Agenda Item 13

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Emma Hardwick; Chief Nurse	Decision		High	Med	Low
	Discussion	✓	✓		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Louise Notley, Associate - Director of Quality Improvement and Programme Director	Strategic				
	Operational	✓			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	All				

Meeting Date: **29 January 2019**

Report Title: **The Report of the Quality Programme Board (QPB)**

PURPOSE:

To provide a summary update to the Board of Directors in respect of the QPB's work in overseeing the delivery of the Trust's Quality Improvement Plan (QIP), providing:

- Assurance, where actions are on track for delivery and assimilation into 'Business as Usual'
- The reporting of exceptions and key risks to the delivery of the Trust's Quality Improvement Plan, together with associated recovery plans
- Summary progress updates on the work of the five workstreams reporting to the QPB, via high-level dashboards
- Recommendations in respect of the Board's reporting to the Oversight and Assurance Group

EXECUTIVE SUMMARY:

The Quality Programme Board met on the 17th January 2019, chaired by Emma Hardwick; Chief Nurse in the absence of Caroline Shaw; Chief Executive Officer. The Programme Director Report provided a summary of the progress against the Quality Improvement Plan from the December to January QPB.

Following the December QPB a review of all QIP actions have been carried out with the SROs applying the revised Amber and Blue BRAG definitions. As a result of this review there have been a significant number of BRAG changes within each workstream. This is reflected in the overall Trust and individual workstream updates, with an increase in the number of Amber actions identified with an 'inherent risk' or 'risk of delivery', due to the Trust's challenged operational, capacity and financial performance, as detailed on the QIP Risk Log. Sickness absence of key roles and capacity gaps are impacting on the progress of actions within the People and Governance and Learning workstreams in particular. Mitigations in place but effectiveness to be evaluated.

The QIP is made up of 327 individual action covering the 94 Must and Should Do Actions.

Of the Must and Should Do actions 68 were duplicate actions, or themes and these were generally combined into one specific issue within the QIP. Graphs to illustrate the progress of the Must and Should actions have been included in this report, in addition to the standard reporting progress of all actions. 71% of Must and Shoulds are Green and on Track for delivery. There is a significant amount of work underway to address these actions, but 'grip and pace' are required to ensure deadlines are met. However, a number of completion deadlines have had to be moved where it has become apparent that the improvement work required to effectively address the Must or Should action is more complex than first anticipated

Emma Hardwick; Chief Nurse and QPB Chair for the January Meeting

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
√	√	√	√	√	√

RECOMMENDATION/S:

The Board is invited to:

- Note the progress of the QIP and the QPB's approved change of Amber and Blue BRAG status definitions.
- The Board is invited to approve the updated Risk Log detailing the risks that could impact on the delivery of the QIP.

Quality Improvement Plan Summary Dashboard and supporting narrative

QIP Progress
Following the December QPB, the Oversight and Assurance Group were informed of the revised BRAG definitions as agreed at this meeting, relating to Amber and Blue ratings and the rationale for these changes. Over the past month the Improvement Project Managers (IPMs) have been working with their respective SROs, paying particular attention to actions with a Green BRAG status, questioning if this rating accurately reflects the level of inherent risk, or if there is a risk to its effective delivery.

Original QIP BRAG Status	
Blue	Completed and Evidenced
Red	Overdue
Amber	At Risk of Delivery
Green	On Track

Revised QIP BRAG Status	
Blue	Complete, Evidenced and Required Outcome Assured / Sustained
Red	Overdue
Amber	Inherent Risk or Risk of Effective Delivery
Green	On Track

As a result of this review there have been a significant number of BRAG changes within each workstream and this is reflected in the overall Trust and individual workstream updates. Whilst a small number of further BRAG changes were made following a focused review on the 10th January with each SRO by the Trust's Improvement Director; Philippa Slinger, it is felt the workstream progress reports now accurately reflect current progress against the QIP actions, risks and completed actions.

All changes to the QIP for the January QPB have been captured on the Change Control Log.

Focused Workstream Review
The Trust's Improvement Director; Philippa Slinger carried out a planned and focused review of four of the five QIP workstreams with the SROs and IPMs. Arrangements are in place to complete the review of the People workstream by the 25th January 2019.

QIPEAG
The second QIP Evidence Assurance Group (QIPEAG) was held on 9th January 2019. 10 actions were presented with evidence for closure. Following review of evidence a further 3 actions were approved and moved to Blue BRAG status. QIPEAG has stipulated that Action Owners are to present evidence for closure to allow QIPEAG members to seek clarification of issues, apply challenge and obtain the necessary level of assurance to support BRAG decision making.

Quality Assurance Framework
A Quality Assurance Framework is being finalised. This framework details the decision making process by the QPB to approve actions to be moved to BAU and will provide ongoing assurance that improvements are embedded and sustained.

Quality Improvement Team
Approval was secured to recruit three 8a Quality Improvement Manager for an eighteen month period offering either fixed term or secondment contracts. Interviews for these posts are

planned for Tuesday 5th February 2019. Appointment timeframes will depend on notice periods.

The QIP continues to be well supported by the three interim Improvement Project Managers.

Communication Strategy
A meeting was held with the Acting CEO, QIP Programme Director and recently appointed Head of Communication in advance of her taking up a full time position. It was agreed to progress with a communication plan for the QIP while the Trust's Communication Strategy is reviewed and agreed. It is recognised that whilst there are pockets of improvement work in progress, divisional engagement and ownership of the QIP is poor and needs to be addressed urgently. A review of the approach adopted by NSFT is to be reviewed by the Improvement Director and for discussion at the February QPB regarding implementing a similar approach at the QEHKL.

The QIP Programme Director and Company Secretary met with the Governors at the January Patient Experience Committee to discuss Governor involvement in the QIP. This was a positive meeting which generated discussion and ideas. It was agreed the QIP Programme Director will direct Governor involvement in the ongoing assurance arrangements of completed actions and will incorporate this in the QIP Quality Assurance Framework.

QIP Risk and Issues Log
The QIP Risk Log was updated for the January QPB and details 4 Trust risks that have the potential to impact on the delivery of the QIP **(See Appendix A, see separate attachment).** Sickness absence of key roles and capacity gaps are impacting on the progress of actions within the People and Governance and Learning workstreams. Current mitigations are in place, with the HR Deputies acting up with allocated responsibilities and portfolios, with additional resource allocated to the Risk and Governance Team. Effectiveness of mitigating actions are to be reviewed. Capacity gaps within both the People and Governance workstreams were raised by QPB as a CKI to Board **(See Appendix B).**

PIR

Activity	Date
PIR Received	11th January 2019
PIR Submission Due	1st February 2019 (co-ordinated by QI Team)
On-site inspection of core services • Urgent and Emergency Care • Medical Care (including older people's care) • Surgery • Maternity • Gynaecology • Services for Children and Young People • End of Life Care • Outpatients	5th & 6th March 2019
Well-Led Inspection	9th to 11th April 2019

The PIR includes a Self-Assessment against each of the domains for the core services. It has been agreed to arrange for the Divisional Triumvirate to complete this Self-Assessment process for the core services that sit within their division, using the CQC Key Characteristics to support decision making. A Self-Assessment check and challenge meeting to agree self-assessment ratings under each CQC domain, has been arranged with the Divisional Triumvirates and Maternity Services on Monday 28th January and will be led by Emma Hardwick; Chief Nurse.

QIP Dashboard
The QIP Dashboard has been established and captures a number of the metrics detailed within

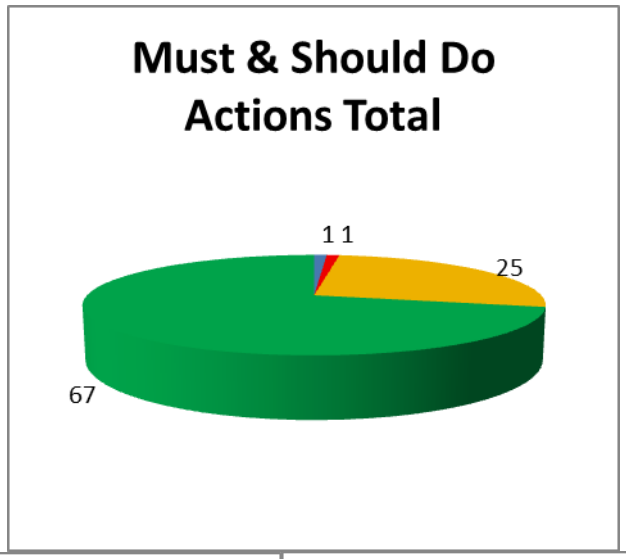
the plan. This dashboard can provide a Trust view of progress against agreed metrics and provide detail at CBU level. This dashboard will be populated further as QIP metrics are approved.

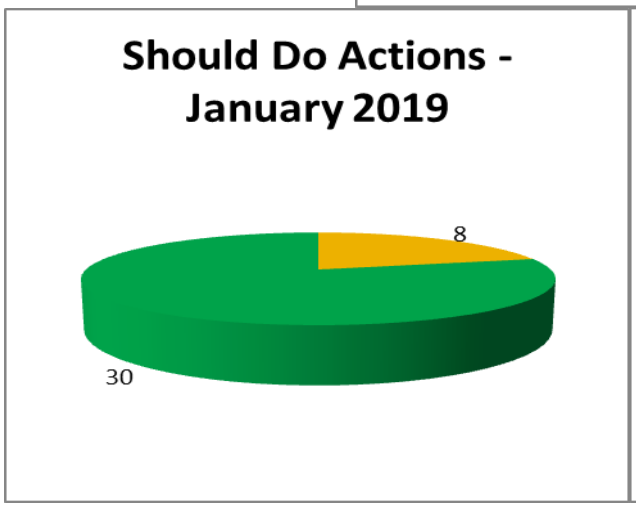
QIP Progress

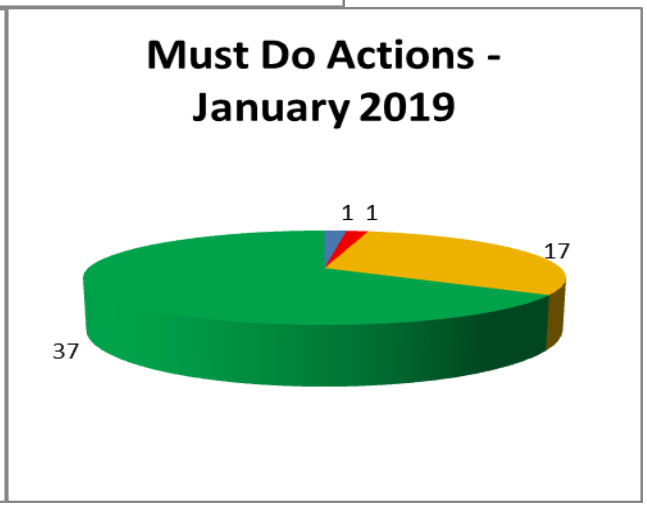
The QIP is made up of 327 individual action covering the 94 Must and Should Do Actions.
Of the Must and Should Do actions, 68 were duplicate actions, or themes and therefore combined into specific issues within the QIP.

The pie charts below illustrate the progress of the 94 Must and Should Do actions within the QIP. 71% of Must and Shoulds are Green and on Track for delivery. There is a significant amount of work underway to address these actions, but 'grip and pace' are required to ensure deadlines are met. However, a number of completion deadlines have had to be moved where it has become apparent that the improvement work required to effectively address the Must or Should action is more complex than first anticipated. All changes have been submitted through the Change Control process for complete transparency.

It is important to note that each Must and Should is made up of a number of detailed actions. Therefore, a Must or Should action will not be approved as complete and BRAG rated Blue, until all its actions have been completed and evidenced.







- The Blue completed Must is the installation of a new sluice on Elm ward to effectively manage waste disposal.

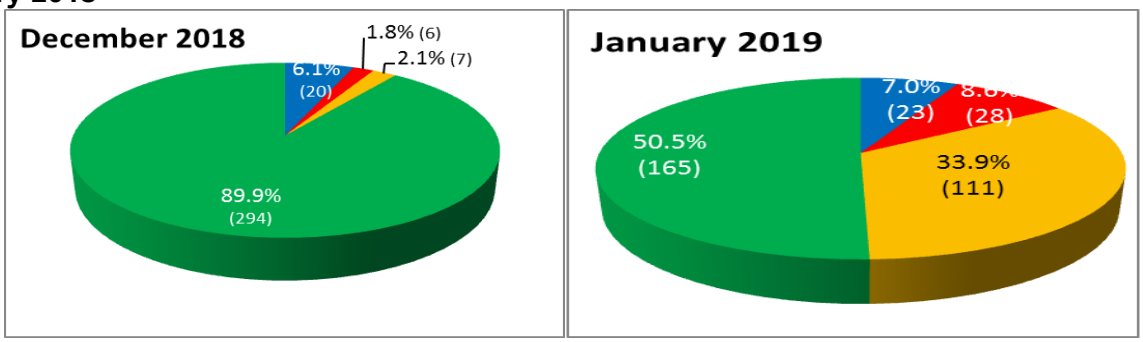
- The Red Must relates to the lack of progress regarding the completion and monitoring of action plans.

- The Amber ratings are linked to actions that carry an inherent risk or are at risk of delivery due to the Trust's challenged operational, capacity and financial performance, as detailed on the QIP Risk Log. Although not exclusively, these actions are associated with patient flow and operational capacity, or capacity within the Risk and Governance Department.

Summary – All Workstreams as Presented to QPB January 2019

ASSURANCE - all workstreams

January 2018

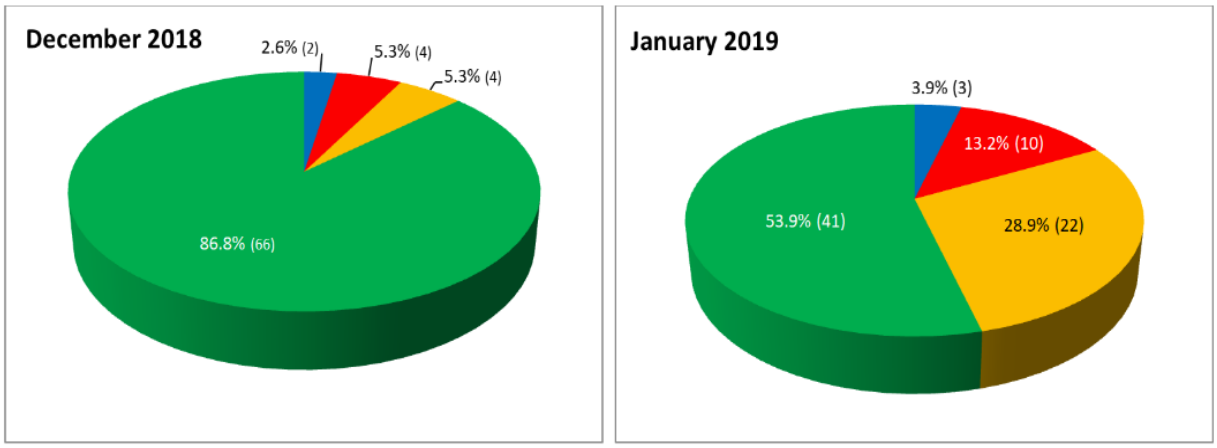


QIP Action Progress By CQC Domain

CQC Domain	Red		Amber		Green		Blue		TOTAL
Safe	13		52		83		11		159
Safe, previous 6 months	17	1	29	3	91	146	17	10	Dec-2018
Effective	2		14		18		3		37
Effective, previous 6 months	3	0	5	1	25	33	3	3	Dec-2018
Caring	0		0		1		4		5
Caring, previous 6 months	0	0	0	0	1	1	7	4	Dec-2018
Responsive	7		18		34		2		61
Responsive, previous 6 months	5	1	8	1	41	57	6	1	Dec-2018
Well-led	6		27		29		3		65
Well-led, previous 6 months	15	4	4	2	37	57	7	2	Dec-2018

People

People Workstream



Actions Moved to Blue Status

P18.2 – Values and Behaviours - Launch of Behaviour framework and Trust Values on 15th October 2018. Evidence presented to the QIP Evidence Assurance Group (QIPEAG) in January

that this 'transactional' task should be closed. The QIPEAG agreed action is complete and the task can be closed.

Red Actions

There are 4 new Red actions

P3.1 – MCA & DoLs Training. A new Action Owner has taken on this task and a new training programme has been created beyond the 31st November 2018 deadline.

P8.1 – Induction – Mitigations in place. The Analysis Report was due to be submitted to the Workforce Committee for sign-off in January, but has been moved to February 2019.

P10.3 – Safe Staffing - Six monthly safe staffing review and reporting to Trust Board. The report will be submitted to 'Private' Trust Board in February and then to 'Public' Trust Board in March.

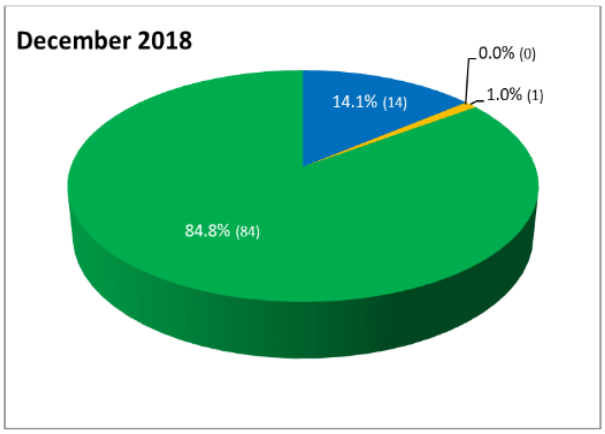
P16.8 – Staff Grievances - Feedback to Board on all methods of raising concerns by staff, including grievances. The scope of this task has been reviewed and more work is involved than originally thought. A comprehensive report will be submitted to Workforce Committee for sign-off on 30 April 2019.

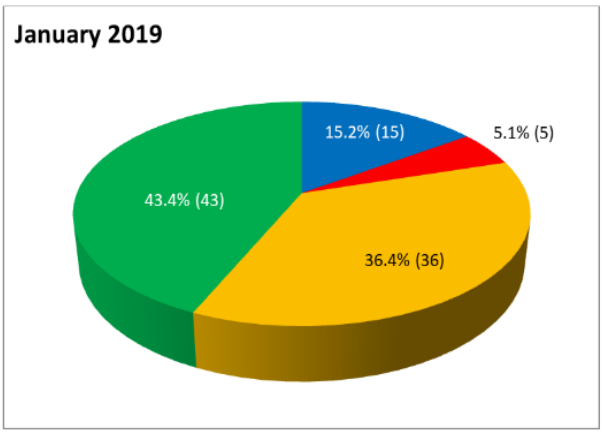
P17.3 – Trust Strategies Effective Communications supporting the implementation of the Corporate Strategy. The Head of Communications left the Trust on 21st December 2018 and this action has therefore not been completed. This task will be reviewed when the new interim Head of Communications starts in late February 2019.

Exec. Lead - Dir. HR&OD, Karen Charman

Caring Safely

Caring Safely





Actions Moved to Blue Status

CS9.1 Resuscitation - Resuscitation trolley with dedicated defibrillator to be in place for the Paediatric Unit containing paediatric resus equipment. Action presented to the Evidence Assurance Group in January, with photographic evidence of a fully equipped trolled in place. EAG agreed action is complete and to be closed.

Red Actions

There are 5 actions which have been moved to red status. All have passed their deadline for delivery.

CS11.1 Resuscitation - The review of Resuscitation workload capacity. The Resuscitation Team Review Report was submitted to the Chief Nurse on 17th January 2019, beyond its 31st December deadline.

CS11.2 Resuscitation - An additional action (dependent upon CS11.1) is a Resuscitation Service Action Plan to ensure the review is managed effectively. A deadline change may be required for this action and will be reviewed by the Chief Nurse.

CS12.2 Medication – The review of education and training for Medicines Management mandatory training has been completed. The new training Workbook are in place. However, compliance for staff to have completed this training is currently at 88% (December 2018), below the threshold of 95%. This action has been rated as red until compliance achieves the Trust threshold.

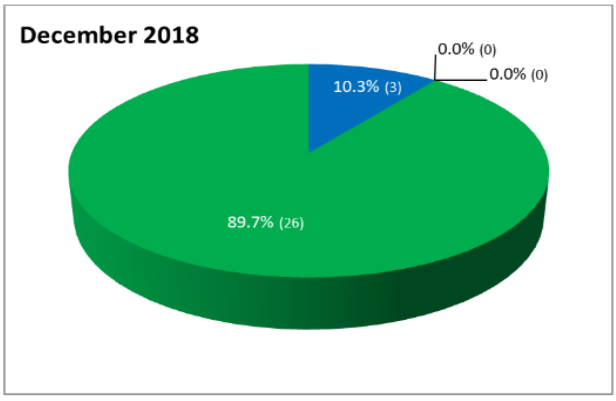
CS13.4 Medication – The draft SOP for daily fridge temperature checks has not been ratified and until this action is completed, the BRAG status is now red as this action became overdue at 31st December.
CS13.5 Medication – This action is dependent upon CS13.4 and will inform the next steps following regular audits of daily fridge temperatures. A deadline change may be required for this action.

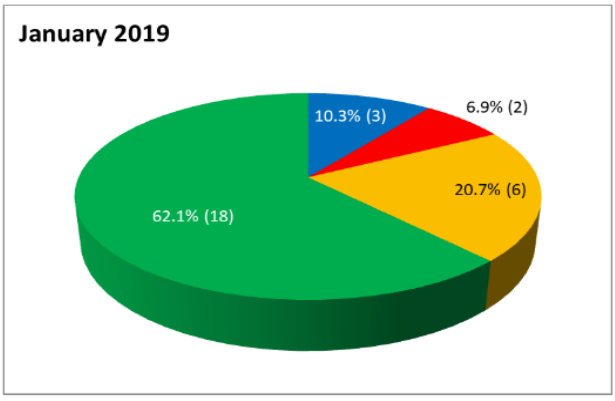
Areas of Focus
There are 4 areas which have been identified as significant risk to the Trust and a review meeting will take place on 22nd January. Action owners will present to the Chief Nurse the current position of each action and the steps being taken to ensure delivery. The areas being focused on are:

- MCA and DoLs
- Safety Huddles
- Resuscitation Trolley Checks
- Fridge Temperature Checks

Exec. Lead – Chief Nurse, Emma Hardwick

Environment

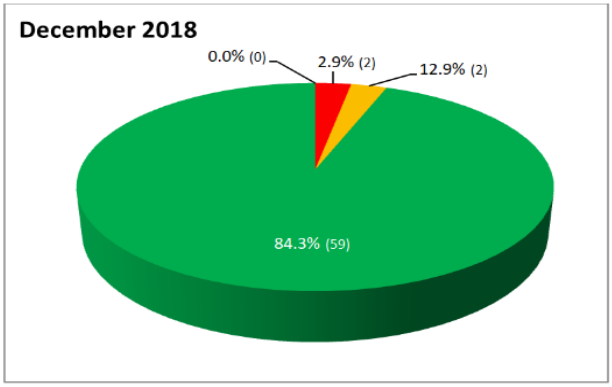


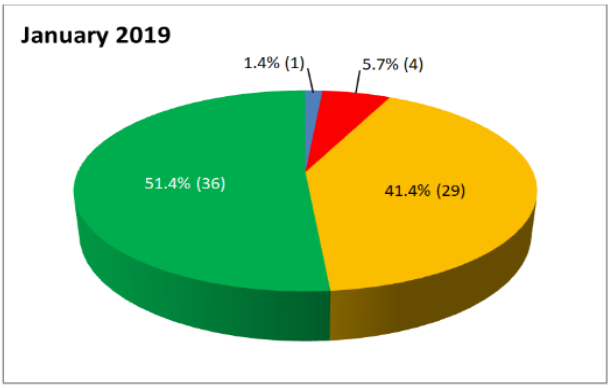


Red Actions
E7.3 & E7.5 – Communication Aids in ED – Alternative hearing aid solution ordered. There remains a need to undertake a Equality Impact Assessment (EAI) as part of wider improvement work. EIA delayed beyond timescales due to delays on the approval of funds.

Exec. Lead – DoF&R, Roy Jackson

Performance





Actions Moved to Blue Status
PF9.3 Diagnostic Imaging - Ensure Trust has enough capacity to routinely meet the 6 week diagnostic test target. Action presented to Evidence Assurance Group (EAG) in January with evidence of Trust improvement on Diagnostic Waiting Time Performance and accompanying

Breach Report. EAG reviewed and accepted the evidence gave a strong position for the Trust on performance over the past 18 months and agreed the action was completed, embedded and to be close.

Red Actions

There are 4 actions which have been moved to red status. All have passed their deadline for delivery.

PF1.2 Manage Overcrowding – Action overdue at 31st December. Review of action to be completed alongside full review of 'Patient Flow' actions including ED, SAU, MAU, Hot Clinics and Medical Outliers. SRO meeting with relevant action owners on 22nd January to assess potential consolidation of actions.

PF1.3 Manage Overcrowding – Action overdue at 31st December. As with CS1.2, a review of all actions is being undertaken on alongside full review of 'Patient Flow' actions including ED, SAU, MAU, Hot Clinics and Medical Outliers. SRO meeting with relevant action owners on 22nd January to assess potential consolidation of actions.

PF4.3 Medical Outliers – Action overdue at 15th December. As above a review of all actions is being undertaken on alongside full review of 'Patient Flow' actions including ED, SAU, MAU, Hot Clinics and Medical Outliers. SRO meeting with relevant action owners on 22nd January to assess potential consolidation of actions.

PF4.5 Medical Outliers - Action overdue at 31st December. As above a review of all actions is being undertaken on alongside full review of 'Patient Flow' actions including ED, SAU, MAU, Hot Clinics and Medical Outliers. SRO meeting with relevant action owners on 22nd January to assess potential consolidation of actions.

Areas of Focus

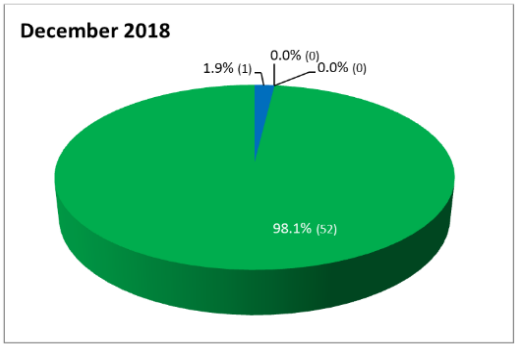
There are 4 areas which have been identified as significant risk to the Trust and the review meeting on 22nd January will include assessment of the current position for these areas. Action owners will provide the Chief Operating Officer (SRO) a position statement on the current status of these areas and the steps being taken to ensure delivery. The areas being focused on are:

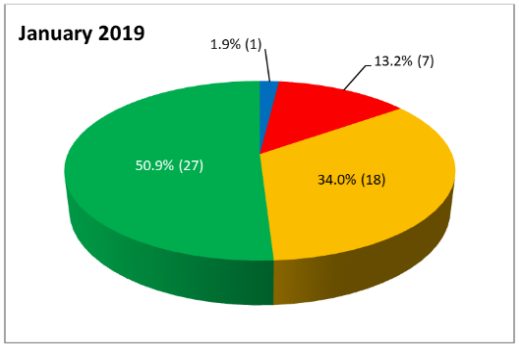
- Internal Professional Standards for ED
- Discharge
- Mental Health
- Diagnostic Reporting

Action owners will also highlight any potential risks and the mitigating actions being taken to address these risks.

Exec. Lead - COO, Jon Wade

Governance and Learning





Red Actions

GL1.3 – Development and introduction of the Accountability Framework (including implementation strategy): Although the action deadline is the 31/01/19, the limited progress on the action and the fact that other actions depend on this one for completion have justified the

status change.

GL1.4 – Review of the Risk and Governance resource and support to the Divisions: The deadline for delivery of the action has passed. Progress in the action is very limited due fundamentally to the workload of the action owner (the same owner is responsible for 26 actions in this workstream). Specialist additional support has been made available to the owner to address capacity issues.

GL6.2 –Review and development of Trust's Risk Register against the findings of the CQC inspection: Action's deadline was 31/12/18 and action has not been completed due to action owner's capacity (as mentioned in action GL1.4). Improvement Project Managers are now providing support in the development of some of the Risk Assessments in order to progress this action in a timelier manner.

GL8.1, GL8.2 & GL8.3 – Review process for the development and implementation of action plans for serious incidents (including sign off, review and monitoring): No progress has been reported on the management of action plans process. The limited progress is linked to the capacity issues identified earlier for the action owner. During the workstream review with the Improvement Director, it was agreed that actions relating the action planning process should be linked to the improvements planned in relation to the Lessons Learnt process (GL7 and GL4.6). Additional support has been made available for the action owner to address capacity issues.

GL12.1 – In-depth review to scope the extent of issue relating to the governance of procedures, guidelines and protocols: Limited progress on the scoping of the issues relating to the governance of procedures, guidelines and protocols. The main cause is the owner's capacity issues mentioned above. As mentioned before, additional support has been made available recently to address the owner's capacity issues. In addition, all CBUs are working on the review of current guidelines (Division 2 is looking for admin support). During the meeting with the Improvement Director, it was agreed that the Trust's guideline library would be compared with a similar organisation to identify gaps and potential efficiencies.

Exec Lead - MD, Nick Lyons

Conclusion and recommendations for reporting to the Oversight and Assurance Group

Next OAG date 22nd January 2019

Deep-Dive topics DNACPR and Safety Huddles

Narrative / reporting recommendations:

The December Oversight and Assurance Group (OAG) takes place on 22nd January 2019 December, before the Trust Board on the 29th January. The OAG have been provided with a summary of progress against the QIP, a draft of the QIP Metrics Dashboard and the Risk Log.

The OAG will be informed of the recalibration of the QIP since the December QPB following the review against the definitions of the AMBER and BLUE BRAG status.

CKIs from the QPB have been included in this report.

QUALITY PROGRAMME BOARD - CHAIR'S KEY ISSUES **Appendix B**

ISSUES FOR REFERRING / ESCALATING TO BOARD / COMMITTEE / TASK & FINISH GROUP

PART A:

ORIGINATOR:	Quality Programme Board (QPB)	**DATE OF MEETING ISSUE RAISED:**	17/01/19	
CHAIR:	Emma Hardwick; Chief Nurse	**LEAD EXECUTIVE DIRECTOR:**	Caroline Shaw	
Workstream / QIP Ref.:	**DETAILS OF ISSUE:**	**FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?**	**RISK REGISTER / BAF REFERENCE**	**PAPER ATTACHED √**
Overall	4 Trust risks that have the potential to impact on the delivery of the QIP and captured in the QIP Risk Log. Sickness absence of key roles and capacity gaps are impacting on the progress of actions within the People and Governance and Learning workstreams. This has the potential to impact on the delivery of the QIP. Current mitigations are in place, with the HR Deputies acting up with allocated responsibilities and portfolios, with additional resource allocated to the Risk and Governance Team. Effectiveness of mitigating actions are to be reviewed.	Alert		
DATE COMPLETED AND FORWARDED TO CLERK OF RECEIVING BOARD / COMMITTEE / TASK & FINISH GROUP:		21/01/19		

PART B:

RECEIVING BOARD / COMMITTEE / TASK & FINISH GROUP:		**DATE OF MEETING ISSUE CONSIDERED:**	
CHAIR:		**LEAD EXECUTIVE DIRECTOR:**	
Workstream / QIP Ref.	**RECORD OF CONSIDERATION GIVEN / APPROVAL / RESPONSE / ACTION:**		
DATE COMPLETED AND FORWARDED TO CLERK OF ORIGINATING BOARD / COMMITTEE / TASK & FINISH GROUP:			