Agenda item 12

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Integrated Quality Improvement Plan Programme Update Reporting for August 2020

EXCELLENCE STARTS HERE

Trust Board of Directors (Public)
06 October 2020

Summary

- To date, 145 (70%) 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). 61 actions remain outstanding.

- 16 actions were taken to EAG in August, of which 8 were approved. Of the 8 that were declined, 5 will be represented to EAG in September as the panel sought additional evidence which has now been collated. Revised dates have been agreed for the other action actions.

- A robust review of the outstanding 61 actions has taken place with respective owners. This pack sets out the output of that work by RAG categorisation. It cannot be overstated the effort and time teams have committed to this programme since its inception, nor the level of appropriate challenge to this latest review. Of the 61 outstanding actions:

    - 36 are on track to deliver as per original plan
    - 14 are past due or rated amber and will be presented to EAG by October with a refocus of individuals time to facilitate
    - 11 are rated red with clear narrative and recovery trajectories

- There will continue to be risk attached to delivery of these actions which may increase if Covid-19 escalates. The Board should take confidence that the programme governance allows for early escalation and intervention to minimise slippage.

- Additional EAG meetings will be scheduled to reflect the significant number of schemes being presented in September and October.

- As a further level of assurance improvements are sustained and becoming embedded in practice, a Clinical Review Programme has been established with high level findings and themes shared with staff and Divisional Leadership Teams and used to inform and direct further IQIP improvement actions.

- Two unannounced CQC inspections took place from 14 – 17 September and 22 -23 September. A separate paper on the visits is on the Board agenda this month. It is important to note the positive feedback from the inspections very much reflects the current position of the Trust's IQIP programme with numerous examples of improvement noticed across all 6 core services visited. Equally, where the CQC raised opportunities for improvement, these were largely already captured and being addressed through the programme. No serious concerns were raised at any point during the visits further demonstrating the robustness of the Trust's approach to this programme.

Summary

- A programme of Quality Improvement Deep Dives has been agreed and shared with the Board of Directors monthly and OAG bi-monthly. These Deep Dives will provide divisions and their clinical teams with an opportunity to share in more detail the quality improvement projects and initiatives undertaken over the past 12 months. They will also provide members of the Trust Broad and our stakeholders with an opportunity to listen to staff describe stories of improvement and the part they have played in improving care for our patients.

- The Board is asked to:

  a) Note the good progress against the planned trajectory;

  b) Comment on the revised trajectory as the reset plan; and

  c) Reach agreement to approve the reset plan as the new programme trajectory

Overall Programme Update

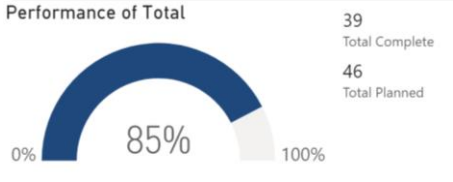
- Since the last report, the Trust evidenced and approved 8 actions bringing the total approved to 145 through the Evidence Assurance Group and the Condition Notices Oversight Group.
- There remain 61 actions which are a combination of conditions, Must and Should Do's still pending completion and validation.

Status	GMC Condition	Must	Section 29	Section 31	Should	Total
Completed & Signed off	**3**	**71**	**15**	**21**	**35**	**145**
Clinical Support Services		5	3	4	3	**15**
Medicine		18	2	6	8	**34**
Standard Practice		30			13	**43**
Surgery		2			4	**6**
Trust Board	3	6			1	**10**
Women & Children		10	10	11	6	**37**
Not Completed		**34**	**6**	**1**	**20**	**61**
Clinical Support Services		1			1	**2**
Medicine		12	6	1	6	**25**
Standard Practice		15			4	**19**
Surgery					4	**4**
Trust Board		5				**5**
Women & Children		1			5	**6**
Total	**3**	**105**	**21**	**22**	**55**	**206**

Overall Programme Status

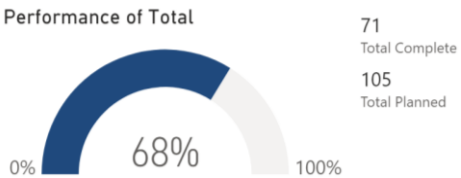
- This slide illustrates the current completion of all actions within the programme.

Conditions and GMC



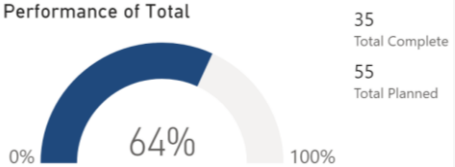
- 2 Conditions were submitted for internal closure at the August IQIP Evidence Assurance Group (IQIP EAG). These related to 29A Warning Notices for Corporate Actions; MCA and NEWS2. However, these were declined as further evidence of improvement have been requested to provide assurance of compliance, retaining the total of completed actions at 39.

Must do's



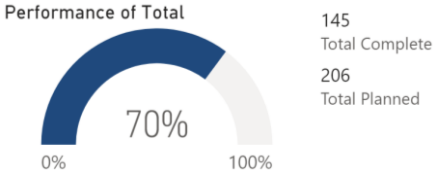
- 4 Must Do actions were approved for closure in August. 1 related to Medicine Division and 3 related to Standard Practice.

Should do's



- 4 Should Do action was approved for closure in August. 2 related to Medicine Division and 2 related to Surgery.

Total Plan



- 70% of all schemes are now approved with evidence.
- There were 16 schemes presented in August. 8 were approved with 5 requiring a strengthening of the narrative which will be represented to EAG in September. These have been updated and ready for submission. 3 actions required further work to demonstrate a greater trend rate of improvement.

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

- 8 actions were approved since the last report.

ID Ref	Area	Category	Description	Owner	Due	Approved
1.3.10	Standard Practice	Must	The trust must ensure the risk register is reflective of all the risks in the service and includes relevant actions to mitigate risk.	Director of Patient Safety	September 2020	20 August 2020
1.3.19	Standard Practice	Must	The trust must ensure that incident investigations and root cause analysis are robust and identified actions and learnings are implemented and shared.	Director of Patient Safety	August 2020	20 August 2020
1.3.9	Standard Practice	Must	The trust must ensure that serious incident action plans are comprehensive and that the completion of actions is monitored.	Director of Patient Safety	August 2020	20 August 2020
2.5.13	Medicine	Must	The trust must ensure that patients are treated individually, with dignity and respect and that they are kept informed of and involved with plans for their care.	Head of Nursing Medicine	August 2020	24 August 2020
3.4.3	Surgery	Should	The trust should improve waiting times from referral to treatment in respect of plastic surgery, general surgery and orthopaedic surgery.	Divisional General Manager Surgery, Divisional Director Surgery	December 2020	28 August 2020
3.4.4	Surgery	Should	The service should ensure that there is a referral to treatment (RTT) recovery plan in place for all specialities and this is monitored effectively.	Divisional General Manager Surgery	August 2020	28 August 2020
3.9.2	Medicine	Should	The trust should review the hours that the ambulatory emergency care unit, the paediatric assessment unit and the rapid assessment team are available to maximise admission avoidance.	ED Operational Manager	August 2020	20 August 2020
3.9.7	Medicine	Should	The trust should ensure there are systems in place to reduce and manage the high number of medical outliers.	Divisional Director Medicine	July 2020	28 August 2020

A review of all outstanding actions has been undertaken with the following 11 actions now RED rated.

- In agreement with owners, revised dates have been agreed for submission to EAG.
- Delivery to EAG will exceed two months of the original submission deadline for these actions. Owners are confident they will meet the revised submission date.

R	Missed original deadline and not expected for review at September EAG To be reviewed by EAG in excess of one month of original submission deadline
A	Due for review at September EAG but with risk Panel will decline due to quality of evidence To be reviewed by EAG within one month of original submission deadline
G	To be reviewed by EAG in line with original submission deadline
PD	Actions declined by EAG or currently past due but to be represented at September EAG

ID Ref	Area	Category	Description	Owner	Original Submission Date	Revised Submission Date	RAG	Commentary
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	31/07/2020	31/10/2020	R	Declined at EAG in July. To be represented in October where more evidence of consistent improvement can be demonstrated.
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	31/07/2020	31/10/2020	R	Declined at EAG in July. To be represented in October following reporting of Q2 KPI's to strengthen evidence base.
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	30/07/2020	31/10/2020	R	Audit of patient notes being undertaken over a three month period to demonstrate good practice. All other information completed.
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	31/05/2020	31/10/2020	R	To be represented at EAG in October. Team feel confident there is a more positive story to be narrated.
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	31/08/2020	30/10/2020	R	Not presented at EAG. Additional evidence sought to demonstrate improvement trend. Aligning to NNUH template,
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	31/08/2020	30/10/2020	R	Special Measures Funding now in place. Work with NNUH underway. Improvement evidence expected by November EAG.
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	30/09/2020	31/12/2020	R	Deferred to enable quarterly learning reports to Divisions and Quality Committee to strengthen evidence base.
2.5.21	Medicine	Must	The trust must ensure that patients at risk of deterioration are appropriately escalated for review.	Head of Patient Experience	31/08/2020	28/02/2021	R	High Risk - Moved under Recognise and Respond forum and new lead appointed. Forum will now track process and performance.
2.5.9	Medicine	Section 29	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.	Head of Patient Experience	31/08/2020	28/02/2021	R	High Risk - Moved under Recognise and Respond forum and new lead appointed. Forum will now track process and performance.
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	31/12/2020	31/03/2021	R	Revised trajectory based on impact of Covid-19 and restoration plan
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	31/01/2021	31/03/2021	R	Revised trajectory based on impact of Covid-19 and restoration plan

5 actions are now AMBER rated with additional support in place to present to EAG by October.

- In agreement with owners, revised dates have been agreed for submission to EAG.
- Delivery to EAG will be one month beyond the original submission deadline **or** be presented in line with the original submission but with concern over the level of evidence available.
- Additional time is being committed to support these actions.

R	Missed original deadline and not expected for review at September EAG To be reviewed by EAG in excess of one month of original submission deadline
A	Due for review at September EAG but with risk Panel will decline due to quality of evidence To be reviewed by EAG within one month of original submission deadline
G	To be reviewed by EAG in line with original submission deadline
PD	Actions declined by EAG or currently past due but to be represented at September EAG

ID Ref	Area	Category	Description	Owner	Original Submission Date	Revised Submission Date	RAG	Commentary
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	30/09/2020	30/09/2020	A	Evidence being collated. Potential evidence may not be sufficient under panel scrutiny.
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	30/09/2020	30/09/2020	A	Will take to EAG this month but additional evidence likely to be sought by panel to demonstrate consistency.
3.11.4	Women & Children	Must	The trust must ensure that all medical and nursing staff have the appropriate completed competencies.	DLT Women & Children	30/09/2020	31/10/2020	A	Training needs analysis to be completed to validate findings. Represented at EAG in October with additional evidence.
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	31/10/2020	31/10/2020	A	Plan to be presented at EAG in October as planned, however recruitment challenges have increased due to loss of agency staff and impact of Covid. Being closely monitored.
3.9.3	Standard Practice	Should	The trust should ensure that internal professional standards are created and monitored.	Divisional Director Medicine	30/09/2020	31/10/2020	A	Evidence being collated with some further work required but confident for October EAG.

9 actions are PAST DUE and will be presented to EAG in September

- Considerable work has taken place for all actions past their original submission deadline to be ready for presentation at EAG in September.

R	Missed original deadline and not expected for review at September EAG To be reviewed by EAG in excess of one month of original submission deadline
A	Due for review at September EAG but with risk Panel will decline due to quality of evidence To be reviewed by EAG within one month of original submission deadline
G	To be reviewed by EAG in line with original submission deadline
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ID Ref	Area	Category	Description	Owner	Original Submission Date	Revised Submission Date	RAG	Commentary
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	31/07/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
2.5.3	Standard Practice	Must	The trust must ensure that fluid balance charts are properly completed.	Head of Patient Experience	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September
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	31/08/2020	30/09/2020	PD	To be represented at EAG in September

36 actions are GREEN RATED

- 36 actions are forecast to deliver against their original submission deadline.

R	Missed original deadline and not expected for review at September EAG To be reviewed by EAG in excess of one month of original submission deadline
A	Due for review at September EAG but with risk Panel will decline due to quality of evidence To be reviewed by EAG within one month of original submission deadline
G	To be reviewed by EAG in line with original submission deadline
PD	Actions declined by EAG or currently past due but to be represented at September EAG

ID Ref	Area	Category	Description	Owner	Original Submission Date	Revised Submission Date	RAG
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	30/09/2020	30/09/2020	G
1.2.5	Standard Practice	Must	The trust must monitor medical staff training rates, and improve appraisal rates to meet the trust target.	Director of HR	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
3.6.7	Standard Practice	Should	The trust should ensure call bells are answered promptly to respond to patient risk and need.	ED Operational Manager	30/09/2020	30/09/2020	G
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	31/08/2020	31/09/2020	G
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	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
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	30/09/2020	30/09/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G

36 actions are GREEN RATED

- 36 actions are forecast to deliver against their original submission deadline.

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ID Ref	Area	Category	Description	Owner	Original Submission Date	Revised Submission Date	RAG
3.8.1	Medicine	Should	The trust should ensure that patients, relatives and carers receive timely emotional support.	ED Matron	31/10/2020	31/10/2020	G
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	31/10/2020	31/10/2020	G
3.12.1	Women & Children	Should	The service should consider performing regular audits of record keeping.	Deputy Head of Midwifery	31/10/2020	31/10/2020	G
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	30/11/2020	30/11/2020	G
3.10.4	Medicine	Should	The trust should ensure that plans in relation to the development of a strategy for the urgent and emergency service are implemented.	DLT Medicine	30/11/2020	30/11/2020	G
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	30/11/2020	30/11/2020	G
3.5.4	Surgery	Should	The service should develop and implement a clear vision and strategy.	DLT Surgery	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
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	31/12/2020	31/12/2020	G
3.15.1	Women & Children	Should	The service should develop and implement a clear vision and strategy.	DLT Women & Children	31/12/2020	31/12/2020	G
3.15.2	Women & Children	Should	The service should ensure staff are aware of the CYP strategy.	DLT Women & Children	31/12/2020	31/12/2020	G
3.15.3	Standard Practice	Should	The service should monitor the progress of the implementation of the strategy.	DLT Women & Children	31/12/2020	31/12/2020	G
3.16.8	Clinical Support Services	Should	The trust should review processes to ensure that patients are able to access diagnostic imaging services in a timely manner.	DLT Clinical Support Services	28/02/2021	28/02/2021	G

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

ID Ref	Area	Category	Description	Owner	End
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	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
2.3.6	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
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
2.5.2	Standard Practice	Must	The trust must ensure patient care records are accurate, complete and contemporaneous and stored securely.	Head of Nursing Medicine	September 2020
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	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
2.5.3	Standard Practice	Must	The trust must ensure that fluid balance charts are properly completed.	Deputy Chief Nurse	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
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
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	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

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

ID Ref	Area	Category	Description	Owner	End
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
1.2.7	Standard Practice	Must	The trust must ensure that staff receive an annual appraisal.	Director of HR	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
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
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
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
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
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
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
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
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
3.6.18	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

Forward plan for completion of actions

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

Area	Completed & Signed off	Historic	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Feb 2021	Mar 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	**34**		**13**	**7**	**1**	**2**	**2**		**59**
Must	18		8	2		1	1		**30**
Section 29	2		2	2		1	1		**8**
Section 31	6		1						**7**
Should	8		2	3	1				**14**
Standard Practice	**43**		**7**	**5**	**1**	**4**		**2**	**62**
Must	30		7	3	1	4			**45**
Should	13			2				2	**17**
Surgery	**6**			**1**	**1**	**2**			**10**
Must	2								**2**
Should	4			1	1	2			**8**
Trust Board	**10**		**2**	**2**		**1**			**15**
GMC Condition	3								**3**
Must	6		2	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	**145**		**22**	**19**	**3**	**12**	**3**	**2**	**206**

Quality Improvement Deep Dive Timetable

Monthly Quality Improvement Deep Dive Timetable
Oversight & Assurance Group

Date OAG	Presentation Title	Presentation Leads
June 16/06/20	Radiology Improvement Journey	Nicola Berns: Divisional Director Mary Burney; General Manager for Clinical Support Services Division
September 22/09/20	The Emergency Department	Divisional Leadership Team, Medicine
	Safeguarding	Head of Safeguarding
November 25/11/20	Staff Engagement and Health & Wellbeing	Deputy Chief Executive, Head of Staff Engagement
	Culture	

Quality Improvement Deep Dive Timetable

Monthly Quality Improvement Deep Dive Timetable
Board of Directors

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

Assurance actions are sustained and embedded

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

The monthly Clinical Review programme recommenced in July.

Clinical Reviews 9th September 2020:

- A peer review approach was adopted with a team of 24 clinical and non-clinical staff, including senior nurses, clinical educators, Governors, porter, volunteer, Pharmacist, General Manager, CCG representative, Safeguarding, Student Nurse. Healthwatch participated in both the July and August clinical reviews

- Key lines of enquiry were structured around completed Must and Should do actions within the IQIP wherever possible, whilst drawing on broader findings through the use of the '15 Steps' methodology, to explore patient and staff experience.

- Ten areas were included in the August review: Emergency Department, Castleacre (Maternity), Denver (Emergency Surgical), Gayton (Trauma & Orthopaedics), Shouldham (Oncology, Palliative Care), West Raynham (Stroke Unit), Rudham (Children's inpatient), Roxborough (Children's Outpatients), Terrington Short Stay and the, Acute Medical Unit.

- The review included a review of the Site and a 'Look Back Team' to follow-up concerns identified during previous inspections, or areas where further assurance is required.

- A separate review of the Section 31 conditions for the Emergency Department (ED) was also completed on 8th August following the merging of Yellow and Green ED.

Findings:

- The diverse nature of the clinical team provided rich and valuable feedback.
- A very positive and enjoyable review overall, with further recognition of good practice and evidence of improvement.
- Positive patient feedback across all areas with generally well-engaged staff.
- No new surprises or risks identified.
- Areas of concern or improvement are aligned to the open / outstanding actions on the IQIP with plans in place to address these.
- Some inconsistencies in aspects of care remain evident
- The reviews carried out on the Emergency Department, Terrington and AMU were particularly positive with good evidence of team working, leadership, staff engagement and very positive patient experience.

Assurance actions are sustained and embedded

Immediate Concern:

- Staff member not wearing PPE appropriately – addressed at time of the visit
- A Resuscitation grab-bag in ED was labelled as missing a few items – escalated and addressed during visit
- A couple of side rooms with doors open and no signage – addressed at time of the visit

Assurance actions are sustained and embedded

Areas of good practice:

- All areas very welcoming except one. This was fed-back following the review. Almost all staff were engaged, enthusiastic and happy to speak to the review team.
- "Hello my name is"… and "How can I help you?" heard on a number of occasions in different areas.
- Sensitive and compassionate care and interactions observed
- Visibility and engagement of CEO and new Chief Nurse mentioned by a number of staff
- Majority of areas clean and tidy
- Staff feel supported and are encouraged to innovate
- Evidence of safe medicines management
- Staff reported their 'voices could be heard'
- Some staff reported they feel like they are coming together as a 'Team' following changes due to COVID-19, but this has been challenging
- Good examples of MDT working
- 100% appraisals for staff in some areas
- Patients looked well cared for and dignity and respect maintained
- Staff exhibited compassion and kindness
- Overall Infection Prevention Control standards were good

Improvements required:

Whilst there were some excellent examples of improvement, care and staff engagement there are inconsistencies which are reflected within the Integrated Quality Improvement Plan

- There remains inconsistencies with nursing documentation including fluid charts although some improvement in patient's risk assessments noted
- Whilst Hello my name is… was heard on a number of occasions, a lack of an individualised approach to care was noted through the identification of a patient by bed and bay number
- Denver and Gayton wards did not feel as well organised, although compassionate interactions noted
- Inconsistent staff's awareness of Mental Capacity Assessment, although some staff demonstrated detailed knowledge
- Not all patients were aware of discharge plans
- Noise at night
- Not all corridors were clear – beds in some corridors
- A small number of equipment required PAT testing
- Appraisal and Mandatory training impacted by COVID-19 and requires a focused approach
- Sluice door unlocked in two areas
- Signage in areas across the Trust is unclear in some areas
- Patient information left displayed on a computer screen
- 'How we are doing' Boards on the wards not updated

Assurance actions are sustained and embedded

Feedback:

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

Actions:

- Immediate concerns were addressed by the individual review teams during the visit
- Findings discussed at IQIP Review Group and actions agreed
- Each area has been asked to share findings with their team and action areas for improvement within localised plans
- Findings shared at the Patient and Carer Experience Forum
- Broader findings will form Key Messages and shared through wider Trust communication channels supported by the Comms Teams
- Findings will continue to inform IQIP actions where relevant
- The two Senior Nurses supporting the Division of Medicine were involved in the review and are focusing their quality improvement work on documentation, professional behaviours and MCA assessment and recording
- 'Look Back Team' to be incorporated in all clinical reviews going forwards