Agenda Item 12

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Programme Update on Integrated Quality Improvement Plan (IQIP)

EXCELLENCE STARTS HERE

Board of Directors
4 August 2020

Summary

- To date, 128 of the 206 actions, which are a combination of conditions, must-do's and should-do's have been approved for closure by the Evidence Assurance Group (EAG). Although only 6 actions were due for completion by June, an additional 5 actions were presented and approved ahead of their completion trajectory. A total of 11 actions were therefore approved in June. No actions were declined.

- 78 actions remain outstanding. 1 action on DNACPR remains outstanding due to a change in the national template negatively impacting on our previous improvement trajectory. Immediate recovery actions have been agreed and this action will be represented to EAG in August.

- The Trust reported a breach to the CQC on 28th May of a Section 31 condition 3 for Diagnostic Imaging after a patient was either not referred, or placed on the 2 week wait lung cancer pathway following an abnormal chest x-ray. An action plan has been developed. There have been no further breaches.

- This report reflects the same position that was presented to Board in July. This is due to the dates Evidence Assurance Group was held in month related to the deadline for papers. A verbal update will be provided to members.

- Good progress is being made on recruiting to the Programme Management Office. Over 30 applications have been received to date for 2 Band 8a Managers with interviews scheduled for 13 August. The substantive Head of PMO advert will be advertised in August.

- The Trust is working with the NHSI&E Improvement Director to secure funds through the Special Measures allocation for 3 staff. Two staff to support the IQIP programme and one staff to support consultant job planning.

- The Trust's sustained progress was noted by the Oversight and Assurance Group (OAG) on 16 June, where a decision was taken by the OAG Chair; Dr Melanie Iles (NHSE/I), to move this meeting to bi-monthly, with the introduction of Deep Dives by QEH clinical teams.

- Following discussion with the Chair of Quality Committee, the Quality Improvement Deep Dive Timetable for the Board of Directors has been approved for the next 6 months.

The Board is asked to note:

(a) the continued improvement in completing actions and the immediate actions relating to the condition breach

(b) efforts to ensure the high number of actions to be evidenced over the next 3 months are appropriately resourced.

(c) the assurance arrangements recently introduced to ensure improvements are sustained and embedded

(d) the decision by the OAG to move this meeting to bi-monthly

(e) the introduction of monthly quality improvement Deep Dive presentations

Overall Programme Update

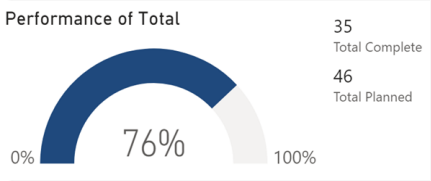
- Since the last report, the Trust evidenced and approved 11 actions bringing the total approved to 128 through the Evidence Assurance Group and the Condition Notices Oversight Group.
- There remain 78 actions which are a combination of conditions, Must and Should Do's still pending completion and validation and the Trust is well positioned to meet this trajectory.

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**3**	**65**	**13**	**19**	**28**	**128**
Clinical Support Services		5	3	4	3	**15**
Medicine		16	1	6	4	**27**
Standard Practice		27			13	**40**
Surgery		2			1	**3**
Trust Board	3	6			1	**10**
Women & Children		9	9	9	6	**33**
Not Completed		**40**	**8**	**3**	**27**	**78**
Clinical Support Services		1			1	**2**
Medicine		14	7	1	10	**32**
Standard Practice		18			4	**22**
Surgery					7	**7**
Trust Board		5				**5**
Women & Children		2	1	2	5	**10**
Total	**3**	**105**	**21**	**22**	**55**	**206**

Overall Programme Status

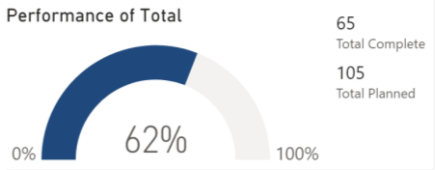
- This slide illustrates the current completion of all actions within the programme.

Conditions and GMC



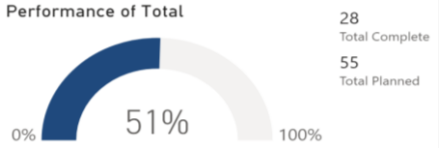
- 2 Notices were approved for internal closure at the June Evidence Assurance Group. These were the 1 Section 29 and 1 Section 31.
- The Trust reported a breach of S31 Condition 3 for Diagnostic Imaging to the CQC on 4th June after a patient was either not referred, or placed on the 2WW lung cancer pathway following an abnormal CXR. Immediate actions included changes to the outpatient CXR referral pathway and a retrospective review of all GP referred patients and placed on the Somerset Lung Cancer pathway in the last 6 months.. All patients were found to have been referred appropriately with no breaches.

Must do's



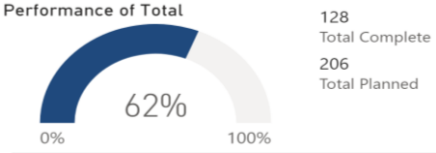
- 4 further Must Do actions were approved for closure in June. 1 related to Clinical Support Services, 2 related to Trust Board and 1 for Standard Practice.

Should do's



- 5 Should Do action was approved for closure in June to date.
- All remaining Should Do actions which were previously deprioritised now have agreed completion dates
- Plans-on-a-Page for all remaining Should-do actions have now been completed and are being monitored through regular meetings with action owners and through divisional Performance Review Meetings.

Total Plan



- 62% of all schemes are now approved with evidence.
- A strengthened monitoring and assurance system is being introduced to reflect the Trust's commitment to complete actions in a timely manner and the quantum of schemes to now be completed through to August 2020. As part of good practice, this approach will be continued for the remainder of the programme.

Actions approved at the Evidence Assurance Group or Conditions and Notices Group in June

- 11 actions were approved since the last report. This includes 1 section 29 and 1 section 31 notice relating to Diagnostic Imaging.
- This exceeded the planned number of 6 actions and reflects the increased focus from the fortnightly divisional review meetings and touchpoint meetings with action owners.
- The PMO and Quality Team have taken steps to secure resource to aid the divisions over the next three months to ensure actions are completed and embedded in practice.

ID Ref	Area	Category	Description	Owner	Approved
1.1.6	Trust Board	Must	The trust must improve the culture, ownership and accountability of clinicians, at all levels across the organisation, to empower and effect change within their working specialties and areas.	Medical Director	22 June 2020
1.2.11	Trust Board	Must	The trust must improve staff, patient and public engagement and communication.	Deputy Chief Executive Officer	22 June 2020
1.2.12	Standard Practice	Should	The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.	Deputy Chief Executive Officer	22 June 2020
1.2.2	Standard Practice	Must	The trust must continue to improve the culture, working relationships and engagement of consultant staff across all services.	Deputy Chief Executive Officer	22 June 2020
1.2.9	Trust Board	Should	The trust should ensure there are appropriate systems to ensure staff feel supported, engaged and listened to.	Deputy Chief Executive Officer	22 June 2020
2.6.4	Clinical Support Services	Section 31	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.	Clinical Lead Clinical Support Services	22 June 2020
2.7.3	Clinical Support Services	Section 29	Incidents in the diagnostic imaging department were not appropriately reported or escalated. We did not see evidence of themes identified and lessons learned. Lessons learnt from incidents were not shared effectively.	Radiology Manager	22 June 2020
3.11.15	Women & Children	Should	The service should ensure consultant handwriting is legible in all medical records.	Clinical Lead Paediatrics	22 June 2020
3.16.10	Clinical Support Services	Should	The trust should ensure effective processes are in place for the timely completion of diagnostic reports.	DLT Division of Clinical Support Services	22 June 2020
3.16.3	Clinical Support Services	Should	The trust should ensure effective processes are established for the cleaning of clinical rooms and equipment in the radiology department.	DLT Clinical Support Services	22 June 2020
3.16.9	Clinical Support Services	Must	Leaders must ensure they are visible and improve relationships between staff and managers.	DLT Clinical Support Services	22 June 2020

Actions to be submitted to the Evidence Assurance Group or Conditions and Notices Group in July

- 14 actions will be presented for approval in July. The team is confident in delivering all 14 actions with meetings scheduled in diaries through until September to maintain focus and pace.

ID Ref	Area	Category	Description	Owner	End
2.5.10	Medicine	Section 29	Staff understanding of the safeguarding process was inconsistent. We identified a serious safeguarding concern that we escalated to senior ward management. We had no confidence that they would take the required action. We escalated this concern to yourself for immediate action.	Lead Professional for Safeguarding Adults and Children	July 2020
2.2.8	Women & Children	Section 29	Systems and processes for identifying and managing risk were neither properly established nor operating effectively. We were not assured that duty of candour was being undertaken as required by the regulations. We were not assured that incidents were being investigated or graded to the appropriate level.	Risk & Governance Matron Women & Children	July 2020
2.1.10	Women & Children	Section 31	The Registered Provider must ensure that all policies and procedures are in line with national best practice and are current.	Risk & Governance Matron Women & Children	July 2020
2.1.9	Women & Children	Section 31	The Registered Provider will ensure that all incidents within the maternity service are reported and investigated in line with trust policy.	Risk & Governance Matron Women & Children	July 2020
1.1.8	Trust Board	Must	The trust must ensure divisional leadership has the capacity to support significant improvements in the safety and quality of care and that inconsistencies across divisions are reduced.	Chief Operating Officer	July 2020
2.1.10	Women & Children	Must	The trust must ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance.	Risk & Governance Matron Women & Children	July 2020
2.5.18	Medicine	Must	The trust must ensure that staff follow procedures in relation to safeguarding and that any safeguarding concerns are reported without delay.	Lead Professional for Safeguarding Adults and Children	July 2020
1.4.5	Standard Practice	Must	The trust must ensure there are sufficient and appropriate induction procedures for agency staff and competency checks for both agency staff and substantive staff who are moved from other areas of the hospital	Deputy Chief Nurse	July 2020
1.3.15	Trust Board	Must	The trust must review, define and implement a corporate strategy aligned to clear strategic priorities. Process for assurance including risk and governance process, accountability frameworks and the board assurance framework need to be revised, aligned and implemented and effectively monitored.	Deputy Chief Executive Officer	July 2020
3.1.14	Surgery	Should	The trust should ensure that patients receive the medicines at the time they are prescribed.	Surgical Matron, Day Surgery Matron	July 2020
3.6.17	Medicine	Should	The trust should ensure that work to review internal professional standards continues in a timely manner.	Divisional Director Medicine	July 2020
3.9.7	Medicine	Should	The trust should ensure there are systems in place to reduce and manage the high number of medical outliers.	Divisional Director Medicine	July 2020
3.9.6	Medicine	Should	The trust should review the availability and use of communication aids and other provisions to meet patients' individual needs within the department.	ED Matron	July 2020
3.1.15	Surgery	Should	Trust should ensure there is effective processes in place for surgical specialities to review patients in the emergency department in a timely way.	Divisional Director Surgery	July 2020

Forward plan for completion of actions

- We are now clear on the achievement trajectory of the 78 outstanding condition notices, must-do actions and should-do actions. The 'historic' column of 1 reflects the action declined in June related to DNACPR (Must-Do).
- Actions are continually discussed at both divisional leadership team level and at the IQIP review Group (Chaired by the CEO) to assess where actions can be brought forward for approval at the Evidence Assurance Group.

Area	Completed & Signed off	Historic	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Future	Total
Clinical Support Services	**15**					**1**				**1**		**17**
Must	5					1						**6**
Section 29	3											**3**
Section 31	4											**4**
Should	3									1		**4**
Medicine	**27**		**5**	**14**	**5**	**5**	**1**	**2**				**59**
Must	16		1	10	2			1				**30**
Section 29	1		1	2	1	2		1				**8**
Section 31	6			1								**7**
Should	4		3	1	2	3	1					**14**
Standard Practice	**40**	**1**	**1**	**3**	**8**	**3**	**1**	**4**	**1**			**62**
Must	27	1	1	3	7	2	1	3				**45**
Should	13				1	1		1	1			**17**
Surgery	**3**		**2**	**1**			**1**	**3**				**10**
Must	2											**2**
Should	1		2	1			1	3				**8**
Trust Board	**10**		**2**		**2**			**1**				**15**
GMC Condition	3											**3**
Must	6		2		2			1				**11**
Should	1											**1**
Women & Children	**33**		**4**		**1**	**2**		**3**				**43**
Must	9		1		1							**11**
Section 29	9		1									**10**
Section 31	9		2									**11**
Should	6					2		3				**11**
Total	**128**	**1**	**14**	**18**	**16**	**11**	**3**	**13**	**1**	**1**		**206**

Forward Plan Risk Assessment

- This table shows the current RAG status of all 78 outstanding actions.
- 1 scheme is currently behind plan. A must-do within the standard practice category:

  The Trust must continue to monitor and take action to improve completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms and that appropriate mental capacity assessments are undertaken for patients with a DNACPR in place.

- While good performance against target was being achieved, the move to a new national form has negatively impacted on our early progress. On-going education sessions with doctors on completing the new form has been implemented with close monitoring via weekly audits to assess outcomes.
- A video is being recorded and will be shared with doctors to aid them in completing the forms, in addition to on-going communication from divisional leadership.
- This action will be reviewed and considered for presentation in August 2020.

Area	Green	Red	Total
Medicine	**32**		**32**
Must	14		14
Should	10		10
Section 29	7		7
Section 31	1		1
Standard Practice	**21**	**1**	**22**
Must	17	1	18
Should	4		4
Women & Children	**10**		**10**
Should	5		5
Must	2		2
Section 31	2		2
Section 29	1		1
Surgery	**7**		**7**
Should	7		7
Trust Board	**5**		**5**
Must	5		5
Clinical Support Services	**2**		**2**
Must	1		1
Should	1		1
Total	**77**	**1**	**78**

Assurance actions are sustained and embedded

- It is recognised that whilst the Evidence Assurance Group provides robust check and challenge, there is a need to establish a more formal and longer-term assurance framework to ensure improvements are sustained and embedded in practice.

Clinical Reviews 15th July:

- The Clinical Review Programme restarted in June with the aim to assure the methodology and application of learning and change in clinical practice has been embedded. A team of 12 clinical and non-clinical staff are involved in the reviews; including the Chief Executive of HealthWatch Norfolk.

- Key lines of enquiry were structured around completed Must and Should do actions within the IQIP and areas of ongoing improvement focus or concern.

- Six areas have been revisited to date including the Acute Medical Unit, Oxborough, Main Outpatients, Gayton, West Raynham and Stanhoe.

- A timetable for further reviews is being developed.

Findings:

- Overall, there was recognition of good practice, evidence of improvement and well-engaged staff.

Immediate Concern:

- Lack of individualised identification of falls and nutritional needs risk on Gayton ward – addressed immediately.

Areas of good practice:

- Welcoming, engaged and enthusiastic staff.
- Sensitive and compassionate care and interactions observed
- Staff described how the organisation feels very different and communication and information has improved
- Visibility and engagement of CEO
- Improvements in nurse staffing and skill mix – AMU
- Positive feedback about diversity of FTSUG Champions
- Patients looked well cared for
- Good examples of MDT working
- Very positive patient feedback from all 6 areas
- IPC standards, including PPE
- Evidence of improvement in nursing documentation on Stanhoe
- Evidence of routine checks such as the Resuscitation trolley
- Positive feedback regarding the ‘Getting it Right’ programme

Assurance actions are sustained and embedded

Improvements required:

- There remains some inconsistencies with MCA on the ReSPECT forms. However, some examples of well completed and comprehensive forms evident
- Mental Health service provision – high number of patients requiring 'enhanced care'
- Meal service and protected meal times was inconsistent and the identification of patients requiring assistance varied – particular concern raised on Gayton Ward
- Call bells ringing for prolong periods of time on one ward
- Clinical Indicator Board 'How are we doing' not consistently up to date
- Senior nurse visibility
- Signage, patient information and customer care in outpatients
- Not all clinic appointments letters clear about telephone appointments causing confusion for some patients

Feedback:

- High level verbal feedback was provided to the Nurse in Charge on the day
- Written report detailing findings sent to each ward and Divisional Leadership Team within 48hrs.

Actions:

- Findings relating to the inconsistencies with ReSPECT documentation have been shared with the End of Life Care Lead to action
- Report findings relating specifically to patient experience, to be shared with the Patient and Carer Experience Forum to address, particularly in relation to meal service, signage and customer care
- Areas of improvement will be monitored through local action plans
- Incoming Chief Nurse and Senior Team will be monitoring the impact of patient outcomes and learning
- The clinical review team will re-visit areas of specific concern in 2 months to review progress and improvement

Timetable for Quality Improvement Deep Dives

- The following sets out the timetable for deep dives into varying clinical and cultural topics with the IQIP.
- The deep dives are presented at the Oversight & Assurance Group and to the Trust Board of Directors and are an important part of narrating the improvement journey.

Deep Dive Timetable 2020		
Date	**Presentation Title**	**Presentation Leads**
July 07/07/20	Radiology Improvement Journey	Nicola Berns: Divisional Director Mary Burney; General Manager for Clinical Support Services
August 04/08/20	End of Life Care	Chief Nurse, Head of Patient Experience, Deputy Medical Director
	Deteriorating Patients	
September 01/09/20	The Emergency Department	Emergency Department Clinical Team
	Emergency Care Pathway	Divisional Leadership Team, Medicine
October 06/10/20	Mortality & Structured Judgement Review and Learning	Deputy Medical Director
	Safeguarding & 24/7 Mental Health Liaison Team Service	Head of Safeguarding & Lead Nurse Older Peoples Care & Liaison Services (MHLT)
November 03/11/20	Fundamentals of Care	Chief Nurse
	Clinical audit & monitoring and management of policies and procedure	Director of Patient Safety
December 01/12/20	Staff Engagement and Health & Wellbeing	Deputy Chief Executive
	Culture	
January 2021	Recruitment & Retention Equality, Diversity and Inclusion	HR Director