COVERSHEET	
Meeting	Board of Directors' meeting in PUBLIC
Paper Title	Quality Improvement Plan
Date of meeting	5 November 2020
Date paper was written	21 October 2020
Responsible Director	Hayley Flavell, Director of Nursing
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Presenter	Hayley Flavell, Director of Nursing

EXECUTIVE SUMMARY

Progress against the Quality Improvement Plan continues to be made with 87% of actions completed or embedded. The first six months of this programme has been largely transactional as the focus has been on ensuring the Trust has robust systems and processes in place to support the delivery of safe, high quality care.

A key element of this work has been to challenge clinical colleagues in their approach and thinking around the care they provide, recognising what they do well but acknowledging when things do not go according to plan and taking swift and appropriate action.

This paper provides a progress update as of 16 October 2020 but also sets out the plan for the next six months and the move to phase two of the programme.

The Board of Directors are asked to take assurance and to :

- Note the content of the report
- Note the progress made in completing 87% of the total 402 actions within the Improvement Plan
- Note the move to Phase Two of the Quality Compliance Programme

Previously considered by	Paper presented to Senior Leadership Operational Group on 22 October. The paper was well received with endorsement for the transition to Phase two of the programme. A number of the transactional actions will go through the agreed assurance process (Green to Blue) in November in addition to increasing the visibility of tangible benefits to patients and improved outcomes.

THE BOARD OF DIRECTORS' (Committee) ARE ASKED TO:			
☐ Approve	☐ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	N/A

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	N/A

MAIN PAPER
SITUATION

Current Position as at 21 October 2020

As at the 21 October, the Trust have completed 351 of 402 actions (87%), this is an improvement of 2% (11 actions) in month. There are 12 actions that are currently off track but with the confidence that they will be delivered by the revised due date. It should be noted that the total number of actions has increased by 2 – this is due to two actions being split into two components for ease of delivery.

In addition there are five actions that have been rated as 'Not yet started'. It should be noted that in the absence of an alternative, this rating has been applied to three of the five actions that have been progressed to date but full completion is now out-with the care group or organisation's control, therefore the actions are currently suspended. Two of the actions have not yet started but are due for completion in October and December 2020.

Table 1 shows a summary of the total action status by Care Group:

Action Plan Summary by Area

Total Number of Actions -

Group	Scope	Total Actions	Embedded	Complete	In Progress	Off Track	Not Yet Started	Percentage Complete
Trustwide	Trust Wide	122	-	97	14	8	3	80%
Urgent and emergency care	Urgent and emergency care	157	7	133	12	3	2	89%
Medical care	Medical care	25	-	25	-	-	-	100%
Scheduled Care	Surgery	37	-	35	2	-	-	95%
	End of life care	9	-	7	1	1	-	78%
	Outpatients	2	-	2	-	-	-	100%
	Critical Care	3	-	3	-	-	-	100%
Women & Children	Maternity	34	1	30	3	-	-	91%
	Children and Young People care	13	-	11	2	-	-	85%
Total		**402**	**8**	**343**	**34**	**12**	**5**	**87%**

Table 2 indicates that as at the 21 October the Trust has completed actions to address 11 of the 29 Section 29a areas for improvement. An action relating to the training for syringe pumps, identified in the Section 29a Warning Notice received in July 2020 has yet to be added to the End of Life section of the programme; however an action plan setting out how compliance will be achieved is in place and being worked through the Corporate Nursing team.

Section 29a Improvement Areas status

Total Number of S29a Areas for Improvement -

Section 29A Notice	Area of inspection	Date	Improvement required	Total S29a Areas	Embedded	Complete	In Progress	Percentage Complete
Section 29A 2018 Part 1 - Wards Risk Assessment	Medical care	Aug-18	17/01/2019	1	-	-	1	0%
Section 29A 2018 Part 2 - Staffing	Critical Care	Aug-18	17/03/2019	4	-	4	-	100%
	Urgent and emergency care	Aug-18	17/03/2019	6	-	2	4	33%
Section 29A March 20	Urgent and emergency care	Nov 19 to Feb 20	31/05/2020	10	-	6	4	60%
Section 29A June 20	Medical care	Jun-20	31/08/2020	3	-	2	1	67%
Section 29A July 20	End of life care	Jul-20	30/09/2020	5	-	2	2	40%
Total				**29**	**-**	**16**	**12**	**55%**

Table 2

The actions to meet the 2018 Section 29a Warning Notices continue to be addressed. Recruitment remains underway to appoint Critical Care Consultant staff to the Trust with a view to implementing a cross-site rota ensuring optimum cover on both sites. The current anaesthetic rota remains in place as mitigation at the Princess Royal Hospital.

The Trust has 12 regulatory conditions applied to the Emergency Departments, which cover a proportion of the issues identified in the warning notices; however evidence is being gathered to support an application to have four conditions lifted by the end of the calendar year thus addressing a number of the actions identified in the table above.

Table 3 shows the Must Take Action Areas for Improvement by Regulation, and indicates that as at the 21 October the Trust has completed actions to address 54 of 88 (61%) Must Take action areas for improvement, this is an increase of 5% (5 actions).

Must Take Improvement Areas - By Regulation

Total Number of Must Take Areas for Improvement -

Regulation	Total Must Take	Embedded	Complete	In Progress	Percentage Complete
Regulation 05: Fit and proper persons – directors	1	-	1	-	100%
Regulation 09: Person Centred Care.	2	-	1	1	50%
Regulation 10: Dignity and respect.	2	-	2	-	100%
Regulation 11: Need for Consent.	3	-	-	3	0%
Regulation 12: Safe care and treatment.	35	-	21	14	60%
Regulation 13: safeguarding.	7	-	3	4	43%
Regulation 15: Premises and equipment.	3	-	2	1	67%
Regulation 16: Complaints.	1	-	-	1	0%
Regulation 17: Good governance.	20	-	17	3	85%
Regulation 18: Staffing.	13	-	6	7	46%
Regulation 20: Duty of candour.	1	-	1	-	100%
Total	**88**	**-**	**54**	**34**	**61%**

Table 3

Table 3a below indicates the Must take actions by accountable Executive

Must Take Improvement Areas - By Accountable Executiv

Total Number of Must Take Areas for Improvement -

Accountable Executive	Total Must Take	Embedded	Complete	In Progress	Percentage Complete
Chief Nurse	35	-	26	9	74%
Chief Nurse / Director of Corporate Services	1	-	-	1	0%
COO	5	-	2	3	40%
Director of Corporate Services	6	-	6	-	100%
Director of Finance	-	-	-	-	0%
Director of Governance	7	-	6	1	86%
Medical Director	17	-	10	7	59%
Workforce Director	9	-	4	5	44%
Workforce Director, Chief Nurse	8	-	-	8	0%
Total	**88**	**-**	**54**	**34**	**61%**

Table 3a

Although this first phase of the programme has been largely aimed at getting the foundations right on which to build the next steps and demonstrate the real benefits to patient care and outcomes there are some initial steps forward to share. Below are some examples of work being undertaken, in addition to some recent feedback received from the mother of a child who attended the Emergency Department:

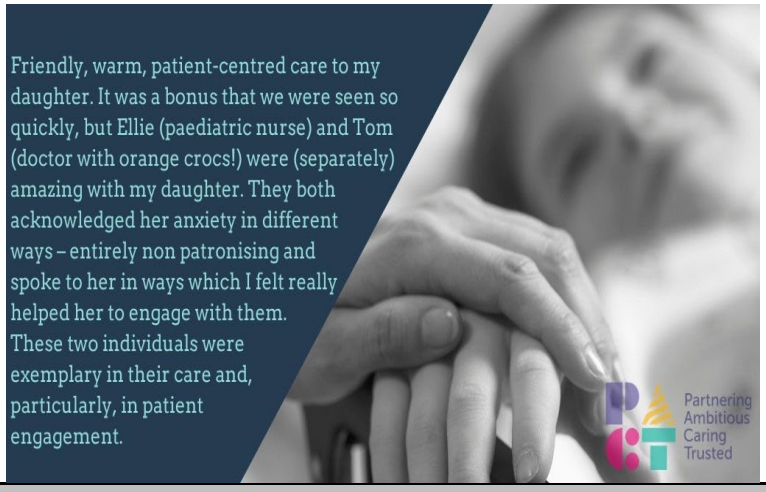
DETERIORATING PATIENT:
One of the key areas of concern has been the recognition and prompt intervention for the most acutely unwell patients, particularly within the Emergency Departments. Much work has been undertaken to improve the care given resulting in >90% of patients consistently receiving a full set of observations on arrival to ED, >95% with observations set in line with protocol, in addition to >95% having a sepsis screening tool completed and appropriate screening actions taken for high risk sepsis.

PAEDIATRIC Triage Emergency Department:
Improvements continue to be recorded in relation to ensuring children are seen quickly and treated in a timely manner. In February 2020 the average time to see a child was between 20 and 40 minutes. Over the last four months the average time where this has exceeded 15 minutes has been on only three occasions = an improvement from between 10-20% in February to between 70-80% currently.

PATIENT EXPERIENCE:
A patient experience improvement plan is now in place across the Emergency Department with quarterly patient engagement events taking place and a quarterly patient experience report provided. The senior nursing leadership has been strengthened with improved oversight and visibility for patient safety, patient flow and timely escalation. Inpatients are given an opportunity on one day of their stay to provide feedback, which has resulted in the purchase of additional televisions and re-visit of the 'sleep charter' on ward 21.

STAFF EXPERIENCE:
Mandatory Training and appraisal compliance has improved to just under the 90% threshold with trajectories in place to achieve full compliance. Dementia awareness, MCA and NEWS2 training across the medicine care group have shown a 10% increase in compliance through the summer and remain on trajectory. There is increased rigour in governance processes and complaints response times are now in line with Trust standards.

PATIENT FEEDBACK:



BACKGROUND

The first phase of the CQC Improvement Action Plan has been to work through the actions across the care groups and corporate areas. Significant progress has been made with three quarters of the actions now completed. This phase has been largely transactional ensuring that we have robust systems and processes in place to deliver safe, high quality care. A key element of this work has been to challenge clinical colleagues in their approach and thinking around the care they provide, recognising what they do well but acknowledging when things do not go according to plan and taking swift and appropriate action.

October will see us moving into phase two of the programme, which will focus entirely on 'what good looks like' and the measures that will substantiate the improvements made and positive outcomes for patients.

To facilitate this in a meaningful way we are focussing on the themes of improvement – for example how we reduce avoidable harm to patients from falls, pressure ulcers and medication errors, how we recognise and respond to our most acutely unwell patients and how we support our most vulnerable patient groups.

ASSESSMENT

Proposed Next steps

The first six months (April to September 2020) of the CQC Improvement Action Plan has been to work through the actions across the care groups and corporate areas. Significant progress has been made with only 13% of the actions remaining to be completed within phase one. The remaining 13% (50 actions) have been reviewed and there are no concerns for delivery at this point. This initial phase has been largely transactional with an objective to fully complete all transactional actions within the overarching Regulation and Compliance Plan on a Page by the end of December 2020.

The Executive Team approved the implementation of the second phase of the programme October 2020 to March 2021 on 6 October. The proposal outline is described below:

a. Progress and monitor all remaining actions through to completion by 31 December 2020. This will continue to be a feature of the Confirm and Challenge meetings.

b. Realign the plan into thematic areas for improvement, rather than by individual care group. The purpose of this is to better engage with subject matter experts across the organisation and reduce silo working and inconsistencies in approach.

   Initial themes have been identified and are indicated in table 6 reflecting the key areas of concern raised by the CQC. Each theme, where possible, has been aligned to the appropriate Trust Group/Committee as an initial suggestion. It is proposed that the groups will have oversight of the required actions, providing advice and guidance to clinical teams where necessary and evidence of improvement through business as usual systems, processes, audits and assessments. The table also indicates an executive lead/senior manager to provide additional support and leadership.

c. Implement a 4-week cycle in order to increase focus and delivery expectations of action owners within each theme of improvement. The cycle of business will also incorporate the meeting schedules of the groups and committees identified in table 4 above. The proposed cycle is set out below:

- Each week will focus on a specific area of the programme with clear actions for delivery agreed. This will specifically include the collection of accurate and sufficient evidence to support real improvement and benefits to patient care.
- An exception report will be provided to the executive meeting for any items requiring escalation or decision.
- A summary progress report will be provided to the last executive meeting of the month to include a proposal for those areas of improvement being submitted to the 'Green to Blue' assurance process – this will be for presentation and approval at the Quality Operational Committee then onward presentation for endorsement at the Quality & Safety Assurance Committee.
- A 'Highlight Report' will be submitted on the last Friday of each month for presentation to the Senior Leadership Committee.
- A report to the Board of Directors of the month end/cumulative position will be provided monthly
- Information will be provided for the slide pack for the monthly SOAG meeting.
- The full QIP document will be 'locked down' at the end of each month and archived, thus recording one version of the truth for each month.

RECOMMENDATION

The Board of Directors is asked to support the transition to phase two of the programme and a transformational approach to deliver the quality compliance programme.

This approach aims to embed sustainable improvements across the organisation to deliver consistent safe, high quality care as part of the wider ‘Getting to Good’ Improvement Plan.

Delivery of these improvements will result in tangible benefits to patients, their families and carers and establish the Trust as the healthcare provider of choice for the local population and surrounding areas.