Agenda item 10

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for August 2021

EXCELLENCE STARTS HERE

Board of Directors (Public)
5 October 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, 33 (40%) of the 2021/22 IQIP actions have been approved for closure as of Month 05

- In August, 3 schemes were presented to the Evidence Assurance Group (EAG):
  - 2 Must Do actions were approved in August
  - 1 Must Do action was declined – Remains 'Behind Plan'

- 26 Actions have been moved to 'At Risk' and currently RAG rated as Amber. These include 12 HR actions relating to Mandatory Training and 5 Radiology actions. Whilst deadlines for all actions were agreed in March 2021, a more detailed review of these actions as part of this improvement work has identified more complex and deep-rooted issues in a number of schemes. This has required additional and broader measures to be taken to ensure long term improvement is achieved, but has resulted in a delay to a number of actions as a consequence.

- 9 of the 'At Risk' actions are planned to be presented to the EAG in September.

- Whilst 6 Actions are 'Behind Plan', significant improvements have been made across all 6 areas. However further evidence of improvement to meet the required KPI, or evidence demonstrating improvements will be sustained is still required. All have recovery actions in place, or agreed resubmission dates.

- At the August Evidence Assurance Group meeting 16 HR actions were presented for supportive discussion on progress and guidance on further evidence required in view of the scope of these actions.

- The EAG continues to provide robust challenge and assurance against other material action plans, including Maternity and Serious Incident Action Plans, to gain assurance and evidence of completion of all individual actions.

- Following the application submitted to the CQC on 7th July requesting the lifting of the remaining 7, S31 Conditions, the CQC have advised that a meeting was held on 28th September to formally review the S31 evidence. It is hoped the Trust will be informed of the outcome of this review early Oct.

- The Monthly Clinical Review Programme continued during August. The review spanned 5 areas with largely positive results, with identified areas of improvement detailed within the report. The review was undertaken by clinical and non-clinical staff, including Senior Nurses, Non-Executive Director with participation from External Stakeholders including QEH Governors and a representative from the Norfolk and Waveney CCG and NHSE/I Colleagues.

The Board of Directors is asked to note:

- Progress at Month 05
- Increase in the number of 'At Risk' actions, rational and recovery actions
- The key findings from the August Clinical Review and action taken

Overall Programme Update

- The reporting numbers reflect 83 actions captured within the new 2021/22 IQIP with 50 open actions covering Conditions, Must and Should Do actions and structured accordingly.

Status	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**7**	**13**	**7**	**6**	**33**
Clinical Support Services		1	2		**3**
Corporate	4			3	**7**
Medicine	2	2	2	1	**7**
Women & Children	1	10	3	2	**16**
Not Completed	**14**	**3**		**33**	**50**
Clinical Support Services	2			3	**5**
Corporate	9	3		23	**35**
Medicine	3			2	**5**
Surgery				3	**3**
Women & Children				2	**2**
Total	**21**	**16**	**7**	**39**	**83**

Corporate Action Themes

- Of the remaining 50 open actions, 35 have been categorised as 'Corporate' actions as these relate to all 4 Divisions and or, all Trust staff.

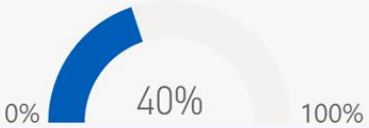
Corporate Theme	Number
End of Life / Palliative Care / MCA / DoLs	7
Staffing	3
Learning from Incidents / Complaints / Regulators	3
Culture	2
HR / Appraisals / Mandatory Training	16
Documentation	4
Total:	35

Overall Programme Status

- This slide illustrates the current completion of all actions within the programme.

Overall

Performance of Total



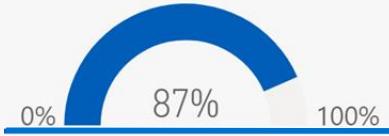
33
Total Complete

83
Total Planned

- Of the 83 total planned actions within the new IQIP, 20 are the completed CQC Conditions
- 2 actions were approved in August

CQC Conditions & Notices

Performance of Total



20
Total Complete

23
Total Planned

- Of the 23 total planned CQC Condition and Warning Notices, 20 are completed actions
- These 20 actions remain open with the CQC
- 3 Medicine 29A Warning Conditions remain open
- An application was submitted to the CQC on 7th July requesting to lift the 7 remaining S31 Conditions

Must's

Performance of Total

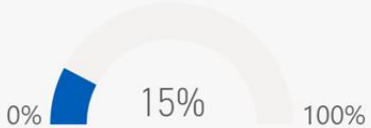
7
Total Complete

21
Total Planned

- 2 Must Do actions were approved in August
- 1 Must Do action was declined in August
- The remaining 14 Must Do actions continue to be reviewed at the fortnightly IQIP monitoring meetings to track progress, escalate concerns and where required, agree recovery actions.

Should's

Performance of Total



6
Total Complete

39
Total Planned

- The remaining 33 Should Do actions continue to be reviewed at the fortnightly IQIP monitoring meetings to track progress, escalate concerns and where required, agree recovery actions.

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. Due to the number of actions due for completion in September on the IQIP, an additional Evidence Assurance Group (EAG) was held on 30th September to review the Maternity Actions and Serious Incident Actions Plans. The fortnightly IQIP meetings monitor progress against agreed trajectories, escalate risks to delivery and agree recovery actions where required.

Main - Area	Completed & Signed off	Behind Plan	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 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	**7**	**4**	**16**	**6**	**4**		**3**			**2**					**42**
Must	4	2	4		2		1								**13**
Section 29		1	1				1								**3**
Should	3	1	11	6	2		1			2					**26**
Medicine	**7**	**1**	**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	**16**			**1**		**1**									**18**
Must	1														**1**
Section 29	10														**10**
Section 31	3														**3**
Should	2			1		1									**4**
Total	**33**	**6**	**22**	**9**	**4**	**4**	**3**			**2**					**83**

Actions approved at the Evidence Assurance Group in August 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	B
016	Corporate	Must	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are in place, ensuring timely management in line with trust policy.	Director of People	31/08/2021	B

Actions declined at the Evidence Assurance Group in August 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
051	Medicine	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	30/06/2021	R

051 Fluid Balance Charts

The EAG was assured the Trust has made significant progress in relation to the completion and accuracy of fluid balance charts. Whilst an enormous amount of work has been undertaken to gain assurance of improvements in completing fluid balance charts and a new fluid balance charts has been launched across all wards, this action was declined due to the new charts still being embedded and compliance figures not yet sustained. It was agreed this action would be presented to the EAG in September to allow additional evidence of sustained compliance data to be evidenced.

This action will be represented to EAG in September 2021

Actions presented for consideration in August 2021

ID	Service	Category	Action Description	Owner	End Date	RAG
017	Corporate	Must	The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.	Director of People	30/11/2021	G
017	Corporate	Must	The trust must ensure that staff receive an annual appraisal.	Director of People	30/11/2021	G
017	Corporate	Should	The service should ensure that nursing appraisal rates are in line with trust targets.	Director of People	30/11/2021	G
017	Corporate	Should	The service should ensure that nursing appraisal rates are in line with trust targets.	Director of People	30/11/2021	G

At the August Evidence Assurance Group meeting these 4 HR actions were presented for supportive discussion on progress made and guidance on further evidence required.

017 Appraisal Rates 4 Actions
These actions are not due to be presented until November 2021. The EAG were assured that significant progress has made in relation to Appraisal Rates, and asked for an additional 2 months worth of compliance data be provided to ensure this improvement is consistently sustained. This remains 'On Track' .
This actions will be submitted to EAG in November.

Actions presented for consideration in August 2021

ID	Service	Category	Action Description	Owner	End Date	RAG
018	Corporate	Must	The trust must ensure that mandatory training attendance, including training on infection prevention and control and safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level.	Director of People	30/09/2021	A
018	Corporate	Must	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure that mandatory training compliance meets the trust target for all staff groups.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete mandatory training in key skills.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete safeguarding adults and children's' training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that staff have completed the relevant life support training for their clinical roles.	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure staffs mandatory and safeguarding training compliance meets the trust target.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that staff complete mandatory training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should improve medical staff compliance with safeguarding training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete mandatory training to improve compliance in line with the trust target.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that safeguarding adults and children's training compliance is in line with the trust target.	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure that staff are up to date with mandatory training.	Director of People	30/09/2021	A

At the August Evidence Assurance Group meeting these 12 HR actions were presented for supportive discussion on progress to date and guidance on further evidence required.

018 Mandatory Training 12 Actions

These actions are due to be presented September 2021. The EAG were assured that significant progress has made in relation to Mandatory Training but require an additional 2 months worth of compliance data to ensure this improvement is consistently sustained. The EAG were assured that significant progress has made in relation to Safeguarding Training and confirmed that the 3 actions relating to Safeguarding could be approved however as these actions are incorporated into the wider action these cannot be formally closed. As this action is due for completion in September it will not be presented until November and will show as 'Behind Plan' from October. This has moved to 'At Risk'.

This action will be submitted to EAG in November.

RAG Rated Programme Position as of August 2021

- The following sets out the overall programme position.
- 6 actions rated as 'Behind Plan' and recovery actions have been agreed.
- 26 actions are 'At Risk' and are currently RAG rated as Amber.

Main - Area	At Risk	Behind Plan	On Plan	Total
Clinical Support Services	**5**			**5**
Must	2			2
Should	3			3
Corporate	**17**	**4**	**14**	**35**
Must	4	2	3	9
Section 29	1	1	1	3
Should	12	1	10	23
Medicine	**1**	**1**	**3**	**5**
Must	1	1	1	3
Should			2	2
Surgery	**2**	**1**		**3**
Should	2	1		3
Women & Children	**1**		**1**	**2**
Should	1		1	2
Total	**26**	**6**	**18**	**50**

Actions At Risk at the end of August 2021

ID	Service	Category	Action Description	Owner	End Date	RAG
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
006	Corporate	Should	The trust should continue to ensure completion of mental capacity assessments for all patients in end of life care.	Chief Nurse	30/09/2021	A
013	Corporate	Must	The trust must ensure that risks are swiftly identified, mitigated and managed. There must be robust, consistent processes in place to ensure that action plans are enacted following audit, mortality reviews, incidents and complaints. There must be clear processes for review, analysis and identification of themes and shared learning.	Director of Patient Safety	30/09/2021	A
018	Corporate	Must	The trust must ensure that mandatory training attendance, including training on infection prevention and control and safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level.	Director of People	30/09/2021	A
018	Corporate	Must	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure that mandatory training compliance meets the trust target for all staff groups.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete mandatory training in key skills.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete safeguarding adults and children's' training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that staff have completed the relevant life support training for their clinical roles.	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure staffs mandatory and safeguarding training compliance meets the trust target.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that staff complete mandatory training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should improve medical staff compliance with safeguarding training.	Director of People	30/09/2021	A
018	Corporate	Should	The service should ensure that all staff complete mandatory training to improve compliance in line with the trust target.	Director of People	30/09/2021	A

Actions At Risk at the end of August 2021

ID	Service	Category	Action Description	Owner	End Date	RAG
018	Corporate	Should	The service should ensure that safeguarding adults and children's training compliance is in line with the trust target.	Director of People	30/09/2021	A
018	Corporate	Should	The trust should ensure that staff are up to date with mandatory training.	Director of People	30/09/2021	A
020	Corporate	Section 29	Staff understanding of and the application of the Mental Capacity Act 2005 was inconsistent in medical care and the emergency department. Training information supporting staff knowledge and understanding of the Deprivation of Liberty Safeguards (DoLS) was incorrect and not in line with the Act.	Chief Nurse	30/09/2021	A
050	Corporate	Should	The trust should ensure staff store patient records securely.	Director of Finance	31/10/2021	A
052	Medicine	Must	The trust must ensure mental capacity assessments are consistently and competently carried out where required.	Chief Nurse	30/09/2021	A
057	Clinical Support Services	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	Clinical Support Services	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
059	Surgery	Should	The trust should ensure patients on the 62-day pathway receive treatment in line with the national target.	Chief Operating Officer	30/09/2021	A
061	Surgery	Should	The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance.	Chief Operating Officer	30/09/2021	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
068	Clinical Support Services	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	Clinical Support Services	Should	The trust should continue to embed the governance and risk management processes.	DLT Clinical Support Services	30/09/2021	A
070	Clinical Support Services	Should	The trust should develop a formalised vision and strategy in radiology.	DLT Clinical Support Services	30/09/2021	A

Actions At Risk at the end of August 2021

001 Learning from Incidents, complaints and audits
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-19. Under the Executive Lead of the Chief Nurse, arrangements are in place which incorporate the capture and sharing of learning and this includes the introduction of Quality Performance Reviews with the Ward/Dept Manager, Heads of Nursing and Chief Nurse. Changes have also been made to the Complaints process, with greater Divisional ownership including phone calls and the offer of local resolution meetings. Learning is also generated from listening to concerns 'first hand' and sharing patient experience and feedback with their teams. The Trust's 3rd Patient Safety Learning event was held on 15 July with good attendance from both Clinical and Non-Clinical staff and a number of external stakeholders. The Trust implemented its Audit Improvement Plan in August 2021.
This action will be presented to EAG in September 2021.

006, 020, 052, Mental Capacity Assessments
Actions due to be presented to the EAG in September. Clear evidence of progress against this actions with strengthened system and processes which underpin mental capacity assessment and referrals. Actions put at risk due to the impact of COVID-19 on staff accessing training and a delay in the uploading of training onto ESR since January 2021. This has since been resolved with updated reports available from August 2021.
This action will be presented to EAG in September 2021.

013 Risks mitigated and actions addressed through audit
This is a broad action which captures a number of required improvements. Significant changes and improvements have been completed, particularly related to risk and the identification and mitigation of risk. Improvements in the Serious Incident process has established a robust approach for the review and completion of actions, all of which are now approved through the Evidence Assurance Group, along with the Maternity and Radiology Improvement Plans. However the need for consistent evidence of actions from complaints, mortality and audit are being strengthened further to meet the required standard. The Trust also developed and launched its Audit Improvement Plan in August 2021.
This action will be presented to EAG in September 2021.

018 Mandatory Training
See slide 10. **This action will be presented to EAG in November 2021.**

Actions At Risk at the end of August 2021

050 Securing Patient Records
Whilst significant improvement has been made, this action was put 'At Risk' following the lack of consistent evidence of medical records being stored securely, as identified during clinical reviews and walk-rounds. Changes to the auditing of medical records has been implemented and arrangements are in place to purchase more secure medical notes trollies used to transport medical records.
This action will be submitted to EAG in October 2021

059, 061, 62-day Pathway
This action was put 'At Risk' due to the COVID-19 pandemic impacting referral to treatment times. Good progress has been made however the Trust has experienced a significant increase in demand post COVID-19. Work continues regarding clinical harm reviews.
This action will be submitted to EAG in September 2021

065 Staffing
Recruitment communications plan are in development to reach out to a wider pool of Midwives and ensure adequate skill mix following an uplift in staffing levels which has increased the vacancy factor at the QEH. It is important to note the recruitment challenges of Midwives at both a national and local level in addition to the impact of COVID-19 on the training of student Midwives. A number of student Midwives have withdrawn from the programme while others have taken posts elsewhere. The Service is working with regional Heads of Midwifery across East of England within a task and finish group to look at overseas recruitment, but this is proving quite a challenge due to the registration with NMC for Midwives who are not trained in the UK.
This action will be submitted to EAG in October 2021

057, 058, 068, 069 and 070 Radiology
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 open IQIP actions within Radiology to 'At Risk'. The majority of these actions are not due for completion until December 2021. Following a mapping exercise of all Radiology actions against the Radiology Culture Assessment Review, 12 existing open actions have been incorporated into the Radiology Improvement Plan. All Radiology Improvement Plan completed actions will be submitted to the EAG for approval.

Actions Behind Plan at the end of August 2021

ID	Service	Category	Action Description	Owner	End Date	RAG
004	Corporate	Must	The trust must address specialist palliative consultant staffing and put measures in place to improve in line with national standards.	Medical Director	31/07/2021	R
004	Corporate	Section 29	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	R
004	Corporate	Should	The trust should continue to address specialist palliative consultant staffing to put measures in place to improve in line with national standards.	Medical Director	31/07/2021	R
012	Corporate	Must	The trust must ensure that regulatory requirements, recommendations and learnings from regulators, external reviews and local audit are utilised to identify actions for improvement and that these are monitored and reviewed effectively.	Director of Patient Safety	31/07/2021	R
051	Medicine	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	30/06/2021	R
060	Surgery	Should	The service should develop and implement a clear vision and strategy.	DLT Surgery	31/05/2021	R

004 Palliative Care

This includes 3 actions which have been placed at 'Behind Plan' as the Trust has been unsuccessful in recruiting into the Palliative Consultant Post. However mitigating actions are in place with the continued use of an innovative mix of staff, with advertisements currently live for Consultant Nurse, Consultant Physician and MDT Coordinator to ensure stability of the service. Appointed into Lead Nurse and MDT Coordinator roles. Clinical Director interviews rescheduled.

012 Learning from External Reviews

This action was declined and has therefore moved to 'Behind Plan' due to the limited evidence from GIRFT reviews and a lack of assurance of the mechanisms in place to monitor findings and recommendations. With a new Standard Operating Procedure in Place to address this, it was agreed to bring this action back in 3 months once this new arrangement has been fully implemented. **This action will be represented to EAG in October 2021**

051 Fluid Balance Charts

See Slide 8

This action will be represented to EAG in September 2021

060 Vision & Strategy

Following the launch of the Trust's Corporate Strategy in 2020, a decision was taken for all Divisional Leadership Teams (DLTs) to develop Divisional Workplans with key objectives and milestones, rather than individual strategies. The Division of Surgery worked with their teams to develop their Divisional Workplan aligned to this action. However, this action was declined in May as final approval of the Division of Surgery's Workplan was outstanding. The Workplan was presented to SLT in June and slight changes requested prior to final approval. This action will be re-presented to the EAG in September 2021 which will allow the Division time to launch their Workplan and provide evidence which will includes the implementation plan, staff engagement and early testing of staff's awareness of the strategy.

This action will be represented to EAG in September 2021

Remaining 7 Section 31 CQC Conditions

- With all Section 31 conditions closed internally with ongoing evidence of compliance and improvement, the Trust applied to the CQC in July to request the remaining 7 Section 31 conditions are lifted. This application is planned for review by the CQC on 28 September. 7 additional pieces of evidence spanning Maternity Services, Diagnostic Imaging and Urgent & Emergency Care were requested and submitted to the CQC ahead of the review date.

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

Clinical Review 25th August 2021
A team of 11 clinical and non-clinical staff were involved in the 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 and NHSE/I Colleagues.

The review spanned 5 areas. Day Surgery, Gayton Ward, Main Theatres, Tilney Ward and the Radiology Department.

Areas of Good Practice:

- Upon initial arrival, only 3 of the 5 areas were welcoming and accommodating to the review team - however once the team introduced themselves staff were friendly and engaging
- Staff were engaged and happy to speak to the review team
- Across all areas review teams observed positive interactions between staff and patients – Communication was calm
- Patients appeared happy and well-cared for across all areas – This was supported by positive feedback from patients
- Staff exuded enormous pride in their areas and spoke very positively about their contributions throughout COVID-19
- Overall compliance with IPAC standards and PPE standards were good
- Staff able to talk about improvements and learning

Areas for Improvement:

- Inconsistent documentation appeared to be a theme across some areas
- The need for a more timely response to call bells in a few areas.
- The review team found computer screens left unlocked and unattended
- A small number of staff expressed feeling unsupported

- **Day Surgery -** The review team did not note any immediate concerns during their review however did note how they found Tristel in two unlocked cupboards in the utility room
- **Gayton Ward -** One relative claimed their mother had not been washed since being admitted – This was raised with the Head of Nursing at the time of the review.
- **Main Theatres -** The review team did not note any immediate concerns during their review, however did escalate equipment along the back corridor – Staff stated this risk is identified on the risk register.
- **Tilney Ward -** The review team noted how a patient had not yet been seen by a speciality doctor. The patient was very happy with the care from the Tilney staff but wanted to know when she would be seen and what the plan for her care would be. A staff member raised concern that not all staff had the skills to care for patients who require Coronary Care following its recent relocation to Tilney.
- **Radiology Department -** Through conversations with staff, they expressed how the implementation of the new Radiology Information System (RIS) has been problematic.

Findings from the review were shared with the Chief Nurse, nursing teams, department managers and Divisional Leadership Teams, to celebrate good practice, address identified areas for improvement, including areas requiring immediate action.

Clinical Review Programme: Reviewer Evaluation Feedback - August

Clinical Review 25th August 2021

The Compliance Team collect reviewer feedback in order to evaluate the effectiveness of the monthly clinical review sessions. The evaluation form consists of nine high level statements and reviewers are asked to indicate the extent to which they agree or disagree with each statement.

Evaluation Question	Agree	Disagree
Overall the clinical review was well-organised, informative and interesting	100%	
I felt well-informed of the reviews objectives and methodology used during the session	100%	
The amount of information contained within the review pack was appropriate	100%	
The materials within the pack provided me with necessary information which was useful	100%	
The review pack was easy to follow and supported me during the review	100%	
The time allocated to review the clinical area was sufficient	90%	10%
The number of participants allocated to the clinical area was suitable	100%	
I will recommend these reviews to other colleagues and share the learning in my area	100%	
I have benefited and learnt from participating in today's clinical review	100%	

Commentary Themes:	
Pack Information	Following feedback gained after Julys session, the pack was shared with attendees three days prior allowing attendees to familiarise themselves with the Clinical Review pack and clinical area they had been assigned to. 100% of participants felt the pack contained appropriate information compared with only 70% the previous month. One participant suggested including compliments as well as complaints data within the pack.
Time Allocated	Following feedback gained after Julys session, the time allocated to review the clinical areas was increased. 90% of participants felt the time allocated to the area was sufficient compared with only 20% the previous month. One participant suggested the reviews take place over a meal time.
Participation	100% of participants felt the number of participants allocated to an area was suitable. One participant suggested the review teams consist of at least one clinical members with someone non-clinical.
Positive Feedback	100% of participants would recommend these reviews to other colleagues and share learning in their own areas 'Very Interesting - I feel able to use some of the working practices within my own department' 'Very well organised as usual' 'Very good team work - Amy is extremely responsive and helpful'

Clinical Review Programme: Identified Areas for Action Update

The table below details a number of themes identified during these clinical reviews and the action taken to address these areas of concern

Theme	Action Required	Action Taken
Patient Records	Patient records are a recurring theme at the monthly clinical reviews . Notes trolleys are often left open / unlocked and notes are left unattended	The current trolleys for transporting records across the Trust are not all lockable. Scoping work is in progress to identify either locking trolleys or a suitable alternative. The Information Governance Lead also continues to audit wards monthly. An alert has been sent to staff to ensure patient records are always safely stored.
Noise at Night	Patients have raised concerns regarding noise at night, either due to staff having loud conversations or call bells / telephones not being answered promptly	In July, The Trust launched the Helping you Sleep Healthier (HUSH) initiative to help patients have a better night's sleep. Small changes have been made to minimise noise such as lowering voices, dimmed lighting, and reducing the usage of electronic devices/deactivating sound.
Meal Trolleys	It has been reported that the new meal trolleys / system for requesting patient meals has resulted in some patients not always being offered a choice of meals.	Immediate action taken. Additional iPads have been ordered for all wards to make the ordering process easier. Changes to the ordering made to ensure wards have enough time confirm patients meal choices. Work is ongoing to make it easier to identify food allergies etc. via drop down boxes.
Corridors	The review team has identified a vast amount of equipment in corridors, particularly along the back corridor behind Main Theatres which is a fire hazard	Weekly checks of all corridors completed by Health & Safety Team. The Fire Service attended site and completed a visual inspection on 06/05/2021. The risk has been identified and added to the Risk Register, with controls in place.
Answering Phones	Phones not always answered in a timely manner and often left to nursing staff in the absence of the Ward Clerk	Communications shared Trustwide 'In The Know' reiterating the importance of answering phones as it is important that we keep our patient's loved ones up-to-date and informed and it is everybody's responsibility. Family Liaison Officers ensure relatives/carers are kept informed and support the answering of calls during visits to the inpatient wards.
Competencies of staff to care for patients who require Coronary Care	A staff member raised a concern that not all staff had the skills to care for patients who require Coronary Care following its recent relocation to Tilney.	Immediate follow-up of concern. Assured that all Registered Nurses on Tilney Ward are able to care for patients who are a level 3 acuity with 10 of the 22 nurses having completed specific Cardiology training. Further training arrangements in place for Registered Nurses on Tilney with further support provided by staff from ITU where required. All Registered Nurses have completed Immediate Life Support and tracheostomy training.