Agenda Item: 11

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for December 2020

EXCELLENCE STARTS HERE

Board of Directors (Public)

2 February 2021

Summary

- To date, 178 (86%) 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). 28 actions remain outstanding.

- 8 actions were taken to EAG in December, of which 4 were approved and 4 were declined. This was expected as several of the declined schemes required compliance with HR training trajectories. While progress is being made, the Trust has yet to achieve full compliance and the current impact of COVID risks the delivery of these actions. It has been agreed for DoHR to lead on a full review of the Trust's Mandatory training arrangements and agree a plan and improvement trajectory to meet the required standard, with aligned PMO support. In the spirit of openness and transparency this plan will be shared with the CQC ahead of its implementation with a meeting planned for w/c 1st February 2021.

- 4 of the 8 actions arising from the initial unannounced CQC visits feedback were approved in December, bringing the total approved to 5 (62.5%).

- Of the 28 outstanding actions, we are reporting 21 as 'behind plan' and 2 as 'at risk' in accordance with our defined risk parameters. In stating this, the complexity of delivering the cultural and behaviour change related to these actions cannot be underestimated. Strong focus and effort continues with revised trajectories and clear outcomes now set by the Evidence Assurance Panel in agreement with action owners. Additional resource is now being recruited to support these efforts via special measures monies from NHSE&I.

- To date, 42 (91%) of the 46 Section and Warning Notice conditions have been approved and moved to Business as Usual by the Trust. There are 4 remaining Warning Notices which require internal closure and relate exclusively to the Section 29A Warning Notice for Medicine

- Formal notification was received from the CQC on the 6th January 2021 from Heidi Smoult; Deputy Chief Inspector of Hospitals, confirming the Trust's application to lift 5, Section 31 Conditions for Maternity Services has been approved. This is a significant decision by the CQC and extremely positive for the organisation. This letter sends a message of confidence in the organisation and its leadership regarding these improvements and provides a further level of assurance through the external validation of improvement evidence.

- Following the unannounced CQC inspections in September 2020 a review has been completed to consider an application to request the lifting of 12 of the remaining 17 Section 31 conditions. A discussion has been held with the CQC Relationship Manager, who has agreed with this decision. A formal application will therefore be made during January 2021.

- Unlike the Section 31 Notices conditions, a formal application to request the lifting of Section 29A Warning Notice conditions is not required, as these are reviewed as part of an on-site inspection only. A mapping exercise of the existing 21, 29A Warning Notice conditions has therefore been completed against the December 2020 Inspection report. The CQC have confirmed that 5 of these conditions were reviewed and they are satisfied these have been met in full. The CQC are therefore removing these conditions. The remaining conditions were not reviewed during the September inspection, but will form part of the Trust's next on-site inspection later this year.

Summary

- The General Medical Council confirmed in December that it has removed the Trust from enhanced monitoring which is further evidence of improvement made

- Grant Thornton have been commissioned to audit the IQIP programme commencing in February. The audit will be completed in March with an assurance rating issued in a report to the Trust in early April.

- In response to the increasing numbers of COVID in-patients and its operational impact on the organisation, clinical reviews were ceased in October, with a plan to recommence in January. This has not been possible, although provisional plans are in place to complete a small scale review in February, adopting a risk based approach to prioritise areas for assessment.

- The Evidence Assurance Group has been effective in assuring progress of IQIP and the internal closure of CQC actions. The EAG format is now being expanded to provide robust challenge and assurance against other material action plans commencing with Serious Incidents and Maternity Improvement Plan actions in January 2021.

- The Trust Board is asked to note:
  a) The challenge in approving a small number of actions December – but the sustained progress being made across the wider programme.

  b) Risk of delivery due to the impact of COVID and mitigating actions in place including increased resource support

  c) The letter from the CQC confirming the lifting of 5 Section 31 Notice conditions for Maternity Services

  d) Confirmation from the CQC of the removal of 5, Section 29A Warning Notice conditions spanning Medicine and Diagnostic Imaging.

  e) The decision to formally apply to the CQC to request the lifting of a further 12 Section 31 conditions.

Overall Programme Update

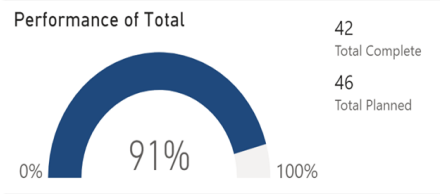
- Since the last report, the Trust evidenced and approved 4 actions bringing the total approved to 178 through the Evidence Assurance Group and the Condition Notices Oversight Group.
- There remain 28 actions which are a combination of conditions, Must and Should Do's still pending completion and validation.

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**3**	**87**	**17**	**22**	**49**	**178**
Clinical Support Services		6	3	4	3	**16**
Medicine		24	4	7	13	**48**
Standard Practice		34			15	**49**
Surgery		2			7	**9**
Trust Board	3	10			1	**14**
Women & Children		11	10	11	10	**42**
Not Completed		**18**	**4**		**6**	**28**
Clinical Support Services					1	**1**
Medicine		6	4		1	**11**
Standard Practice		11			2	**13**
Surgery					1	**1**
Trust Board		1				**1**
Women & Children					1	**1**
Total	**3**	**105**	**21**	**22**	**55**	**206**

Overall Programme Status

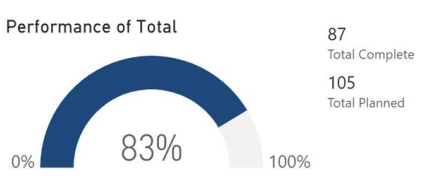
- This slide illustrates the current completion of all actions within the programme.

Conditions and GMC



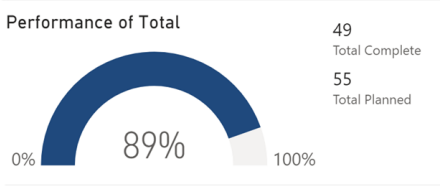
- The General Medical Council confirmed in December that it has removed the Trust from enhanced monitoring.
- 5 Section 31 Notice conditions for Maternity Services have been formally lifted by the CQC
- 5 Section 29A Warning Notice conditions spanning Medicine and Diagnostic Imaging have been closed by the CQC

Must do's



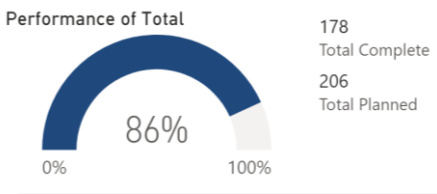
- One must–do action was approved this month by the Evidence Assurance Group relating to the reviewing, monitoring and updating of clinical policies (1.3.7).

Should do's



- Three should-do's were internally approved for closure this month. 1 in Surgery relating to timely surgical reviews in the emergency department (3.1.15); and two in Women & Children's relating to the implementation of their divisional strategy (3.15.1 and 3.15.2)

Total Plan



- 86% of all schemes are now approved with evidence.
- 91% of conditions are now approved with evidence.
- Focus is now on delivery of the final 28 schemes.
- The complexity of the remaining schemes requires additional resource input which is currently being sourced.

Formal Section and Warning Notice Closure by CQC

Section 31 Notice Conditions	
Maternity	The Registered Provider must ensure with immediate effect that staff reviewing, interpreting and classifying Cardiotocography (CTG) traces are trained and competent to do so.
	By 1 August 2018 the provider must submit to the Care Quality Commission written evidence of the completion of CTG training for all midwifery and medical staff that are currently working.
	The Registered Provider will ensure that there is a consultant obstetrician of the day nominated and who has oversight of the delivery suite from 9am to 7pm, Monday to Friday, with appropriate presence between 7pm Friday and 9am Monday.
	The Registered Provider will ensure a clear process and on call rota in place for consultant obstetric cover out of hours.
	The Registered Provider will ensure that all women and babies will receive ongoing risk assessments for the duration of their maternity care.
29A Warning Notice Conditions	
Medicine	Risk assessments were not fully completed for patients or actions taken to mitigate risk. National Early Warning Score 2 (NEWS 2) observations were not completed according to the correct time intervals. Escalation of patients with NEWS 2 scores that should trigger escalation and review was inconsistent
	There were control of substances hazardous to health (COSSH) contraventions in medical ward areas and hot water risks in sluice areas.
	Staff in the emergency department did not always ensure that patients and their relatives or carers were treated with dignity and respect.
Diagnostic Imaging	Staff in diagnostic imaging were unclear of the escalation process to ensure the correct escalation of patients with significant findings on diagnostic imaging.
	Staff were unclear about their scope of practice. Staff within cross sectional imaging were working outside of the existing Patient Group Direction (PGD) and administering contrast to children. Staff we asked were unsure where to access guidance. Not all staff were up to date with basic life support and anaphylaxis training.

Actions approved at the Evidence Assurance Group in December

- Four actions were approved by the Evidence Assurance Group this month.

ID Ref	Area	Category	Description	Owner	Due	Approved
1.3.7	Standard Practice	Must	The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.	Director of Patient Safety	December 2020	16 December 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	October 2020	16 December 2020
3.15.1	Women & Children	Should	The service should develop and implement a clear vision and strategy.	DLT Women & Children	December 2020	16 December 2020
3.15.2	Women & Children	Should	The service should ensure staff are aware of the CYP strategy.	DLT Women & Children	December 2020	16 December 2020

Actions declined at the Evidence Assurance Group in December

- Four actions were declined by the Evidence Assurance Group. The rationale for each are narrated in the 'behind Plan' slide with other actions overdue.
- We know these actions and the future trajectory of actions are challenging as they require a real demonstration of embeddedness of practice or performance against operational targets which have been hampered by the impact of Covid-19. The focus and oversight remains strong and the visibility and ownership of each action by division is robust.

ID Ref	Area	Category	Description	Owner	Due	Date Declined
1.2.10	Standard Practice	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	December 2020	16 December 2020
1.2.5	Standard Practice	Must	The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.	Divisional Director Women & Children	December 2020	16 December 2020
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	December 2020	16 December 2020
1.4.3	Standard Practice	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 HR	December 2020	16 December 2020

RAG rated programme position as of December

- The following sets out the overall programme position from the two previous slides. There is work underway to bring the red and amber actions back to EAG with more substantial evidence for assessment to internally close.

Area	At Risk	Behind Plan	On Plan	Total
Standard Practice	2	11		13
Must		11		11
Should	2			2
Medicine		8	3	11
Must		5	1	6
Section 29		3	1	4
Should			1	1
Clinical Support Services			1	1
Should			1	1
Surgery		1		1
Should		1		1
Trust Board		1		1
Must		1		1
Women & Children			1	1
Should			1	1
Total	2	21	5	28

RED	**Behind Plan:** Missed original deadline submission, but with revised date agreed by EAG
AMBER	**At Risk:** Expected to miss original deadline submission with work to mitigate slippage
GREEN	**On Plan:** To be presented to EAG in line with original submission deadline

Actions Behind Plan at the end of December

ID Ref	Area	Category	Description	Owner	Due	RAG
2.5.1	Medicine	Section 29	Records did not provide a full plan of individualised care and did not accurately reflect the needs or wishes of patients. Patients preferences and individual needs were not considered. There was inconsistent and incomplete record keeping in the emergency department. An individualised plan of care was not established for patients at the end of life. Patients requiring end of life care did not always receive appropriate care that met their needs.	Head of Nursing Medicine	December 2020	
2.5.4	Medicine	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.	Lead Nurse for Older People, Lead Professional for Safeguarding Adults and Children	September 2020	
2.5.23	Medicine	Must	The trust must address specialist palliative consultant staffing and put measures in place to improve in line with national standards.	Medical Director	December 2020	
2.5.4	Medicine	Must	The trust must ensure mental capacity assessments are consistently and competently carried out where required.	Lead Nurse for Older People, Lead Professional for Safeguarding Adults and Children	September 2020	
3.9.1	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.	ED Operational Manager	September 2020	
2.5.4	Medicine	Must	The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.	Lead Nurse for Older People, Lead Professional for Safeguarding Adults and Children	September 2020	
2.5.4	Medicine	Must	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards	Lead Nurse for Older People, Lead Professional for Safeguarding Adults and Children	September 2020	
2.5.14	Medicine	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	December 2020	
2.5.8	Standard Practice	Must	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.	Head of Patient Experience	October 2020	
1.3.6	Standard Practice	Must	The trust must ensure clear processes are in place for sharing learning from incidents, complaints and audits with staff.	Director of Patient Safety	December 2020	
2.5.2	Standard Practice	Must	The trust must ensure patient care records are accurate, complete and contemporaneous and stored securely.	Head of Nursing Medicine	December 2020	

Actions Behind Plan at the end of December

ID Ref	Area	Category	Description	Owner	Due	RAG
1.2.4	Standard Practice	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 HR	November 2020	
2.5.3	Standard Practice	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	September 2020	
1.4.3	Standard Practice	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 HR	December 2020	
1.3.18	Standard Practice	Must	The trust must ensure that processes for incident reporting, investigation, actions and learning improve and become embedded across all services.	Director of Patient Safety	December 2020	
1.3.21	Standard Practice	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	December 2020	
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	December 2020	
1.2.10	Standard Practice	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	December 2020	
1.2.5	Standard Practice	Must	The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.	Divisional Director Women & Children	December 2020	
3.5.4	Surgery	Should	The service should develop and implement a clear vision and strategy.	DLT Surgery	December 2020	
1.3.17	Trust Board	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	December 2020	

Actions Behind Plan at the end of December

Narrative:

2.5.1: Individual Care Plans - There is a risk to this scheme in assuring a sustainable trend line of improvement although there is strong leadership from the Deputy Medical Director and Head of Nursing – Medicine through the newly established Documentation Group.

2.5.4: MCA - This actions was declined due to lack of sufficient evidence. A review of work to address these actions will now take place to better understand how to progress. An audit plan will be developed and EAG has asked for regular updates to monitor improvements and will be brought back in February.

2.5.23: Palliative - At risk due to the concern over the successful recruitment to the palliative consultant role.
2.5.14

3.9.1: Four-hour ED - This action was declined pending a sustained improvement in the national 4-hour standard and will be represented to EAG in the latter part of Q4.

2.5.8: DNACPR - Due to the complex nature of this action, it is being brought to EAG in March. Fortnightly meetings are being established to support delivery to this date.

1.3.6: Shared learning – Work to embed learning from complaints and incidents is still on-going and will be brought back to EAG in March when teams feel assured they have a strong evidence-base, which is not in place currently.

2.5.2: Care Records – Further work is required and in agreement with the Head of Nursing, this will be audited and presented in February.

1.2.4: HR process: Progress has been achieved but more evidence is needed to demonstrate completion and compliance. This will be presented in February.

2.5.3: Fluid balance – audits are on-going to monitor improvement with a revised submission date of February.

Actions Behind Plan at the end of December

Narrative:

1.4.3: Mandatory Training – This will be presented to EAG in December as improvements have been made and there is a clear trajectory towards compliance. The risk is EAG may want to achieve compliance prior to approving.

1.3.18: Process embedded - Work to embed learning from complaints and incidents is still on-going and will be brought back to EAG in
1.3.21 March when teams feel assured they have a strong evidence-base, which is not in place currently.

1.2.7: Staff Appraisals - This scheme was declined due to the recent September 2020 CQC Report whereby a further Should Do Action was identified regarding mandatory training compliance across the trust. The panel requested that this is re-presented in April 2021.

1.2.10 Duty of Candour - The panel have requested that this scheme is re-presented in January 2021, and includes a bespoke graph which displays the 3 phases across the past 12 months.

1.2.5: Training rates – This scheme was declined due to the recent September 2020 CQC Report whereby a further Should Do Action was identified regarding mandatory training compliance across the trust. The panel requested that this is re-presented in April 2021.

3.5.4 Surgery Strategy – This will be re-presented in March as EAG required a more detailed strategy with key performance indicators stated. This will be re-presented in March 2021.

1.3.17: Regulatory learning - This will likely be presented to EAG in March as there is a requirement to build a robust evidence-base of sustained learning.

Actions At Risk at the end of December

ID Ref	Area	Category	Description	Owner	Due	RAG
3.4.2	Standard Practice	Should	The trust should ensure patients on the 62-day pathway receive treatment in line with the national target.	Divisional General Manager Surgery	March 2021	
3.9.8	Standard Practice	Should	The trust should ensure that patients commence treatment for cancer within 62 days in line with national guidance.	Deputy Chief Operating Officer	March 2021	

3.4.2: 62-day pathway - This action is at risk due to the potential impact of a second peak of Covid-19.

3.9.8: 62-day pathway - This action is at risk due to the potential impact of a second peak of Covid-19.

Actions to be submitted to the Evidence Assurance Group in January

- None of the outstanding 28 actions are due in January however Evidence Assurance Group will meet to assess actions from the Women & Children Action Plan as part of the expanded role of this forum.

Forward plan for completion of actions

- Actions are continually discussed at both divisional leadership team level and at the Quality to assess where actions can be brought forward for approval at the Evidence Assurance Group.

Area	Completed & Signed off	Historic	Feb 2021	Mar 2021	Apr 2021	Total
Clinical Support Services	**16**		**1**			**17**
Must	6					**6**
Section 29	3					**3**
Section 31	4					**4**
Should	3		1			**4**
Medicine	**48**	**8**	**2**		**1**	**59**
Must	24	5	1			**30**
Section 29	4	3	1			**8**
Section 31	7					**7**
Should	13				1	**14**
Standard Practice	**49**	**11**		**2**		**62**
Must	34	11				**45**
Should	15			2		**17**
Surgery	**9**	**1**				**10**
Must	2					**2**
Should	7	1				**8**
Trust Board	**14**	**1**				**15**
GMC Condition	3					**3**
Must	10	1				**11**
Should	1					**1**
Women & Children	**42**				**1**	**43**
Must	11					**11**
Section 29	10					**10**
Section 31	11					**11**
Should	10				1	**11**
Total	**178**	**21**	**3**	**2**	**2**	**206**

Actions arising from the two unannounced CQC visits

- Eight actions arising from the unannounced CQC visit will now be monitored within the programmes governance framework.
- Four actions were completed and approved by EAG this month, bringing the total internally approved to 5 (62.5%).
- Continued progress of the other actions is being monitored as per the timescales set.

Ref No:	Letter Issue Date	Core Service	CQC Inspection Findings	New Action Y/N	Action Owner	Trust IQIP Plan Completion Date	RAG Status
4	18/09/2020	Urgent and Emergency Medicine	There appeared to be a reliance on EDIS for the monitoring of target data, with minimal local discussions around targets and performance across the clinical team	Yes	Divisional Leadership Team	30-Nov	C
9	18/09/2020	Maternity	The leadership team was newly established and had not had enough time to address all their concerns and embed best practice.	Yes	Divisional Leadership Team	30-Apr	G
10	18/09/2020	Maternity	The culture within the obstetricians was challenging and showed some resistance to change. However, leads were open about their concerns and had plans in place to address them.	Yes	Divisional Leadership Team	30-Apr	G
12	24/09/2020	Surgery	Venous thromboembolism (VTE) assessments were not consistently completed on Gayton and Elm wards. This issue was particularly noted in medical patients being cared for on the ward. In addition, it was not clearly recorded whether VTE assessments completed at pre admission assessments were reviewed/ reassessed on admission to hospital.	Yes	Divisional Director	31-Dec	C
13	24/09/2020	Surgery	Some surgeons felt that they were not fully supported by “middle managers” although senior leadership was praised. They were also “unhappy” with the number of cancelled procedures as a result of increased activity within the trust.	Yes	Divisional Leadership Team	31-Dec	C
14	24/09/2020	Surgery	We observed anaesthetic medication prepared for administration (150 mls Propofol in three syringes) unattended in one anaesthetic room. The anaesthetic staff reported that they had briefly left the room.	Yes	Divisional Director	30-Nov	C
16	24/09/2020	End of Life Care	Some staff felt that they had not been consulted in changes to ward activity, and that they had not been provided with adequate training to manage different patient groups. They also felt unsupported when they escalated concerns to the bed management team about risks of accepting patients, particularly out of hours.	Yes	Deputy Chief Operating Officer	28-Feb	G
17	24/09/2020	Diagnostic Imaging	Staff were not always fully engaged with changes within the department, and some staff reported that that they felt unsupported as a result of gaps or changes to leadership.	Yes	Divisional Leadership Team	30-Dec	C