Agenda item 10

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

Integrated Quality Improvement Plan Programme Update Reporting for October 2020

EXCELLENCE STARTS HERE

Board of Directors (Public)
1 December 2020

Summary

- To date, 170 (83%) 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). 36 actions remain outstanding.
- 19 actions were approved in the last reporting period which is a significant achievement that all teams should be proud of. Focus now turns to embedding some of the more trust-wide learning and practices, as well as the development of local strategies.
- Fortnightly meeting are being strengthened further to increase support to deliver these changes and to maintain pace and focus through a potential increase in Covid-19 patients. The appointment of an interim PMO Manager in late September has aided this effort and will remain in post through March to assure momentum.
- 10 schemes are rated as behind plan and 8 actions are at risk this month. These are being managed closely by Divisions and respective support teams.
- Good progress is being made to deliver the 8 new actions resulting from the unannounced CQC visits in September. One action has been closed with plans in place for the remainder. Updated positions are detailed on slide 14.
- A review of the Section 31 notices has commenced to recommend which conditions will be incorporated in an application to the CQC requesting these are lifted. This will be completed for the December Quality Committee and January Board
- The Trust Board is asked to:
    a) note the exceptional work by teams to achieve 170 actions being internally closed
    b) the increased support in place for the remainder of the programme
    c) strong grip over the new actions resulting from the CQC unannounced visits

Overall Programme Update

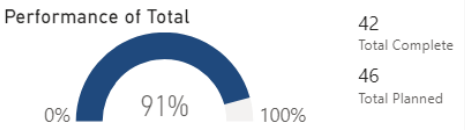
- Since the last report, the Trust evidenced and approved 19 actions bringing the total approved to 170 through the Evidence Assurance Group.
- There remain 36 actions which are a combination of conditions, Must and Should Do's still pending completion and validation.

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**3**	**85**	**17**	**22**	**43**	**170**
Clinical Support Services		6	3	4	3	**16**
Medicine		23	4	7	13	**47**
Standard Practice		33			15	**48**
Surgery		2			4	**6**
Trust Board	3	10			1	**14**
Women & Children		11	10	11	7	**39**
Not Completed		**20**	**4**		**12**	**36**
Clinical Support Services					1	**1**
Medicine		7	4		1	**12**
Standard Practice		12			2	**14**
Surgery					4	**4**
Trust Board		1				**1**
Women & Children					4	**4**
Total	**3**	**105**	**21**	**22**	**55**	**206**

Overall Programme Status

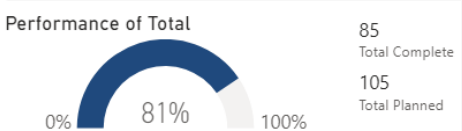
- This slide illustrates the current completion of all actions within the programme.

Conditions and GMC



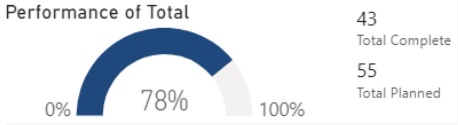
- 2 conditions were approved this month relating to patients being treated with dignity and respect within the ED (2.5.12) as well as improved management oversight in medical care (2.5.15). The former was reinforced through feedback from the unannounced CQC visit and subsequent response letter in September.

Must do's



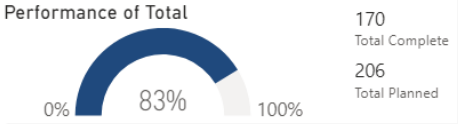
- 9 further Must Do actions were approved for closure in October, of which 2 were Trust Board, 1 standard practice, 4 Medicine, 1 Clinical Support and 1 Women & Children.

Should do's



- 8 should do actions were approved of which 5 are in Medicine, 1 in Women and Children and 1 in standard practice.

Total Plan



- 83% of all schemes are now approved with evidence.
- 91% of conditions are now approved with evidence.
- This was the most successful month for approving actions.
- Focus is now on delivery of the final 36 schemes.
- Teams are confident in the actions required and continue to be fully committed.

Actions approved at the Evidence Assurance Group in October

- 19 actions were approved since the last report. This is a significant achievement and reflects the dedication and focus of operational teams.

ID Ref	Area	Category	Description	Owner	Due	Approved
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	October 2020	31 October 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	October 2020	27 October 2020
1.3.2	Standard Practice	Must	The trust must ensure that there is an effective and consistent process for governance, quality improvement and risk management in all departments and across divisions to ensure appropriate escalation to the board.	Director of Patient Safety	December 2020	31 October 2020
1.8.2	Medicine	Should	The trust should ensure morbidity and mortality meeting need to have a focus on the end of life care journey and how to improve end of life care.	Deputy Medical Director	December 2020	27 October 2020
2.3.16	Medicine	Must	The trust must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival. The registered provider must ensure that this clinical assessment and the rationale for level of care provided is clearly documented in patients' records.	ED Matron	September 2020	31 October 2020
2.5.12	Medicine	Section 29	Staff in the emergency department did not always ensure that patients and their relatives or carers were treated with dignity and respect.	Lead Nurse	October 2020	27 October 2020
2.5.15	Medicine	Section 29	There was a lack of management oversight and assurance in relation to the risks identified during the inspection in medical care, the emergency department, end of life care and gynaecology services. There was no clear leadership for the end of life care service.	DLT Medicine	October 2020	31 October 2020
2.5.25	Medicine	Must	The trust must ensure effective ownership and monitoring of performance to drive improvement within the service.	Head of Patient Experience	October 2020	27 October 2020
2.5.26	Medicine	Must	The trust must ensure that a personalised plan of care is successfully implemented across the organisation to ensure that end of life patients receive person-centred care that meets their needs.	Head of Patient Experience	October 2020	27 October 2020
2.5.27	Medicine	Must	The trust must ensure systems and processes are in place, and effective, to identify patients who require end of life care and to instigate an appropriate pathway.	Head of Patient Experience	October 2020	27 October 2020
3.11.4	Women & Children	Must	The trust must ensure that all medical and nursing staff have the appropriate completed competencies.	DLT Women & Children	October 2020	27 October 2020
3.12.1	Women & Children	Should	The service should consider performing regular audits of record keeping.	Deputy Head of Midwifery	October 2020	27 October 2020
3.16.4	Clinical Support Services	Must	The trust must ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.	DLT Clinical Support Services	October 2020	31 October 2020
3.6.18	Medicine	Should	The trust should ensure that the standards are monitored on an ongoing basis once they are in place.	Divisional Director Medicine	September 2020	27 October 2020
3.6.6	Standard Practice	Should	The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	Deputy Medical Director	December 2020	27 October 2020
3.6.7	Medicine	Should	The trust should ensure call bells are answered promptly to respond to patient risk and need.	ED Operational Manager	September 2020	27 October 2020
3.8.1	Medicine	Should	The trust should ensure that patients, relatives and carers receive timely emotional support.	ED Matron	October 2020	27 October 2020
3.8.3	Medicine	Should	The trust should ensure that patients' pain levels are assessed, addressed and monitored in line with national guidance.	ED Matron, ED Clinical Lead	October 2020	31 October 2020
3.9.3	Standard Practice	Should	The trust should ensure that internal professional standards are created and monitored.	Divisional Director Medicine	October 2020	27 October 2020

Actions declined at the Evidence Assurance Group in October

ID Ref	Area	Category	Description	Owner	Due	Date Declined	RAG
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	27 October 2020	Red

Narrative:

3.1.15: Additional information was sought for this scheme to improve the trend line of evidence. This will be re-presented to EAG by December 2020

RAG rated programme position as of October

- 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	Green	Amber	Red	Total
Clinical Support Services	1			1
Should	1			1
Medicine	3	3	6	12
Must	1	1	5	7
Section 29	1	2	1	4
Should	1			1
Standard Practice	8	4	2	14
Must	8	2	2	12
Should		2		2
Surgery	2	1	1	4
Should	2	1	1	4
Trust Board	1			1
Must	1			1
Women & Children	3		1	4
Should	3		1	4
Total	18	8	10	36

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 October

- Ten actions are rated as behind plan.

ID Ref	Area	Category	Description	Owner	Due
2.5.3	Standard Practice	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	September 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
2.5.4	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
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
2.5.6	Medicine	Must	The trust must ensure that Deprivation of Liberty Safeguards (DoLS) are properly applied for and that training materials are accurate and supported by the Act.	Lead Nurse for Older People, Lead Professional for Safeguarding Adults and Children	September 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
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
3.11.11	Women & Children	Should	The department should ensure that all relevant maternity staff are trained and competent to implement the Gap and Grow package.	Practice Development Midwife	October 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

Actions Behind Plan at the end of October

Narrative:

2.5.3: Fluid Balance: This will be brought back to EAG in February along with the evidence for Section 29A, Condition 1 - nursing documentation. (2.5.1)

2.5.4: MCA: These actions were declined due to lack of sufficient evidence although progress has been made. Evidence of further compliance is required following new actions in place which includes training and MCA assessment. Regular progress updates to EAG have been agreed with planned resubmission in February 2021, or earlier if evidence provides the required level of assurance.

2.5.6: DoLS: Clear progress has been made and will be brought back to EAG in November for review.

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.

3.1.15: ED Surgical Review: Additional information was sought for this scheme to improve the trend line of evidence. This will be re-presented to EAG by December 2020.

3.11.11: Gap and Grow: This action will be presented to EAG in November as it is pending an improvement on consultant training increasing from the current 50%. Nursing compliance is very strong.

3.9.1: ED Performance: This action was declined pending a sustained improvement in the national 4-hour standard. It has been agreed to resubmit this in February to align with the UEC programme.

Actions At Risk at the end of October

- Eights action are rated as at risk.

ID Ref	Area	Category	Description	Owner	Due
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
2.5.23	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
2.5.14	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
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
2.5.2	Standard Practice	Must	The trust must ensure patient care records are accurate, complete and contemporaneous and stored securely.	Head of Nursing Medicine	December 2020
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
3.5.2	Surgery	Should	The trust should ensure strategies to manage access to the service and patient flow through the service are embedded.	Divisional General Manager Surgery, Head of Nursing Surgery	November 2020

Narrative:

2.5.1: Documentation: 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. Agreed for submission to EAG in February.

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

1.2.4: Staff grievances: This is unlikely to be achieved in November as the Trust has yet to manage employment cases in line with Trust policy, although there has been improvements in other areas.

2.5.2: Documentation: Forming part of the documentation review, we are flagging as at-risk as this will be dependent on consistent evidence. An early progress assessment may move this out of 'at-risk' and to on-plan, based on work being undertaken.

Actions At Risk at the end of October

Narrative:

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.

3.5.2: Access to Surgical services: This will be presented to EAG in November although there is concern of evidence of embedding being viewed as not sufficient by EAG panel members.

Actions to be submitted to the Evidence Assurance Group in November

- Efforts continue to assess actions that can be brought forward. At the time of writing, it is anticipated five actions will now be presented.

Narrative:

2.5.6: **DoLs (Corporate)** - The trust must ensure that Deprivation of Liberty Safeguards (DoLS) are properly applied for and that training materials are accurate and supported by the Act. (Currently behind plan)

3.11.11: **Gap & Grow Training (W&C)** - The department should ensure that all relevant maternity staff are trained and competent to implement the Gap and Grow package. (Currently behind plan)

3.5.2: **Strategy (Surgery) -** The trust should ensure strategies to manage access to the service and patient flow through the service are embedded. (Due November 2020)

3.1.12: **Information Collection (Surgery) -** The trust should ensure that information relating to the individual needs of patients is collected in a timely way. (Due December 2020)

04/2020*: EDIS Reliance (ED) – There appears to be a reliance on EDIS for the monitoring of target data, with minimal local discussions around targets and performance across the clinical team.

**New action following CQC unannounced inspection in September 2020.*

Forward plan for completion of actions

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

Area	Completed & Signed off	Historic	Nov 2020	Dec 2020	Feb 2021	Mar 2021	Apr 2021	Jun 2021	Total
Clinical Support Services	**16**				**1**				**17**
Must	6								**6**
Section 29	3								**3**
Section 31	4								**4**
Should	3				1				**4**
Medicine	**47**	**6**		**3**	**2**		**1**		**59**
Must	23	5		1	1				**30**
Section 29	4	1		2	1				**8**
Section 31	7								**7**
Should	13						1		**14**
Standard Practice	**48**	**2**	**1**	**9**		**2**			**62**
Must	33	2	1	9					**45**
Should	15					2			**17**
Surgery	**6**	**1**	**1**	**2**					**10**
Must	2								**2**
Should	4	1	1	2					**8**
Trust Board	**14**			**1**					**15**
GMC Condition	3								**3**
Must	10			1					**11**
Should	1								**1**
Women & Children	**39**	**1**		**2**			**1**		**43**
Must	11								**11**
Section 29	10								**10**
Section 31	11								**11**
Should	7	1		2			1		**11**
Total	**170**	**10**	**2**	**17**	**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.
- One action has already been closed. Plans on a Page have been drafted for the remainder of the schemes.
- Good progress is being made.

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

Ref No:	Letter Issue Date	Core Service	CQC Inspection Findings	New Action Y/N	Action Owner	Trust IQIP Plan Completion Date	RAG Status	Commentary
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-Dec	G	Information has been gathered and will be presented in November to EAG. There is substantial evidence available from the team to support a strong submission.
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	The external maternity concluded in October and an action plan has been developed with full divisional leadership team input with oversight from the Medical Director as Senior Responsible Officer. The final plan which consists of 63 specific actions with measurable KPI's of success is being submitted to IQIP-RG for approval on 16 November.
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	As per above, the detailed plan addresses the challenges with date-specific actions. The completion date has been set for April so that evidence of embedding can be demonstrated through Quarter 4 of 2020 - 21.
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	G	Significant work has been undertaken under the leadership of the Medical Director. The Trust has been above national target for the previous three months 97.99%(June); 98.3% (July); and 97.5% (August). The Trust further improved to 98.6% in September and is on plan to submit in December.
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 *31 July 2021	G	The Trust has put an established Theatres Restoration programme in place which is actively monitoring utilisation, performance and other metrics. A bespoke engagement plan is being developed with the initial planning meeting held on 09 November.
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	This action has been internally closed following submission of evidence and a request from EAG to undertake spot checks to evidence non-recurrence; which were completed. A review of Datix will also be monitored to ensure on-going compliance with the standard operating procedure.
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	We will continue to build on the work to date and undertake a review of training and implement additional training so people feel more confident and supported in their roles. A review of escalations will be completed and lessons will be shared.
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	31-Dec *31 July 2021	G	A bespoke engagement plan has been developed with input from staff with the Trust's Head of Culture and is scheduled to occur on 15 December.

31 July 2021 is the date when embedded learning will be reassessed for these 2 actions.