The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

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| **Meeting:** | Board of Directors (in Public) | | |
| **Meeting Date:** | 5 April 2022 | **Agenda item:** | 11 |
| **Report Title:** | Compliance Plan and Governance Arrangements | | |
| **Author:** | Louise Notley - Director of Patient Safety | | |
| **Executive Sponsor:** | Caroline Shaw - Chief Executive Officer | | |

**Implications**

**Link to key strategic objectives**
*[highlight which KSO(s) this recommendation aims to support]*

| KSO1 | KSO2 | KSO3 | KSO4 | KSO5 | KSO6 |
|---|---|---|---|---|---|
| ***Safe and compassionate care*** | ***Modernise hospital and estate*** | *Staff engagement* | *Partnership working, clinical and financial sustainability* | *Healthy lives staff and patients* | *Investing in our staff* |

| | | |
|---|---|---|
| **Board assurance framework** | KS01.<br>KSO2. | |
| **Significant risk register** | 2592, 2643, 2244, 2915, 2199, 2757, 392, 2989, 2849, 2853 | |
| | Y/N | If Yes state impact/ implications and mitigation |
| **Quality** | Y | Risks in relation to the quality of care that patient's receive, as well as the quality of patient experience, are aligned to KSO 1. |
| **Legal and regulatory** | Y | Risks in relation to potential legal and regulatory action faced by the Trust (particularly in relation to CQC enforcement notices) are aligned to KSO 1. |
| **Financial** | N | None identified |

**Assurance route**

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|---|---|
| **Previously considered by:** | CELM on 14/03/2022<br>Quality Forum Members (outside of the standard meeting in view of CQC submission deadline)<br>Quality Committee on 29/03/22 |

**Executive summary**

| **Action required:** *[highlight **one** only]* | **Approval** | Information | Discussion | Assurance | Review |
|---|---|---|---|---|---|

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|---|---|
| **Purpose of the report:** | The purpose of this report is to inform the Board of Directors:<br>• The transition of the Trust's current Integrated Quality Improvement Plan (IQIP) to a Compliance Plan (CP), following the CQC Inspection Report published in February 2022. |
| **Summary of Key issues:** | Following publication of the CQC Inspection findings, this report details the arrangements in place for the IQIP to now evolve into 5 key Quality Improvement Plans supported by a Compliance Plan. This Compliance Plan will ensure all the Open Must and should Do actions from the 2021/22 IQIP and the 13 new Must and Should Do actions from the latest CQC report are monitored and delivered during 2022/23. |
| **Recommendations** | The Board of Directors is asked to:<br>a) Approve the 2022/23 Compliance Plan and its submission to the CQC<br>b) Approve the new Quality Improvement Governance structure and assurance arrangements<br>c) Note the Exit Recovery Support Programme meeting scheduled for 25 April 2022 |
| **Acronyms** | CQC – Care Quality Commission<br>EAG – Evidence Assurance Group<br>IQIP – Integrated Quality Improvement Plan<br>CAR – Chairs Assurance Report |

**Background and Context**

The Trust's Integrated Quality Improvement Plan (IQIP) was developed in response to the Care Quality Commission's (CQC) 2019 inspection report, which raised significant concerns about the quality and safety of care across a number of core services at the Queen Elizabeth Hospital and the Trust's failure to address key safety issues, since being placed in Special Measure in 2018.

A robust governance and assurance framework was developed to support the monitoring and reporting of progress against the IQIP in 2019 and has continued to provide significant assurance and accuracy of progress to the Trust Board, sub-committees and key external stakeholders ever since.

With evidence of sustained improvement since 2019, the CQC recently published the findings of its unannounced core service inspection in December 2021 and Well-Led Inspection in January 2022. The report details significant improvement in the core services inspected and Well-Led ratings and confirms the CQC's recommendation to remove the Trust from the Recovery Support Programme (previously Special Measures). In turn, the Trust has only been issued with 4 Must and 9 Should Do actions and no Section or Warning Notice Conditions. This is in stark comparison to the 2019 report, where the Trust was issued 206 Must & Should Do actions and 43 Section and Warning Notice Conditions.

**Compliance Plan (See Appendix 1)**

The latest CQC report reflects how the organisation's leadership has strengthened and matured over the past 2 years in conjunction with robust governance and assurance processes, supporting long-term improvement. It is therefore important the IQIP now evolves, moving Must and Should Do's actions into a single Compliance Plan aligned to the 2022/23 Trust priorities and key Quality Improvement Plans. This will allow the organisation to build on the improvements of the past 2 years and inform its own 'journey of improvement', underpinned by leadership and culture programmes, transformation, quality improvement, and compliance.

In turn, the success of the IQIP governance framework has started to influence reporting arrangements for broader Trust Quality Improvement Plans. It is important therefore to now apply this tested governance framework to key Trust Quality Improvement Plans, to ensure a structured and standardised approach is applied with clear reporting through to the Trust Board.

The IQIP will therefore evolve and becomes a Compliance Plan, incorporating the remaining 'open' Must and Should Do actions from the 2021/22 IQIP with the 13 new Must and Should Do actions from the latest CQC Report. The Compliance Plan will be aligned to all five Trust Quality Improvement Plans with clear reporting through to the Trust Board.

The Compliance Plan will follow the same format as the IQIP to ensure the reporting style and transparency of progress continues. All actions have been aligned to the relevant Trust Strategic Objectives and include completion dates agreed with action owners. In turn, all actions will be supported by detailed Plans on a Page, or directly

linked to one of the five Trust Quality Improvement Plans. These links are clearly identifiable within the Compliance Plan to support transparency of monitoring whilst avoiding duplication.

The Compliance Plan will be aligned to the five key Trust Quality Improvement Plans and follow a standardised reporting arrangement as detailed below.

**Trust Quality Improvement Plans:**

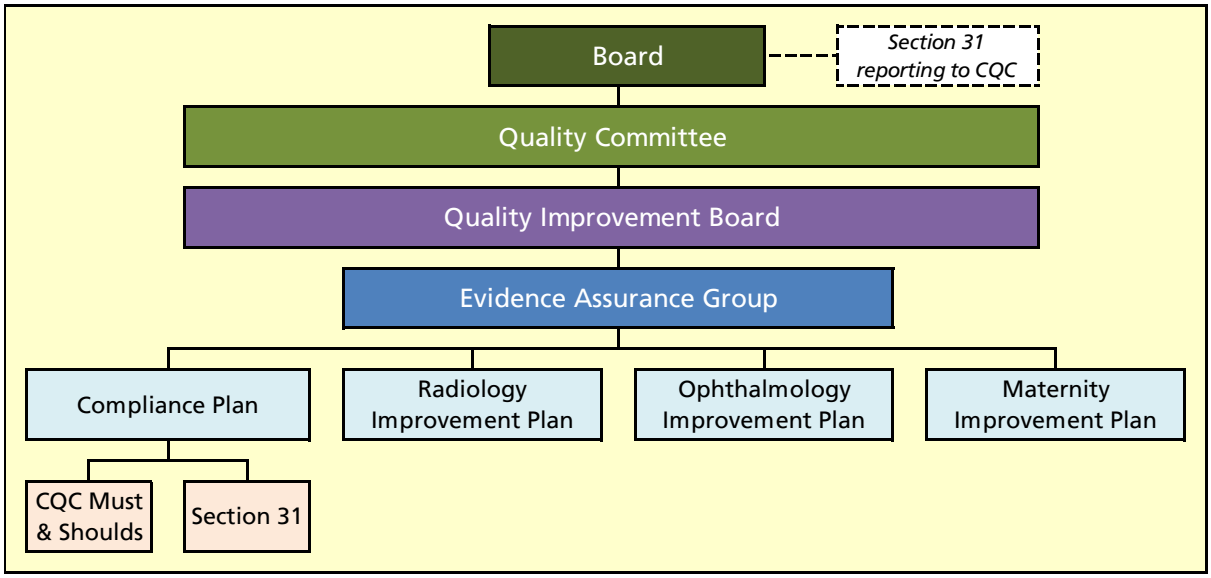
| | | |
|---|---|---|
| Maternity | Ophthalmology | Elective Recovery |
| Radiology | Urgent and Emergency Care | |

The Trust was required to submit its plan to address the CQC's findings within 3 weeks of publication of the CQC Inspection Report. Therefore the review and approval by both the Executive Team and all members of the Quality Forum has been completed outside the standard reporting timetable, but still in line with the Trust's governance arrangements.

**Governance, Monitoring and Assurance**

In response to the CQC's recommendation for the Trust's removal from the System Oversight Framework 04 (SOF 04) a review of the Trust Governance Structure has been undertaken and will come into effect as of April 2022. Within the new Governance framework the Quality Improvement Board (formally the Quality Forum) will be responsible for the monitoring and reporting of the Compliance Plan together with the Radiology, Maternity and Ophthalmology Quality Improvement Plans as detailed below. The Urgent and Emergency Care and Elective Recovery will be monitored through the Responsive Executive Group, reporting to the Hospital Management Board and through to the Finance and Activity Committee in line with the Trust's proposed new Governance arrangements.

## QUALITY IMPROVEMENT




To ensure there is continued effective monitoring and reporting of progress against open actions, the Compliance Plan will follow the same governance arrangements as the IQIP, with all actions presented to the Evidence Assurance Group (EAG) prior to closure. Monitoring of progress against the Compliance Plan and relevant Quality Improvement Plans will be the responsibility of the Quality Improvement Board,

reporting to the Quality Committee for assurance. The Chairs Assurance Report (CAR) from Quality Committee to Public Board will provide assurance of progress against the Compliance Plan and associated Quality Improvement Plans.

The EAG has functioned well since June 2019, with an established monthly monitoring and reporting rhythm of evidence submitted. It is important to build on the current arrangements, recognising progress to date and the more recent inclusion of Serious Incident Actions and actions from the Radiology, Ophthalmology and Maternity Improvement Plans. To support this change, the EAG has been expanded to twice monthly meetings, one chaired by the Medical Director (MD), (as per existing arrangements), the other Chaired by the Director of Patient Safety (DoPS).

The EAG meetings will be split and held monthly covering:

- EAG Group One - IQIP actions & SI action plans
- EAG Group Two – Maternity, Radiology & Ophthalmology actions

The outcome of the EAG will continue to be reported monthly to the Quality Improvement Board (formally the Quality Forum) and through to Quality Committee.

**Next Steps**

- The Chair, CEO and agreed members of the Executive Team are required to attend an Exit Recovery Support Programme meeting scheduled for 25 April 2022, together with an ICB designate and NHSE/I. This is a national meeting required as part of the process for exiting the Recovery Support Programme (formerly Special Measures). The Trust is required to submit an information pack in advance, which is under development.
- The Trust submitted a bid to apply for Exit Package funding for 2022/23. Peter Cutler; System Improvement Director has confirmed an offer by NHSEI to fund 3 of the 4 posts detailed within this Exit Package and will confirm the remainder of the funding imminently.
- The Compliance Team will work with Compliance Plan action owners to agree Plans on a Page, where required to support action completion. This work will be completed by 31 March 2022.