Agenda item 11

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for September 2020

EXCELLENCE STARTS HERE

Trust Board of Directors (Public)
03 November 2020

Summary

- To date, 151 (73%) 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). 55 actions remain outstanding.
- 18 actions were taken to EAG in September, of which 6 were approved. This was a disappointing outcome but resulted from a number of factors - mainly time constraints in compiling sufficient information against each action during two visits from the CQC as well as teams responding to c200 information requests. Another factor was EAG seeking a more sustained trend of improvement post the impact of Covid-19, which is right in terms of obtaining assurance.
- A number of measures have now been implemented to address the 12 actions behind plan as well as those actions due for review in October. These include:

  a) Additional senior time commitment from the Director of Transformation, the new interim Better Hospital Team (PMO) Manager, the Associate Director of Quality Improvement, the Quality team and the 2 dedicated nurses funded by Special Measures funding this month.
  b) Task-and-finish meetings established to fast-track actions and evidence for audits and analytics.
  c) Weekly review meetings, where required to ensure pace is maintained.

- As a result of this effort, 3 of the declined actions will be re-submitted to EAG the week of 26 October and 02 November. A further 19 actions have been prepared and will be reviewed by EAG for closure over the same fortnight. This should give the Board confidence the impact of the visits has been appropriately mitigated and the resiliance of the operational teams is strong.
- The RAG rating of outstanding schemes is set out on slide 9. In line with good governance, each scheme is rated against the defined criteria. This means schemes rated Red (Behind Plan) will retain this categorisation until EAG internally close the action. No change in submission deadlines will occur for the remainder of the programme.
- Plans on a Page for the 8 actions arising from the unannounced CQC visits will all be completed by the time of this meeting and a verbal update will be provided. Work to evidence completion of these actions is already underway with good ownership by Divisions.
- The Board is asked to note:

  a) The challenge in approving actions in September – and the immediate measures put in place to recover the position for October

  b) Note progress on developing plans for actions arising from the CQC visit – to be monitored within the same governance framework as the original actions.

Overall Programme Update

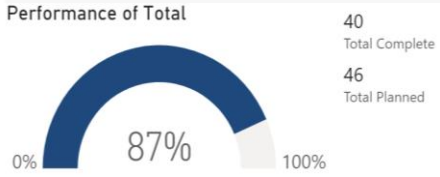
- Since the last report, the Trust evidenced and approved 6 actions bringing the total approved to 151 through the Evidence Assurance Group and the Condition Notices Oversight Group.
- There remain 55 actions which are a combination of conditions, Must and Should Do's still pending completion and validation.

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**3**	**76**	**15**	**22**	**35**	**151**
Clinical Support Services		5	3	4	3	**15**
Medicine		19	2	7	8	**36**
Standard Practice		32			13	**45**
Surgery		2			4	**6**
Trust Board	3	8			1	**12**
Women & Children		10	10	11	6	**37**
Not Completed		**29**	**6**		**20**	**55**
Clinical Support Services		1			1	**2**
Medicine		11	6		6	**23**
Standard Practice		13			4	**17**
Surgery					4	**4**
Trust Board		3				**3**
Women & Children		1			5	**6**
Total	**3**	**105**	**21**	**22**	**55**	**206**

Overall Programme Status

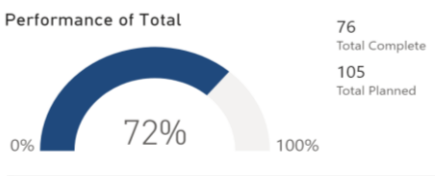
- This slide illustrates the current completion of all actions within the programme.

Conditions and GMC



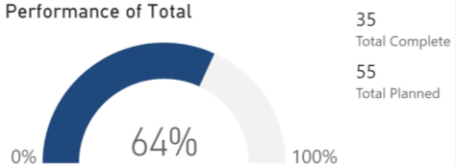
- 1 section 31 condition within Medicine was approved for closure in September.

Must do's



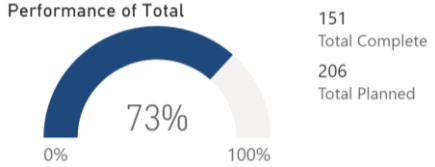
- 5 further Must Do actions were approved for closure in September. 1 related to Medicine Division, 2 related to Standard Practice and 2 related to Trust Board.

Should do's



- There were no should do's approved for closure in September.

Total Plan



- 73% of all schemes are now approved with evidence.
- There were 18 schemes presented in September. Only 6 were approved with 12 requiring a strengthening of the narrative which will be represented to EAG in Q3. The CQC visit and the request to compile c200 pieces of evidence led to insufficient evidence being provided or a lack of robust narrative. The Better Hospital Team, IQIP team as well as dedicated IQIP nurses will be increasing their time to ensure all historic actions and those due in October have additional support wrapped around them to improve the approval rate moving forward.

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

- Six actions were approved since the last report. This is significantly less than the 18 actions submitted to Evidence Assurance Group in September. Steps have been taken to ensure these are re-presented to EAG at pace. This report describes the rationale for this anomaly in detail on slides 7 & 8.
- The Board should take assurance that extra resource has being pulled in to support teams collate evidence and write robust narrative for October.

ID Ref	Area	Category	Description	Owner	Due	Approved
1.3.16	Trust Board	Must	The trust must review, simplify and provide clarity to the governance, risk and quality performance processes. To improve oversight at board and provide adequate measures for assurance that quality improvement progress is being made, with robust evidence of appropriate check and challenge.	Director of Patient Safety	September 2020	28 September 2020
1.3.4	Standard Practice	Must	The trust must ensure that serious incidents are identified, reported and investigated in a timely manner.	Director of Patient Safety	September 2020	28 September 2020
1.3.8	Trust Board	Must	The trust must ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	Director of Strategy	September 2020	21 September 2020
2.3.14	Medicine	Must	The trust must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line with relevant national clinical guidelines within 15 minutes of arrival.	ED Matron	September 2020	30 September 2020
2.3.6	Medicine	Section 31	The registered provider must ensure that there is an effective system in place to robustly clinically assess all patients who present to the emergency department in line with relevant national clinical guidelines within 15 minutes of arrival. The registered provider must ensure that the staff required to implement the system are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.	ED Matron	September 2020	30 September 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	September 2020	27 July 2020

Actions declined at the Evidence Assurance Group or Conditions and Notices Group in September or behind plan

ID Ref	Area	Category	Description	Owner	Due	Date Declined
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	September 2020	21 September 2020
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	December 2020	21 September 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	September 2020	28 September 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	30 September 2020
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	21 September 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	September 2020	21 September 2020
2.5.3	Standard Practice	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	September 2020	21 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	21 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	21 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	21 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	21 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	21 September 2020

Actions declined at the Evidence Assurance Group or Conditions and Notices Group in September or behind plan

ID Ref	Area	Category	Description	Owner	Due
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
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
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

Narrative:

1.2.5: These schemes were declined with agreement that a trajectory is developed in order to achieve 90% compliance. This will continue
1.2.7 escalated through Divisional PRM's as well as monthly updates to EAG for information to agree when the action can be internally closed. HR are developing trajectory.

1.3.18: Good work was noted however there was a requirement from EAG that further embedded practice is required. This will be re-presented to EAG in November (2 months).

2.3.16: EAG sought an audit of 50 sets of notes across four separate months to demonstrate evidence of rationale for clinical assessment is documented within the notes. More robust narrative on systems was also sought. This will be re-presented in October pending completion of the audit.

2.5.1: EAG sought baseline audits be undertaken with the Deputy Medical Director to redefine the subsets. This will be re-presented in Q4
2.5.2 given the scale of work to demonstrate sustained improvement.

2.5.3: A more robust audit tool is required to demonstrate improvement with fluid balance charts. EAG have requested a trajectory to monitor month-by-month prior to any decision to approve closure. This will be continually reviewed and assessed when ready for re-submission to EAG.

Actions declined at the Evidence Assurance Group or Conditions and Notices Group in September or behind plan

Narrative:

2.5.4: These actions were declined due to lack of sufficient evidence. A review of work to address these actions will now take place to
2.5.6 better understand how to progress. An audit plan will be developed and EAG has asked for regular updates to monitor improvements.

3.6.18: This was postponed due to extended annual leave and will be presented in October.

3.6.7: The data available does not adequately demonstrate an improvement. Data quality issues will be addressed and a new method of assessing timeliness of responding to call bells will be actioned.

3.9.1: This action was declined pending a sustained improvement in the national 4-hour standard.

RAG rated programme position as of September 2020

- 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
Medicine	14		9	23
Must	5		6	11
Section 29	5		1	6
Should	4		2	6
Standard Practice	14	1	2	17
Must	10	1	2	13
Should	4			4
Women & Children	6			6
Should	5			5
Must	1			1
Surgery	4			4
Should	4			4
Trust Board	3			3
Must	3			3
Clinical Support Services	2			2
Must	1			1
Should	1			1
Total	43	1	11	55

R	**Behind Plan:** Missed origianl deadline and will not be presented to EAG for more than one month
A	**At Risk:** Missed original deadline but will be presented to EAG within one month
G	**On Plan:** To be presented at EAG in line with original submission deadline
C	**Completed:** Internally approved by the Evidence Assurance Group

Original actions to be submitted to the Evidence Assurance Group or Conditions and Notices Group in October

ID Ref	Area	Category	Description	Owner	End
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
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
3.12.1	Women & Children	Should	The service should consider performing regular audits of record keeping.	Deputy Head of Midwifery	October 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
1.1.8	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
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
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
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
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
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	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
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	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
3.9.3	Standard Practice	Should	The trust should ensure that internal professional standards are created and monitored.	Divisional Director Medicine	October 2020
3.8.1	Medicine	Should	The trust should ensure that patients, relatives and carers receive timely emotional support.	ED Matron	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
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
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

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	Oct 2020	Nov 2020	Dec 2020	Feb 2021	Mar 2021	Jun 2021	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	**36**	**9**	**7**		**5**	**2**			**59**
Must	19	6	3		1	1			**30**
Section 29	2	1	2		2	1			**8**
Section 31	7								**7**
Should	8	2	2		2				**14**
Standard Practice	**45**	**4**	**2**	**1**	**8**		**2**		**62**
Must	32	4	1	1	7				**45**
Should	13		1		1		2		**17**
Surgery	**6**		**1**	**1**	**2**				**10**
Must	2								**2**
Should	4		1	1	2				**8**
Trust Board	**12**		**2**		**1**				**15**
GMC Condition	3								**3**
Must	8		2		1				**11**
Should	1								**1**
Women & Children	**37**		**3**		**3**				**43**
Must	10		1						**11**
Section 29	10								**10**
Section 31	11								**11**
Should	6		2		3				**11**
Total	**151**	**13**	**16**	**2**	**19**	**3**	**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. Meetings are scheduled to draft plans and agree completion dates for presentation to the next Trust Board meeting. The Trust was already aware of these areas of improvement. Other actions arising from the visits are already within the original CQC programme with a clear timetable for submission to EAG established.

Core Service	CQC Inspection Findings	Action Owner	RAG Status	Commentary
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	Divisional Leadership Team	G	Urgent and Emergency Care Improvement Group has been established with a plan approved by Senior Leadership Team in October. Senior full-time dedicated resource now in post to lead and embed improvements. Information dashboards to be more visible and central to improvement work.
Maternity	The leadership team was newly established and had not had enough time to address all their concerns and embed best practice.	Divisional Leadership Team	G	Building on culture and engagement work already undertaken, an external maternity review has been commissioned and commenced from September. The review will provide recommendations to strengthen culture and engagement within the service, which will be implemented and monitored via Divisional Board.
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.	Divisional Leadership Team	G	External maternity review has commenced 28 September for a period of 6 weeks. This will supplement efforts already in place to address concerns and improve the culture with improvements monitored by Divisional Board.
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.	Divisional Director	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 will continue to highlight this through Divisional Performance Review Meetings, Clinical Director Meetings, Medical Director blog and through sub-committees to the Board and Trust Board. A new action will be agreed to strengthen this work and to sustain a more consistent approach.
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.	Divisional Leadership Team	G	A restoration plan for elective care is to meet national productivity targets commenced from June 2020 with senior oversight. This will reduce the number of cancelled procedures and further improve utilisation. A bespoke engagement plan is being developed for surgeons and day surgery staff to strengthen communication and support.
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.	Divisional Director	G	A reminder of standard operating procedures will be issued. Clinical oversight through senior clinical management teams as well as back to floor Fridays will ensure such learning opportunities are shared with teams.
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.	Deputy Chief Operating Officer	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. On-going engagement with teams will take place to measure improvements.
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.	Divisional Leadership Team	G	A bespoke engagement plan will be put in place to further support teams feeling engaged and supported. Recruitment to vacant posts is on-going with additional measures to improve recruitment already in train.