % completed with 10 WD's	PH2 Required	PH2 completed	PH2 count completed with 10 WD's	PH2 % completed with 10 WD's
February	12	12	12	100%	9	9	7	78 %
March	29	28	28	97%	20	20	18	90 %
April	13	13	13	**100%**	13	13	9	**69%**
May	17	16	15	**88%**	11	11	11	**100%**

Medicine Only	Total Phase 1 Due	Phase 1 How many completed	How many completed within 10 WD's	Phase 1 10 WD compliance	Total of Phase 2 Due	Phase 2 How many completed	How many completed within 10 WD's	Phase 2 10 WD compliance
February	4	4	4	100 %	3	3	1	33 %
March	8	7	7	88 %	6	6	4	67 %
April	4	4	4	100 %	4	4	0	0 %
May	9	8	7	78%	4	4	4	100%

Actions At Risk at the end of May 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
057	Diagnostic Imaging	Must	The trust must ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.	DLT Clinical Support Services	31/12/2021	A
058	Diagnostic Imaging	Must	The trust must be assured that the out of hours staffing arrangement is sustainable and robust to provide safe care and treatment to patients.	DLT Clinical Support Services	31/12/2021	A
068	Diagnostic Imaging	Should	The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.	DLT Clinical Support Services	31/12/2021	A
069	Diagnostic Imaging	Should	The trust should continue to embed the governance and risk management processes.	DLT Clinical Support Services	30/09/2021	A
070	Diagnostic Imaging	Should	The trust should develop a formalised vision and strategy in radiology.	DLT Clinical Support Services	30/09/2021	A

Clinical Support Services Actions - Radiology – 057, 058, 068, 069 and 070

Following the findings of the Radiology Culture Assessment and discussion at the Quality Forum in May the decision was taken to change the RAG status of all 5 IQIP actions within Radiology to 'At Risk'.

A Radiology Improvement Plan incorporating the 5 'At Risk' actions, is being finalised and will be monitored at the Quality Forum monthly from July and shared with the Quality Committee for Assurance. Completed actions from the Improvement Plan will mirror the IQIP process and evidence will be submitted to the Evidence Assurance Group for approval.

The Radiology Improvement Plan will include a clear set of actions:

- Stabilising Radiology, improving the culture and making significant changes to the leadership structure of the department
- Improving communication about and engagement in the implementation of the new RIS/PACs
- Simplifying rostering arrangements
- Proactively addressing issues of long-term sickness, bullying, nepotism and introduce a pledge of fairness and equity
- Ongoing engagement with the team

Actions to be submitted to the Evidence Assurance Group in June 2021

ID Ref	Service	Category	Action Description	Owner	End Date	EAG Date	RAG Status
005	Corporate	Should	The service should ensure that staff take appropriate action for patient safety alerts	Director of Patient Safety	June 2021	22/06/2021	G
051	Medicine	Must	The trust must ensure that fluid balance charts are properly completed	Deputy Chief Nurse	June 2021	22/06/2021	A
063	Medicine	Should	The trust should ensure staff complete appropriate resuscitation equipment check	DLT Medicine	June 2021	22/06/2021	G

Whilst 4 actions are due to be submitted to the Evidence Assurance Group in June 2021 in line with the forward planner, only 3 actions will be presented following agreement at the Trust Wide Fortnightly IQIP meeting to delay action 003 relating to Duty of Candour until August 2021.

Remaining 7 Section 31 CQC Conditions

- With all Section 31 conditions closed internally with ongoing evidence of compliance and improvement, the Trust is finalising its CQC application to request the lifting of the seven remaining conditions.

Urgent & Emergency Care			
037	Medicine	The registered provider must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line with relevant national clinical guidelines within 15 minutes of arrival. The registered provider must ensure that the staff required to implement the system are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.	B
038	Medicine	The registered provider must ensure that clear inclusion and exclusion criteria is in place for the 'fit to sit' area in minors. The registered provider must ensure that there are sufficient numbers of staff available to monitor and review patients who have been placed in the 'fit to sit' area.	B
Maternity & Midwifery Services			
040	Women & Children	The Registered Provider will ensure that there is appropriate escalation of deteriorating patients in line with current guidelines and best practice with full medical handover at 9am and 7pm, with ward rounds at 12.30pm and 5pm.	B
041	Women & Children	The Registered Provider must ensure that a senior daily clinical review is undertaken for every birth in the unit.	B
042	Women & Children	The Registered Provider must ensure there is executive director oversight and a system of monitoring and recording to ensure that senior clinical review is in place.	B
Diagnostic Imaging			
048	Clinical Support Services	The registered provider must ensure that an effective system is in place for the regular oversight of the appropriate escalation of significant findings. This should include diagnostic imaging undertaken out of hours to ensure that any patients at risk are escalated appropriately.	B
049	Clinical Support Services	The registered provider must ensure that there is robust system in place to facilitate effective clinical governance within the diagnostic imaging department. This is to include oversight of training, compliance to scope of practice, learning from incidents and escalation processes. The registered provider must ensure that there is a systematic approach to audit to measure compliance with protocols, processes and professional standards. The registered provider must ensure that there are processes in place for effective communication within the diagnostic imaging department.	B

Clinical Review Programme: Assurance Actions Sustained and Embedded

It is recognised that whilst the Evidence Assurance Group provides robust check and challenge, it is essential the Trust has a mechanism to ensure improvements are sustained and embedded.

Clinical reviews were introduced in 2019, but paused during both the first and second wave of COVID-19. Following a pause of 5 months, the Clinical Reviews were recommended in March 2020. These are being 'scaled up' each month as the Trust moves into its Recovery and Restoration from COVID phase and once again include external stakeholders.

Key Lines of Enquiry (KLOE) informed by the IQIP and broader quality metrics direct the reviews and help monitor the impact of improvements on quality of care including patient and staff experience.

Clinical Review 28th May 2021

A team of 11 clinical and non-clinical staff were involved in this review, including senior nurses and members of the Patient Safety Directorate, as well as participation from external stakeholders including QEH Governors and a representative from the Norfolk and Waveney CCG. The review was limited to 6 wards, and included a look back team which revisited the areas from Aprils review.

In view of the significant pressures on staff as a result of COVID and an increase in the number of complaints over the past few months, the KLOE focused on patient and staff experience whilst drawing on broader findings through the use of the '15 Steps' methodology.

The aim of the review is to capture areas of good and excellent practice and innovation that staff should feel proud of and in turn encouraged to tell their 'improvement story'. Any areas of immediate risk identified are addressed accordingly and areas for improvement addressed through ward/department action plans.

Ambulatory Emergency Care / Same Day Emergency Care, Castleacre , Central Delivery Suite, Radiology Department, Shouldham Ward, West Newton Ward and 'Look Back' were all visited as part of this review.

Areas of Good Practice:

- Five of the six ward areas were welcoming and accommodating on arrival. Almost all staff were engaged, enthusiastic and happy to speak to the review team
- Observed positive interactions between staff and patients
- Patient care was good, caring and compassionate - Very positive feedback from patients on three of the wards visited
- Evidence of safe medicines management – robust processes
- Majority of areas were clean and tidy – I am clean stickers up-to-date
- Staff felt cared for, included, supported and encouraged to innovate on most areas
- Staff in particular noted how well the team have gelled together, especially as the team is relatively new and staff were pulled from different areas
- Majority of patient notes were well documented with risk assessments complete
- Overall compliance with infection prevention control standards and personal protective equipment standards were good

Areas for Improvement:

- On three wards the review team observed that not all patients were wearing face masks – This will followed up as part of a combined action, appreciating some patients are unable to wear or tolerate these
- **AEC / SDEC -** The review team did identify one day when the resus trolley had not been checked but the team were aware. The team explained how the member of staff who typically completes this check was on annual leave; therefore the review team suggested that going forward this check should not be person dependent.
- **Castleacre & CDS -** The review team felt that sharing of information could be improved – staff on both areas were unable to talk about complaints and incidents.
- **Radiology -** Through conversations with staff it was apparent morale is low. Staff expressed concerns regarding staffing and management although they also highlighted this is beginning to improve.
- **Shouldham –** There was a lack of storage on the ward with one bathroom being used to store equipment
- **West Newton -** Documentation was inconsistent particularly for Pain Assessments, Bed Rail Assessments and Stool Charts

Clinical Review Actions and Next Steps

Feedback:

- High level verbal feedback was provided to the Nurse in Charge / Department Manager on the day of the review
- Written report detailing findings was sent to each ward, Matron, Ward Manager and Divisional Leadership Team within 48hrs.

Actions:

- Any immediate concerns were addressed by the individual review teams during the visit
- Deputy Chief Nurse attended the feedback session and will action the more generic themes regarding the Quality Metrics Board and IPC concerns regarding very few in-patients wearing masks.
- Each area is required to share findings with their team and action areas for improvement within localised plans.
- Findings to be shared at the Patient and Carer Experience Forum
- Broader findings form Key Messages and shared through wider Trust communication channels supported by the Communications Team
- Findings will continue to inform IQIP actions where relevant