Agenda item 10

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for October 2021

EXCELLENCE STARTS HERE

Board of Directors (Public)
07 December 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, 43 (52%) of the 2021/22 IQIP actions have been approved for closure as of Month 07
- In October, 6 actions were submitted for closure to the Evidence Assurance Group (EAG):
  - 5 actions were approved
  - 1 action was declined
- 12 HR actions were due to be submitted for closure in September in line with completion date relating to Mandatory Training. These were discussed at the EAG in August. Although the EAG was assured the Trust has made significant progress in relation to Mandatory Training, and compliant with the Trust's target, an additional 2 months of compliance data has been requested to ensure these improvements are sustained. These 12 actions are rated as 'Behind Plan' and will be submitted to EAG in November 2021.
- No actions are currently RAG rated as Amber 'At Risk'.
- 25 Actions are 'Behind Plan' but all have recovery actions in place or resubmission dates agreed. 16 of these actions are being presented to EAG in November
- A mapping exercise of the 5 open Radiology action has been undertaken against the Radiology Improvement Plan. The Quality Forum have approved revisions to 4 of 5 action completion dates, the details of which have been included within this report.
- Whilst deadlines for all actions were agreed in March 2021, a more detailed review as part of the 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. Demonstrating improvements are sustained is essential for long term improvement and a key measure for the CQC. In turn, sustained operational pressures as a result of the COVID-19 pandemic has also impacted on the delivery of a number of actions against original timeframes. This may also result in a number of existing open actions becoming 'At Risk' over the next few months as the Trust navigates its way through winter.
- The EAG continues to provide robust challenge and gain assurance and evidence of completion of all individual actions. Due to the widening of the scope of the EAG against other material action plans, including Serious Incident Action Plans, Maternity, Radiology, Ophthalmology and Clinical Audit Improvement Plans, there will be two EAG meeting held monthly from January 2022.
- The Monthly Clinical Review Programme continued in October with visits to Castleacre Ward, Central Delivery Suite, Elm Ward, Leverington Ward, Marham Ward and Rudham 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 07
- Revised completion dates of 4 Radiology Actions
- 25 'Behind Plan' actions and rational with recovery actions
- The key findings from the October Clinical Review Visits

Overall Programme Update

- The reporting numbers reflect 83 actions captured within the new 2021/22 IQIP with 40 open actions covering Conditions, Must and Should Do actions and structured accordingly.

Status	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**11**	**14**	**7**	**11**	**43**
Clinical Support Services		1	2		**3**
Corporate	7	1		6	**14**
Medicine	3	2	2	2	**9**
Surgery				1	**1**
Women & Children	1	10	3	2	**16**
Not Completed	**10**	**2**		**28**	**40**
Clinical Support Services	2			3	**5**
Corporate	6	2		20	**28**
Medicine	2			1	**3**
Surgery				2	**2**
Women & Children				2	**2**
Total	**21**	**16**	**7**	**39**	**83**

Corporate Action Themes

- Of the remaining 40 open actions, 28 have been categorised as 'Corporate' actions as these relate to all 4 Divisions and or, all Trust staff.

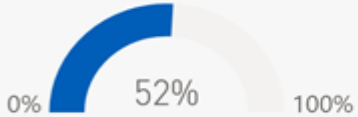
Corporate Theme	Number
End of Life / Palliative Care / MCA / DoLs	5
Staffing	2
Culture	2
HR / Appraisals / Mandatory Training	16
Documentation	3
Total:	28

Overall Programme Status

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

Overall

Performance of Total



43
Total Complete

83
Total Planned

- Of the 83 total planned actions within the new IQIP, 43 have been completed
- 5 actions were approved in October
- 1 action was declined in October

CQC Conditions & Notices

Performance of Total

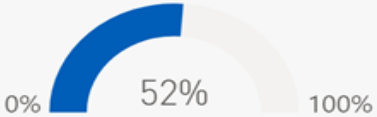
21
Total Complete

23
Total Planned

- 2 actions remain open relating to the Medicine 29A Warning Conditions

Must's

Performance of Total



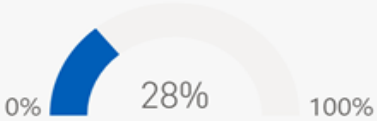
11
Total Complete

21
Total Planned

- 2 Must Do actions were approved in October
- The remaining 10 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



11
Total Complete

39
Total Planned

- 3 Should Do actions were approved in October
- 1 Should Do actions was declined in October
- The remaining 28 Should Do actions continue to be reviewed at the fortnightly IQIP monitoring meetings to track progress, escalate concerns and where required, agree recovery actions.

Section 31 & 29A Warning Conditions

- Of the four remaining Section 31 conditions these have been closed internally by the Trust and compliance monitored as part of business as unusual at Divisional and Corporate level. A weekly compliance report is also submitted to the Chief Executive Leadership Meeting, which is chaired by Caroline Shaw; CEO, confirming no breaches of these conditions.
- No breaches of these conditions have been detected since May 2020.
- Two 29A Warning Conditions remain open on the Trust's Integrated Quality Improvement Plan (IQIP). These relate to Documentation and Palliative Care Consultant Cover.

Section 31 Condition Status

Core Service	Date Received	Total Section 31 Conditions Received	Date Lifted	Number of S31 Lifted	Total Section 31 Conditions Remaining
Maternity & Midwifery Services	July 2018	10	Jan 2021	5	1
			April 2021	2	
			October 2021	2	
Urgent & Emergency Care	March 2019	8	April 2021	6	1
			October 2021	1	
Diagnostic Imaging	May 2019	4	April 2021	2	2
Total Remaining Section 31 Conditions		**22**		**18**	**4**

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.

Main - Area	Completed & Signed off	Behind Plan	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Total
Clinical Support Services	**3**			**1**	**2**		**2**							**8**
Must				1	1									**2**
Section 29	1													**1**
Section 31	2													**2**
Should					1		2							**3**
Corporate	**14**	**19**	**4**		**3**			**2**						**42**
Must	7	3	2		1									**13**
Section 29	1	1			1									**3**
Should	6	15	2		1			2						**26**
Medicine	**9**	**3**												**12**
Must	3	2												**5**
Section 29	2													**2**
Section 31	2													**2**
Should	2	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	**43**	**25**	**4**	**2**	**5**		**2**	**2**						**83**

RAG Rated Programme Position as of October 2021

- The following sets out the overall programme position.
- 25 actions rated as 'Behind Plan' and recovery actions have been agreed.

Main - Area	Behind Plan	On Plan	Total
Clinical Support Services		**5**	**5**
Must		2	**2**
Should		3	**3**
Corporate	**19**	**9**	**28**
Must	3	3	**6**
Section 29	1	1	**2**
Should	15	5	**20**
Medicine	**3**		**3**
Must	2		**2**
Should	1		**1**
Surgery	**2**		**2**
Should	2		**2**
Women & Children	**1**	**1**	**2**
Should	1	1	**2**
Total	**25**	**15**	**40**

Clinical Support Actions aligned to the Radiology Improvement Plan

- A mapping exercise of the 5 Radiology actions within the IQIP has been completed against the Radiology Improvement Plan
- 4 actions have a revised completion date to align to the Radiology Improvement Plan as detailed below.

ID Ref	Service	Category	Action Description	OLD Date	NEW Date aligned with RIP	NEW RAG Status
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.	31/12/2021	31/01/2022	G
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.	31/12/2021	31/12/2021	G
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.	31/12/2021	31/01/2022	G
069	Clinical Support Services	Should	The trust should continue to embed the governance and risk management processes.	30/09/2021	31/03/2022	G
070	Clinical Support Services	Should	The trust should develop a formalised vision and strategy in radiology.	30/09/2021	31/03/2022	G

Actions approved at the Evidence Assurance Group in October 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
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	B
009	Corporate	Should	The trust should ensure the service has enough support staff on all wards to provide the right care and treatment.	Director of People	31/10/2021	B
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	B
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	B
050	Corporate	Should	The trust should ensure staff store patient records securely.	Director of Finance	31/10/2021	B

Actions declined at the Evidence Assurance Group in October 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
007	Corporate	Should	The trust should ensure that waiting times from referral to achievement of preferred place of care and death are timely.	Chief Nurse	31/10/2021	R

007 Timely Referral to Preferred Place of Care and Death

The Palliative Care Lead Nurse gave assurance that further evidence is available to demonstrate the current referral to achievement times of preferred place of care and death. Unfortunately this evidence had not been included within the submission to EAG and therefore the action was declined and will be represented in November 2021.

This action will be presented to EAG in November 2021.

Actions Behind Plan at the end of October 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
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	R
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	R
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	R
018	Corporate	Should	The service should ensure that all staff complete mandatory training in key skills.	Director of People	30/09/2021	R
018	Corporate	Should	The service should ensure that all staff complete safeguarding adults and children's' training.	Director of People	30/09/2021	R
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	R
018	Corporate	Should	The trust should ensure staffs mandatory and safeguarding training compliance meets the trust target.	Director of People	30/09/2021	R
018	Corporate	Should	The service should ensure that staff complete mandatory training.	Director of People	30/09/2021	R
018	Corporate	Should	The service should improve medical staff compliance with safeguarding training.	Director of People	30/09/2021	R
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	R
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	R
018	Corporate	Should	The trust should ensure that staff are up to date with mandatory training.	Director of People	30/09/2021	R

Actions Behind Plan at the end of October 2021

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
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
007	Corporate	Should	The trust should ensure that waiting times from referral to achievement of preferred place of care and death are timely.	Chief Nurse	31/10/2021	R
015	Corporate	Should	The service should ensure that performance in national and local audits is in line with targets. (UEC)	Director of Patient Safety	31/10/2021	R
015	Corporate	Should	The service should ensure that performance in national and local audits is in line with targets. (Med)	Director of Patient Safety	31/10/2021	R
015	Corporate	Should	The trust should ensure that compliance with national and local audits is in line with targets (EOL)	Director of Patient Safety	31/10/2021	R
052	Medicine	Must	The trust must ensure mental capacity assessments are consistently and competently carried out where required.	Chief Nurse	30/09/2021	R
055	Medicine	Must	The trust must improve its performance times in relation to ambulance turnaround delays, four-hour target, patients waiting more than four hours from the decision to admit until being admitted and monthly median total time in A&E.	Chief Operating Officer	31/10/2021	R
055	Medicine	Should	The service should ensure that care and treatment are accessible at the time of need and referral to treatment times and waiting times are in line with national standards.	Chief Operating Officer	31/10/2021	R
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	R
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	R
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	R

Actions Behind Plan at the end of October 2021

018 Mandatory Training
This actions incorporates 12 individual HR actions all relating to Mandatory Training across the Trust. These actions were due to be submitted for closure in September in line with completion date. However the actions were discussed at the EAG in August. Although the EAG was assured the Trust has made significant progress in relation to Mandatory Training and the Trust is compliant, an additional 2 months of compliance data has been requested to ensure these improvements are sustained. Core Mandatory Training compliance is above the Trust target of 80%, with May - 83%, June - 85%, July - 85%, August 84%, September 80% and 83% for October.
These 12 actions will be submitted to EAG in November 2021.

004 Palliative Care
This includes 3 actions which have been placed at 'Behind Plan' as there have been no applicants for the Consultant Physician roles covering QEHKL and Tapping House Hospice. An innovative skill mix approach has been adopted to mitigate the Consultant vacancies. A Lead Nurse has been recruited to take on a leadership role, and Consultants in the Integrated Care of Older People with an interest in Palliative Care are also now integrated to the team together with a Clinical Director. Although the Trust still has the lack of extra consultants it is considered that a significant amount of work has been taken regarding the skill mix of the team to best address its needs and meet this condition and therefore it has been agreed to present this action to the EAG for closure in November.
This action will be submitted to EAG in November 2021

055 Ambulance Turnaround Four Hour Target,
This actions formed part of the discussion with the CQC regarding the impact of COVID-19 on national performance standards and expectations regarding evidence to demonstrate this action has been addressed. The CQC confirmed they recognise the national challenges and would look at the systems and process the organisation has put in place since 2018 to safely assess and treat patients with the Emergency Department, including pathways of care, responding to increasing demand, escalation and oversight of the department. In view of this discussion, a decision will now be made by the COO when this action will be submitted to the EAG, whilst considering the current significant pressures across the Urgent and Emergency Care pathway.

052 Mental Capacity Assessments
Whilst the panel were assured of good progress a three month retrospective audit is to be undertaken to identify the proportion of patients who required an MCA, had an MCA, and it was correctly completed. Audit to be led the Trust's Safeguarding Lead and Lead Nurse for Palliative and EoLC. Further comms has been sent to all staff emphasising the importance of completing MCA and DoLS as part of mandatory training, with a focus on Medical staff.
This action will be presented to EAG in December 2021.

007 Timely Referral to Preferred Place of Care and Death
See Slide 11

Actions Behind Plan at the end of October 2021

015 National and Local Audit Targets
These actions form part of the wider Clinical Audit Improvement Plan with recovery actions and revised submission dates of February 2022
This action will be presented to EAG in February 2022.

065 Staffing
Recruitment communications plans 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. Adverts live for B5/6 Midwives & B7 Maternity Core Team Leaders. Midwifery Staffing vacancy rate is currently 17.37WTE for October down from 20.5WTE in September, this includes the Board approved uplift to meet the Birthrate + minimum safe staffing levels, but excludes the 8 additional midwives funded by the CCG in response to the Ockenden bid. This action forms part of the wider Maternity Improvement Plan with an ongoing recruitment campaign in place.
This action will be submitted to EAG in December 2021

059, 061, 62-day Pathway
The group were assured of the progress and the significant process changes relating to the 62-day pathway over the past 18months. The Trust also currently benchmarks well against NNHU and JPUH regarding this standard. However, the COVID-19 pandemic has had a significant impact on referral to treatment times at both national and local levels. Therefore, demonstrating the Trust consistently meets this national standard is not currently achievable and the action needs to be considered within this national context. A discussion was held on 6/10/21 with the CQC for advice on how to achieve this action in light of the COVID-19 pandemic and its impact on national performance standards. The CQC highlighted these 'Should Do' actions are advisory and not enforceable and would therefore look at the changes the Trust has made since they were issued in 2018 and 2019. This would need to include improvements to systems and processes in the management of patients on the 62day pathway and monitoring and governance arrangements which support the achievement of this standard, rather than the expectation this standard is consistently achieved.
In view of this information a decision will now be made by the COO when this action will be submitted to the EAG in view of the significant changes and improvements made since 2018.

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

- 4 actions are due to be presented to the EAG in November in line with the forward plan
- 16 'Behind Plan' action is also being presented

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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
007	Corporate	Should	The trust should ensure that waiting times from referral to achievement of preferred place of care and death are timely.	Chief Nurse	31/10/2021	R
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

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

- 4 actions are due to be presented to the EAG in October in line with the forward plan
- 2 'Behind Plan' action is also being presented

ID Ref	Service	Category	Action Description	Owner	End Date	RAG Status
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	R
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018	Corporate	Should	The service should improve medical staff compliance with safeguarding training.	Director of People	30/09/2021	R
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	R
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	R
018	Corporate	Should	The trust should ensure that staff are up to date with mandatory training.	Director of People	30/09/2021	R

Grant Thornton Internal Audit

- Grant Thornton have been commissioned to undertake an internal audit against the Trust Integrated Quality Improvement Plan which is expected to take place over a 6 week period.

- There will be two elements to this audit:

  - Desktop review of evidence;

  - Clinical visits to assess progress with a selection of closed actions.

- The Trust selected 10 closed schemes for review and Grant Thornton have selected an additional 11 closed schemes.

- Grant Thornton will review the process to deliver quality improvements across services to assess if:
  - the IQIP is governed by an effective governance framework that provides robust assurance;
  - the robustness and consistency of the approval process is sufficiently rigorous;
  - the implementation of the schemes marked as closed is evident in the clinical areas and becoming embedded in practice;
  - staff have an awareness of the IQIP and its purpose.

- The on-site visit will be on the 6th and 7th January as part of this audit

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.

The programme is recognised by other Trust as good practice. Brighton & Sussex University Hospital have recently asked us to share documents and assessment templates for the Clinical Review Programme.

Clinical Review 27th October 2021

A team of 11 clinical and non-clinical staff were involved in this review, consisting of the Director of Patient Safety, Compliance Manager, Risk and Governance Lead for Surgery, Clinical Audit Manager, Gynaecology Services Matron, Training Manager and Clinical Educator, as well as external participation from one QEH Governor, one Non-Executive Director, the Chief Executive Officer from Healthwatch and the Assistant Director of Clinical Quality from NHSE/I.

The review spanned 6 wards - Castleacre Ward, Central Delivery Suite, Elm Ward, Leverington Ward, Marham Ward and Rudham Ward.

In view of the significant pressures on staff as a result of COVID, the KLOE focused on patient and staff experience whilst drawing on broader findings through the use of the '15 Steps' methodology.

Areas of Good Practice:

- All review teams felt they had positive visits to all wards
- All areas were welcoming and accommodating on arrival - All staff were engaged, enthusiastic and happy to speak to the review team
- Across all wards the review team observed positive interactions between staff and patients – Staff introduced themselves
- Whilst all ward areas were busy, staff appeared calm and in control
- It was evident that staff on the wards share positive team spirit
- The wards exhibited really good multidisciplinary team working
- Patient care was good, caring and compassionate across all wards
- Patient feedback was positive – Patients and relatives feel informed
- Patients talked about feeling able to talk to any member of ward staff and know that their request would be actioned
- Staff demonstrated learning from serious incidents and complaints
- Staff praised the support they had received during and post COVID-19
- Most wards were able to talk about their improvement journeys
- Most wards felt confident about speaking up and knew the method for raising concerns

Areas for Improvement:

- Most ward information boards were blank / not up to date
- A number of areas raised concerns about staffing and recruitment challenges
- Call bells and ward telephone calls were not always answered promptly
- On the whole documentation was good, however on Elm Ward the review team found one instance where a patient did not have a fluid balance chart completed (not documented in the notes) and on Marham Ward the review team found one instance where low oxygen scores for NEWS 2 were not acted on (not documented in the notes)

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
16yr patients on Surgical Wards	A 16 year old patient was admitted to a surgical ward and the parents were informed they were unable to accompany them due to visiting restrictions	The ward had since rectified this error and the parents had been allowed to visit and stay with the patient during their inpatient episode. The team escalated this immediately to the Nurse in Charge and it was agreed to revisit previous communications that had been shared to ensure that all staff were aware that should a 16 – 18 year old patient be admitted to any surgical area the parents are allowed to be with them at all times .
Fluid Balance Charts	The review team found one instance where a patient did not have a fluid balance chart completed (not documented in the notes	Refresher training has been offered to staff and an in-depth audit was completed on the ward with finding shared with the Matron for further discussion at team meetings.
Unlocked sluice door	The review team found an unlocked sluice door behind the nurses station on Marham Ward	The door lock was broken and therefore unlockable. This has now been replaced and is fully working and locked.
'Smiley Cards'	Feasibility of introducing a pictorial card to overcome language barriers	The New menu tablets have pictures to support patients to choose their meals. A digital version of the Learning Disabilities Information is being reviewed by the Liaison Nurse. A system wide approach including Access Migrant Support in King's Lynn to support people who were born or grew up outside the UK to understand what different parts of the NHS are for is being discussed with the Patient Experience Teams across Norfolk and Waveney.
CPAP Training	There is a lack of equipment training for CPAP on Rudham ward	Respiratory Nurse and Practice Development Nurse are providing equipment training.
Top 3 Risks	The review team found that staff on the ward were not able to consistently articulate the wards top 3 risks	The Risk Manager provides a monthly snapshot of the highest current risks to each area. In addition the Risk Manager has designed a Risk Awareness and Management video and quiz for all new Trust employees, which will form part of the Trust induction pack. This module will be included in the new ESR framework with an estimated rollout date of January 22. A more comprehensive Level 2 Risk Management training module has also been refined.
Pharmacy Support	There is a lock of Pharmacy support on Leverington Ward due to current workforce vacancies within the Pharmacy Department	Raised with the Chief Nurse at the feedback session. Discussions in progress regarding Pharmacy support for Leverington Ward.