Agenda item 10

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for April 2021

EXCELLENCE STARTS HERE

Board of Directors (Public)

1 June 2021

Summary

- The following slides display the progress against the 83 actions within the 2021/22 IQIP with all deadlines built into the IQIP's Forward Plan and include a RAG status and narrative update by exception.

- 24 (29%) of the 2021/22 IQIP actions have been approved for closure as of Month 01. There are no actions behind plan.

- The number of actions RAG rated at Amber – At Risk has increased from 4 to 9 following a discussion of the Radiology Culture Assessment findings at the Quality Forum in May. In view of the nature of these findings and their potential impact on the current Radiology improvement actions within the IQIP. These actions will be included in the Radiology Improvement Plan.

- Seven, Section 31 conditions remain on the Trust's certificate of registration. It is proposed an application to remove these remaining conditions is made to the CQC around June 2021 in preparation for the Trust's Well-Led inspection.

- Three conditions remain open on the IQIP. These are 29A Warning Notice conditions and relate to Documentation, MCA and DoLS and Palliative Care Consultant Cover, plan work continues against the improvement actions.

- The Monthly Clinical Review Programme continued in April with an evening visit to Emergency Department, Denver, Elm/SAU, Necton, and Stanhoe. A general 'Site' inspection was also undertaken. Overall assessments were very positive, with the high-level findings captured within this report.

- Further assurance of the Trust's sustained improvement has been noted as part of three external visits over the past 2 weeks. Extremely positive feedback was received as part of the IP&C Peer Review Follow-Up visit on 13 May by NHSE/I & N&W CCG, noting 'sustained excellent IP&C standards' with clear ownership of IP&C by staff.

- A visit by Sue Holden, National Director for Intensive Support & Peter Cutler Improvement Director also noted a significant change in confidence and engagement, with teams sharing their learning. Similar feedback was shared by Ed Garratt; Chief Executive NHS Ipswich & East Suffolk CCG, North East Essex CCG, West Suffolk CCG who was extremely positive about the organisation, its leadership, cultural change and engagement of staff.

- This external feedback provides a further level of assurance of sustained improvement, alongside the assurances of the Trust's Quality Improvement Programme.

- **The Board of Directors is asked to note:**

- 2021/22 IQIP Progress at Month 01
- The decision to move the 5 Radiology actions to Amber
- The recommendation to submit an application to request the lifting of all remaining 7, Section 31 Conditions in early June 2021
- The key findings from the Clinical Review visit completed during April and the positive feedback from three external visits

Overall Programme Structure – 2021/22 IQIP

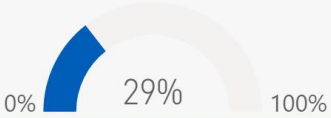
- The total count of 2021/22 IQIP actions has reduced from 93 to 83 following the official removal of 10 Section 31 Conditions with seven Section 31 Conditions remaining on the Trust Certificate of Registration.

Status	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**4**	**13**	**7**		**24**
Clinical Support Services		1	2		**3**
Corporate	2				**2**
Medicine	2	2	2		**6**
Women & Children		10	3		**13**
Not Completed	**17**	**3**		**39**	**59**
Clinical Support Services	2			3	**5**
Corporate	11	3		26	**40**
Medicine	3			3	**6**
Surgery				3	**3**
Women & Children	1			4	**5**
Total	**21**	**16**	**7**	**39**	**83**

Overall Programme Status

Overall

Performance of Total



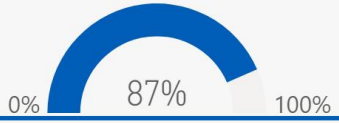
24
Total Complete

83
Total Planned

- Of the 83 total planned actions within the new IQIP, 20 are the completed CQC Conditions
- With new POAP and completion deadlines there are no plans overdue and 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



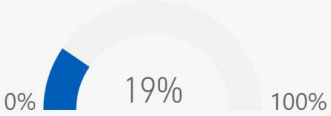
20
Total Complete

23
Total Planned

- 20 completed actions have been included with the 2021/22 IQIP, while they remain open with the CQC
- The three actions which remain open are 29A Warning Conditions. All 3 POAP's have been strengthened and now form cross-divisional actions to ensure improvements are consistent across all divisions.
- Following formal notification of the lifting of 10 Section 31 Conditions these have been removed from the overall count taking the total number down to 23.

Must's

Performance of Total



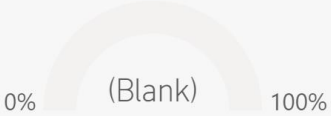
4
Total Complete

21
Total Planned

- 1 Must Do action was declined for closure at the April Evidence Assurance Group as there is a need to validate the presented data. This action is not due until December 2021, therefore the panel will review this action in August 2021 to review milestones, metrics and targets.
- The 17 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



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Total Complete

39
Total Planned

- There were no Should Do actions due for closure in March
- The 39 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.

Reporting Month (as at end)

April 2021

Forward Plan for 2021/22 IQIP

- 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 fortnightly IQIP meeting continue to monitor progress against agreed trajectories, escalate risks to delivery and agree recovery actions where required.

Main - Area	Completed & Signed off	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 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	**2**	**1**	**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	**13**	**2**		**1**			**1**		**1**					**18**
Must		1												**1**
Section 29	10													**10**
Section 31	3													**3**
Should		1		1			1		1					**4**
Total	**24**	**4**	**4**	**6**	**1**	**22**	**9**	**4**	**4**	**3**			**2**	**83**

Actions declined at the Evidence Assurance Group in April 2021

ID Ref	Service	Category	Action Description	Owner	End Date	EAG Date	RAG Status
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	23/03/2021	A

068 - Access to Service

This action was declined in April as the panel requested internal trajectories for timely assessments in diagnostic imaging. There was also a need to validate the presented data.

Whilst this action was declined by EAG in April, the Radiology Culture Assessment findings have since been shared with the Executive Team and Radiology Department. In view of the nature of these findings a further discussion was held at the Quality Forum in May to consider their impact on the current Radiology improvement actions within the IQIP. Following consideration of these findings the decision was taken to change the RAG status of all five Radiology actions from Green to Amber and to include these and associated recovery actions into the Radiology Improvement Plan. This plan is currently being developed with the team and led by the Chief Operating Officer.

RAG rated programme as of April 2021

- The following sets out the overall programme position.

Main - Area	At Risk	On Plan	Total
Clinical Support Services	**5**		**5**
Must	2		**2**
Should	3		**3**
Corporate	**2**	**38**	**40**
Must	2	9	**11**
Section 29		3	**3**
Should		26	**26**
Medicine		**6**	**6**
Must		3	**3**
Should		3	**3**
Surgery		**3**	**3**
Should		3	**3**
Women & Children	**2**	**3**	**5**
Must	1		**1**
Should	1	3	**4**
Total	**9**	**50**	**59**

Following review of the Radiology Culture Assessment findings the total number of Amber - At Risk actions has increased to 9, to include all 5 Radiology actions

RED	Behind Plan
AMBER	At Risk
GREEN	On Track

Actions At Risk at the End of April 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
056	Women & Children	Must	The trust must ensure that anaesthetists complete PROMPT (Practical Obstetric Multi- Professional Training) training.	DLT Women & Children	31/05/2021	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

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, arrangements are in place which will incorporate the capture and sharing of learning. Following discussion at the Quality Forum, the 4 Divisional Leadership Teams have been asked to strengthened plans to ensure learning is effectively and consistently shared.

056 PROMPT

Training has been held and an MDT training group meeting has also taken place with Anaesthetic representation. The Anaesthetic College Tutor is working to ensure junior attendance on PROMPT. Whilst training compliance has improved from 61% in March to 74% April, further recovery actions with the Divisional Director of Surgery were agreed at the Quality Forum in May to ensure the compliance PROMPT training target will be achieved by the end of May 2021. Compliance as of 20 May is 81% with 3 Anaesthetists due to attend training on 21 May 2021. This will improve compliance further to 92%.

065 Staffing

A Working group across the system will explore the recruitment of oversees midwives. First meeting held on 2 May 2021 to discuss recruitment of Midwives from Hong Kong. Work commenced with the Junior Health and Care Academy to inspire young people in our region to follow a career in Nursing and Midwifery. System wide plans are developing a blended learning approach to support all staff moving into CoC teams and are currently undertaking a training needs analysis . There is currently a robust competency framework for newly qualified Band 5 Midwives moving into Band 6 roles, with plans underway to develop a similar framework for Band 6 Midwives moving into Senior Midwifery roles.

Actions At Risk at the End of April 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, including the accuracy of data. 3 Divisions have demonstrated improvement and compliance as evidenced at the EAG in January. However, the Division of Medicine has not achieved compliance. Further discussion was held at the Quality Forum in May. The Division of Medicine have recovery actions in place which include the substantive appointment of a Risk & Governance Manager who will be responsible for ensuring Phase 2 DOC is monitored and completed by 10 days. The Medical Director has confirmed she will also now be meeting with any Consultant who fails to complete DOC.

Actions At Risk at the End of April 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 – 057, 058, 068, 069 and 070

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

A Radiology Improvement Plan which will also incorporate these open actions, is being developed with key milestones and will be monitored at the Quality Forum monthly from June and to the Quality Committee for Assurance. Completed actions from the Improvement Plan will mirror the IQIP process and be submitted to the Trust Wide 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 May 2021

ID Ref	Service	Category	Action Description	Owner	End Date	EAG Date	RAG Status
008	Corporate	Should	The service should ensure that staffing levels are maintained to ensure patients safety.	Chief Nurse	31/05/2021	25/05/2021	G
056	Women & Children	Must	The trust must ensure that anaesthetists complete PROMPT (Practical Obstetric Multi- Professional Training) training.	DLT Women & Children	31/05/2021	25/05/2021	A
060	Surgery	Should	The service should develop and implement a clear vision and strategy.	DLT Surgery	31/05/2021	25/05/2021	G
067	Women & Children	Should	The service should ensure that there is midwifery representation at the Cardiotocography (CTG) meetings.	DLT Women & Children	31/05/2021	25/05/2021	G

Remaining 7 Section 31 CQC Conditions

- With all Section 31 conditions closed internally with ongoing evidence of compliance and improvement, it is proposed an application to remove these remaining conditions is made to the CQC around June 2021.
- These condition are listed below:

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 are 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 recommended in March 2020. These are being 'scaled up' each month as the Trust moves into its Recovery and Restoration phase and will include external stakeholders from May 2020.

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 April 2021

A team of 11 clinical and non-clinical staff were involved in this review, including senior nurses, clinical educators, The review was limited to 5 wards, and included a general review of the site and involved QEH staff only.

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 must be acted on accordingly and areas for improvement must be addressed through ward/department action plans.

Accident and Emergency, Denver Ward, Elm Ward including Surgical Assessment Unit, Necton Ward, Stanhoe Ward and Site were all visited as part of this review.

The next Clinical Review is planned for Friday 28th May which will include External Stakeholders and Governors.

Clinical Review Programme: High-Level Findings

Areas of Good Practice:

- Four of the five ward areas were welcoming and accommodating on arrival. The site review found the Main Entrance to be calm, clean and spacious at the time of the review
- Almost all staff were engaged, enthusiastic and happy to speak to the review team
- Observed positive interactions between staff and patients
- Very positive feedback from patients on three of the wards visited
- Sensitive and compassionate care and interactions observed
- 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
- Some staff reported they feel like they are coming together as a 'Team' following changes due to COVID-19, but this has been challenging
- Majority of patient notes were well documented with risk assessments complete
- Good evidence of Bed Rails assessment on Stanhoe following a recent serious incident
- 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 despite not eating or drinking – This will followed up as part of a combined action
- Whilst some improvements were noted on Necton following the Clinical Review findings in March, there is a need for continued intense support
- On both Elm Ward and Denver Ward patients often expressed how the ward was especially noisy at night and that often call bells / telephone calls are ringing for long periods of time
- Quality Indicator Boards were out of date – this was identified across all wards reviewed
- During the site review a lack of storage facilities was evident with bed frames and wheelchairs scattered across numerous corridors and streets - this is particularly noted along the back corridor by the kitchens - this was escalated following the review

Clinical Review Actions

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:

- 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.
- The Quality Improvement Lead was involved in the review and will be addressing areas for improvement in-between monthly reviews
- Each area has been asked 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 will form Key Messages and will be shared through wider Trust communication channels supported by the Communications Team
- Findings will continue to inform IQIP actions where relevant
- ‘Look Back Team’ to be incorporated in all clinical reviews going forwards