Agenda Item: 09.1

Programme Update on Integrated Quality Improvement Plan (IQIP)

Trust Board 7 April 2020

WE LISTEN WE ACT WE CARE

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Summary

- To date, 82 of the 206 actions, which are a combination of Conditions, Must and Should Do action, have been approved for closure by the Evidence Assurance Group (EAG). A total of 6 were approved in February.

- 124 actions remain outstanding and whilst the plan is overall on trajectory, there are 44 further actions due within March and April. To support this increase, the Programme Management Office (PMO) have set up weekly meetings with action leads to ensure any concerns are highlighted and escalated at pace.

- It should also be noted that current operational pressures and activation of the Pandemic Plan in response to COVID-19 presents a risk to ensuring teams have sufficient capacity to meet multiple priorities. As a mitigation, additional resource will be employed to work alongside Divisions to provide the necessary support.

- At Month 11, we are reporting 78 actions currently on plan with 3 Must Do actions at risk and 3 Must do actions behind plan as defined by the IQIP RAG rating approach (see appendix A). Rationale for the slippage is detailed within this report.

- 40 Should Do actions still require detailed plans-on-a-page. We remain on track for these to have similar plans-on-a-page as the conditions and Must Do actions completed by early April 2020.

- An interim IQIP Programme Manager commenced in post 30 March to provide additional capacity to support Divisions in collating evidence and meeting the current trajectory to close actions.

The Board is asked to:

(a) Note the current position at Month 11 and work to address the 3 must-do actions currently rated at risk or behind plan

(b) Note the increasing operational pressures and activation of the Pandemic Plan in response to COVID-19 and the potential risk this poses to progress against the IQIP

(c) Note the increase in governance support and additional resource over the next three months to better ensure compliance with trajectory.

(d) Note the report and on-going work to complete the plans-on-a-page for the remaining 40 Should Do actions

Overall Programme Update

- At the time of writing this report; of the 206 actions, the Trust has assessed, validated and approved 82 actions through the Evidence Assurance Group

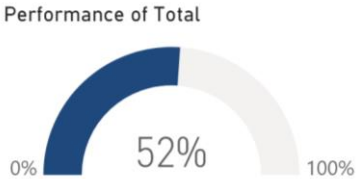
- There remain 124 actions which are a combination of conditions, Must and Should Do's still pending completion and validation – and the Trust is establishing a clear trajectory of when these actions will be completed and is holding divisions and corporate departments to account for delivery through its governance framework

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off		**43**	**10**	**14**	**15**	**82**
Clinical Support Services		3	2	3		**8**
Medicine		12	1	5	1	**19**
Standard Practice		15			10	**25**
Surgery		2			1	**3**
Trust Board		3				**3**
Women & Children		8	7	6	3	**24**
Not Completed	**3**	**62**	**11**	**8**	**40**	**124**
Clinical Support Services		2	1	1	3	**7**
Medicine		17	7	2	11	**37**
Standard Practice		31			15	**46**
Surgery					3	**3**
Trust Board	3	9			1	**13**
Women & Children		3	3	5	7	**18**
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

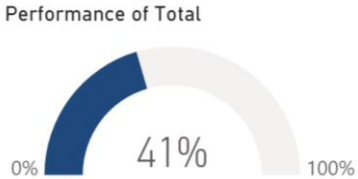


24
Total Complete

46
Total Planned

- 2 Conditions were approved for internal closure at the February IQIP Evidence Assurance Group. 1 was within the Section 31 Notices for Urgent and Emergency Care and 1 within the Section 29A Warning Notice for Maternity Services.
- Following the recommendation to the Trust Board to apply to the CQC to lift 5 of the Section 31 conditions, the Medical Director has written to the O&G Consultants to seek their agreement and support with this application

Must do's

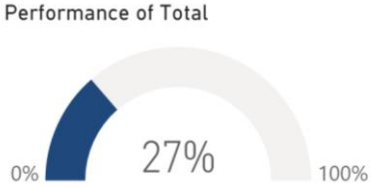


43
Total Complete

105
Total Planned

- 2 further Must Do actions were approved for closure in February and were related to the condition notices listed above
- 2 Must Do actions failed to be submitted in February but plans in place to present these at the Evidence Assurance Group (EAG) in March. Despite this the YTD performance against trajectory is on plan.

Should do's

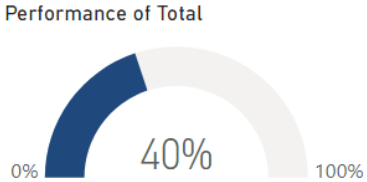


15
Total Complete

55
Total Planned

- 1 Should Do action was approved in February. Prioritisation of the completion of the Conditions and Must Do actions continues as planned
- Detailed plans on a page for the remaining 40 Should do actions will be completed by early April to enable monitoring and reporting of the entire programme. A revised trajectory will then be presented to the Board in May.

Total Plan



82
Total Complete

206
Total Planned

- There remains considerable work by operational and clinical teams to meet the forecast trajectory, in particular for schemes due March and April 2020. Further PMO support is being secured to support action owners in the progressing and compiling of evidence.

Actions approved by the Evidence Assurance Group or Conditions and Notices Group in February

- No actions submitted to the Evidence Assurance Group were declined this month.

ID Ref	Area	Category	Description	Owner	Approved
2.2.1	Women & Children	Must	The trust must ensure that service users with high risk care pathways receive consistent care planning and appropriate consultant review.	Clinical Lead Obstetrics & Gynaecology	24 February 2020
2.2.1	Women & Children	Section 29	There was a lack of ownership for care planning for high-risk service-users by consultants. Service-users with high-risk care pathways, such as twin pregnancies, did not routinely see the same consultant and experienced delays in care planning.	Clinical Lead Obstetrics & Gynaecology	24 February 2020
2.3.17	Medicine	Must	The trust must ensure that clear inclusion and exclusion criteria is in place for the 'fit to sit' area in minors and that there are sufficient numbers of staff available to monitor and review patients who have been placed in the 'fit to sit' area.	ED Matron, ED Operational Manager	24 February 2020
2.3.7	Medicine	Section 31	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.	ED Matron, ED Operational Manager	24 February 2020
3.1.4	Standard Practice	Must	The trust must ensure that medicines are stored, prescribed and administered safely, in line with trust policy.	Surgery Matron	24 February 2020
3.11.8	Standard Practice	Should	The service should ensure that all equipment in all areas is checked daily as per trust guidelines.	Deputy Head of Midwifery	24 February 2020

Actions that failed to be submitted to Evidence Assurance Group in February and actions required

ID Ref	Area	Category	Description	Owner	Due
1.3.20	Standard Practice	Must	The trust must ensure that staff completing root cause analysis or complex investigations are competent to do so.	Director of Patient Safety	February 2020
1.4.4	Standard Practice	Must	The trust must ensure that there is an effective system in place for agency staff to report incidents.	Deputy Chief Nurse	February 2020
3.1.12	Standard Practice	Should	The trust should ensure that information relating to the individual needs of patients is collected in a timely way.	Head of Nursing Surgery	February 2020

Narrative:

1.3.20
This action was due to be completed at the end of February but was delayed due to a change of action owner, previously Deputy Director of Patient Safety, moving under the Director of Patient Safety in January 2020. This action also needed to include the latest RCA training carried out and the sharing of all RCA trained staff with the Divisional Leadership Teams. Whilst this action was completed at the end of February, it had missed the February Evidence Assurance Group (EAG), but is due to be presented at the March EAG.

1.4.4
This action was due to be completed at the end of February, but was delayed due to action owner (Deputy Chief Nurse) being away from the Trust for an extended period of time due to overseas nurse recruitment and annual leave. Evidence for this action is due to be presented to the March EAG.

3.1.12
The deadline for this action is as per the original completion timescale. Plans on a Page for the remaining Should Do actions are due to be completed by the end of March and will include revised timeframes. It was agreed that Conditions and Must Do actions would be prioritised.

Month 11 IQIP Plan Progress Update

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

- This table shows the current RAG status of all 124 outstanding actions at Month 11.
- Information for each action is recorded on the IQIP tracker facilitating a single record of the programme's position. Rationale for behind-plan and at-risk schemes are detailed on the following pages.

Area	Should do's pending	Behind Plan	At Risk	On Plan	Total
Clinical Support	**2**			**5**	**7**
Must				2	2
Section 29				1	1
Section 31				1	1
Should	2			1	3
Medicine	**12**			**25**	**37**
Must	1			16	17
Section 29				7	7
Section 31				2	2
Should	11				11
Standard Practice	**14**	**3**	**3**	**26**	**46**
Must		3	3	25	31
Should	14			1	15
Surgery	**3**				**3**
Must					0
Should	3				3
Trust Board	**2**			**11**	**13**
GMC Condition				3	3
Must	1			8	9
Should	1				1
Women's & Childrens	**7**			**11**	**18**
Must				3	3
Section 29				3	3
Section 31				5	5
Should	7				7
Total	**40**	**3**	**3**	**78**	**124**

Actions 'at risk' at Month 11

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

ID Ref	Area	Description	Owner	End
1.5.4	Standard Practice	The trust must continue to review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in any escalation areas when in use.	Deputy Chief Operating Officer	March 2020
1.5.4	Standard Practice	The trust must continue to review the bed management and site management processes within the organisation to increase capacity and flow.	Deputy Chief Operating Officer	March 2020
2.5.3	Standard Practice	The trust must ensure that fluid balance charts are properly completed.	Lead Nurse Safe Compassionate Care	June 2020

Narrative:

This table sets out the 3 **Must DO** actions at risk currently. The Quality team and PMO team are working with teams to address delays and return to forecast trajectory date.

1.5.4

A comprehensive review of the form and function of the Trust's Site Team has been undertaken resulting in a proposed restructure. A full Site Team 'Management of Change' consultation commenced in December 2019 which was due to conclude in Jan 2020. Further issues came to light during the consultation process which resulted in the consultation being extended until end of March 2020. It is anticipated evidence for this action will be submitted to the April IQIP Evidence Assurance Group.

2.5.3

The action relating to fluid balance is combined within the Trust's documentation improvement actions as part of the Section 29A. Whilst there is evidenced improvement in the recording of patient's fluid balance, there is a lack of assurance of the pace of improvement and measurable outcomes in relation to wider documentation and there are concerns that improvement is not embedded in practice. Under the instruction of the Medical Director a new Steering Group is being set up and led by the Deputy Medical Director and Deputy Chief Nurse to lead on an MDT approach to improvement in record keeping.

Actions 'behind plan' at Month 11

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

ID Ref	Area	Description	Owner	End
2.5.8	Standard Practice	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.	Lead Nurse Safe Compassionate Care, Resus Manager	January 2020
1.3.20	Standard Practice	The trust must ensure that staff completing root cause analysis or complex investigations are competent to do so.	Director of Patient Safety	February 2020
1.4.4	Standard Practice	The trust must ensure that there is an effective system in place for agency staff to report incidents.	Deputy Chief Nurse	February 2020

Narrative:

This table sets out the 3 **MUST DO** actions at risk currently. The Quality team and PMO team are working with teams to address delays and return to forecast trajectory date.

2.5.8
Ongoing DNACPR audit data has demonstrated improvement with compliance, however the original timeframe has been impacted by the launch of the ReSPECT document in February within the organisation and across the STP. Implementation of this document is managed through the Safe and Compassionate Care Workstream as a Strategic Priority. DNACPR compliance with a specific question relating to the assessment of Mental Capacity Assessments continues as part of the Resuscitation Teams audit programme.

1.3.20
This action has been completed with Root Cause Analysis Training for key staff spanning all Divisions. Evidence will be submitted to the March IQIP Evidence Assurance Group for review and to seek approval to close this action.

1.4.4
Changes have been made to the induction of Agency/Bank staff to allow them intranet access to all QEHKL policies and procedure and access to Datix incident reporting. Datix incident reporting has been included on the Skills Passport held by Bank staff. A review of incidents reported by Agency and Bank staff will form evidence when submitted in March to the Evidence Assurance Group to seek closure of this action.

Forward plan for completion of actions

- We are clear on the current categorisation of all 124 outstanding actions as well as the current achievement trajectory. Following the completion of plans for all outstanding Must Do as well as the 40 Should Do actions, a revised timetable will be shared. This will be reported at the May Board.

Area	Completed & Signed off	Historic	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Dec 2020	Jan 2021	Future	Total
Clinical Support Services	**8**	**2**	**2**	**2**									**1**	**15**
Must	3		1										1	**5**
Section 29	2			1										**3**
Section 31	3			1										**4**
Should		2	1											**3**
Medicine	**19**	**4**	**8**	**6**	**8**	**4**		**3**	**1**		**1**	**2**		**56**
Must	12		1	5	6	1		2	1			1		**29**
Section 29	1				1	3		1			1	1		**8**
Section 31	5			1	1									**7**
Should	1	4	7											**12**
Standard Practice	**25**	**13**	**11**	**1**	**3**	**6**	**1**	**3**	**1**	**1**	**1**	**1**	**4**	**71**
Must	15	3	8	1	3	5	1	3		1	1	1	4	**46**
Should	10	10	3			1			1					**25**
Surgery	**3**	**3**												**6**
Must	2													**2**
Should	1	3												**4**
Trust Board	**3**	**1**	**1**	**2**	**1**	**1**		**1**	**1**		**2**	**3**		**16**
GMC Condition												3		**3**
Must	3	1	1	2		1		1	1		2			**12**
Should					1									**1**
Women & Children	**24**		**7**	**3**	**3**			**2**	**1**	**2**				**42**
Must	8		1		1				1					**11**
Section 29	7		2	1										**10**
Section 31	6		2	1	2									**11**
Should	3		2	1				2		2				**10**
Total	**82**	**23**	**29**	**14**	**15**	**11**	**1**	**9**	**4**	**3**	**4**	**6**	**5**	**206**

Appendix A: IQIP RAG Rating Approach

- In order to ensure the Board and relevant committees have effective oversight of each action, a strengthened monitoring function is in place for the programme. This provides a single and clear definition across all conditions, notices, must do and should do actions.

Status Rating	Description
Not started	Work on condition or notice has not commenced however a start date has been identified.
On plan	Milestones are being met for the reporting period stated and there are no risks identified to completion of the condition or notice.
At risk	Milestone has not been achieved within 10 working days of expected delivery date; however clear actions are being taken to support condition or notice being achieved by stated completion date.
Behind Plan	Milestones have not been achieved and condition or notice will not be achieved by stated completion date. In this case, a revised plan will need to be agreed and approved by the relevant
Embedded	All milestones for the condition or notice have been achieved and no further milestones are required.
Embedded with evidence	Evidence is being collected to assure the milestones are delivering the expected key performance indicators.