SUMMARY REPORT		
TRUST BOARD IN PUBLIC	**3 May 2018**	**Agenda Number: 08**
Title of Report	**Quality Improvement Programme update**	
Accountable Officer	Kate Shields, Deputy Chief Executive	
Author(s)	Programme Management Office	
Purpose of Report	Quality Improvement Plan Update, including summary of CQC Section 29a submission	
Recommendation	The Trust Board is recommended to Receive the update report	
Consultation Undertaken to Date	Update presented at Quality Improvement Delivery Board (QIDB - 18/04/18) and the Quality Assurance Committee (QAC - 24/04/18)	
Signed off by Executive Owner	Thomas Lafferty	25.04.18
Reviewed by Executive Team	Quality Improvement Delivery Board	18.04.18
Reviewed by Board Committee (where applicable)	Quality Assurance Committee	24.04.18
Reviewed by Trust Board (where applicable)	Trust Board	03.05.18
Date(s) at which previously discussed by Trust Board / Committee	05.04.18	
Next Steps	Trust Board to receive routine updates	

Executive Summary

The update will outline:

- An update on Programme progress with an Executive Summary outlining Workstream progress since the 21/03/2018 and a Programme Plan on a Page which highlights the historical Programme Milestones due for delivery from March to May 2018 with an associated RAG rating for delivery. Please note: A Planning Review is underway to ensure that the programme is inclusive of the commitments and timescales agreed within the CQC Section 29a submission on the 13/04/18 and that the relevant elements agreed at the recent risk summits are incorporated into the Programme
- A summary of the actions which were undertaken to ensure compliance (not the full submitted report) and a summary of the longer term sustainability plan against each warning notice area

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Trust Board
Quality Programme update

Agenda 08

03/05/2018

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Quality Programme Update

- For a high-level view of the Programme, please refer to the Programme Plan on a Page (attached PDF) for a RAG rated view of the March – May 2018 Milestones for delivery
- The Programme Plan on a Page captures a retrospective view of the last 30 days and, prospective view of the next 30 days of milestones for delivery. Please note that from the 01/05/18 this will have been revised following a Programme planning review
- The Planning Review will ensure that the programme is inclusive of the commitments and timescales agreed within the CQC Section 29a submission on the 13/04/18 and any other relevant elements agreed at the recent risk summits. The Quality Improvement Delivery Board has added two further projects to the programme to ensure sustainability against the urgent actions taken to address the CQC notice. This is to ensure we continue to monitor progress via the Quality plan. Included formally as a project is Critical Care Flow, Risk Assessment Prior to Surgery and the Harm Review Process.
- Following the exercise above, Executives will consider the size, priorities and leadership of each element of the programme as we move into the second phase of delivery
- The Planning Review will ensure that projects map out their next 60 days delivery as project transition into their second phases of delivery
- The following slide provides an executive summary of Programme Workstream progress

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Quality Programme Update - Executive summary of Workstream progress

Strong Governance

- Policies and procedures for the Duty of Candour and Incident Management have been ratified and shared by email, trust intranet, screensavers and video as appropriate
- The management training and appointment of investigating officers for serious incidents has improved following a review of capacity and capability

Tackling Delays

- All agreed Level 1 KPIs will be reviewed on the 24 April 2018 to confirm RAG thresholds and appropriate trajectories against plans to improve data quality and integrity
- All project leads have met to establish their delivery objectives of their project and their links back to the Transformation Team and the wider RTT Recovery
- A review of workstream priorities will be undertaken following the Surgery Section 29A submission to ensure Trust priorities are underpinned with sustainable plans
- The priority in the workstream is to have speciality led RTT plans to address the backlog aligned closely to the delivery of harm reviews

Safety Culture

- Ward Accreditation testing has been undertaken on Phoenix and the Trauma Ward. The schedule for commencing the in-patient wards through accreditation will start on the 27th of April
- The ED Safety Checklist has been rolled out in Majors 0700-1900 for the first two weeks in April. This will be scaled up to 24/7 from the 4th week in April and commence in Resus from the beginning of May. 38% (56/145) of staff have been through the toolbox education and engagement process so far
- The NHSI Theatre Review report has now been received and the recommendations are being built into the overall plan for WHO within the Quality Plan

Maternity

- The inaugural Maternity Governance Group meeting took place on the 13th of April 2018 and will meet monthly going forward to monitor and embed sustainable improvement
- A draft plan is being developed to address the ongoing monitoring requirements for Section 29A and to ensure the improvements are transferred to business as usual where appropriate
- The revised MEOWS audit process continues with daily audits and improvement being shown since its introduction in February 2018
- The focus through May will be to debrief the teams on a pending AHSN SCORE survey and develop a bottom up action plan incorporated into the overall Maternity Quality Plan

Culture & Leadership

- Phases 3 and 4 of the Medical leadership development programme has been scoped and agreed with team members having visited Bournemouth to learn from their transformation
- The programme and the leadership academy will address areas not covered by FMLM Staff engagement and sessions are scheduled for June along with a team building day with the Army

Engagement & Communication

- The Trust Improvement newsletters have been published and circulated and a open team talk has been videoed and shared via an all staff email on the 4th April 2018
- An Increased exposure of Board visits is being supported through the use of social media and the ‘Wander Wall’ activity tracker

Immediate Next Steps - Programme governance

- Decision required on the sustainability against each Section 29A submission regarding the governance of ongoing monitoring to ensure future compliance (Quality Plan or BAU)
- All plans updated post Section 29A submission to include output focused delivery milestones to drive KPI improvement
- Cross workstream interdependency mapping conducted post Section 29A submission

~ Placeholder ~

~ Please refer to Programme Plan on a Page (PDF) for a RAG rated view of March – May 2018 Programme Milestones for delivery ~

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Update on Six Key Deliverables - Summary of Section 29A Submission*

* Please note this is not the full submission but provides a summary view of the Actions taken and the Governance and Sustainability which will underpin the longer term improvement

Area	Actions undertaken	Sustainability plan
Critical care *(Delayed discharges/ overnight discharges/ High bed occupancy)*	• Operating policy updated to include delayed or overnight discharges with communications out to site teams and critical care staff • Compliance monitored through a dashboard and non-compliance analysed for learning • New process for booking critical care beds six weeks prospectively for elective	• Implement newly adapted 'Safer Bundle' into critical care incorporating a 17:00 senior review to identify and request potential beds for the following day • Continue analysis of data identifying and finding resolution for any themes
Equipment *(Lack of systems/processes to ensure equipment is repaired, maintained or tested)*	• Audited/RFID tagged medical devices to provide an accurate asset inventory; 81% complete as at 11/04/18 • Introduced central function to oversee external contracts • Formed a 'Medical Equipment Board' to oversee medical device provision & related risks • Classified devices by risk level and set associated ambitious KPIs for service and maintenance. Prioritised maintenance of very high risk devices to ensure KPIs for this group are met	• Conclude asset tagging and communicate with divisions to identify gaps/high risk areas • Complete recruitment of additional technician / other technical vacancies • Make RFID system available to clinical staff by 30/09/18 following development of clinical front-end changes • On an on-going basis Medical Equipment Board meetings to review compliance and continue work to improve medical device governance
Fracture Clinic *(Environmental issues for children/ separate appointments for safeguarding)*	• Whole area refurbished – new chairs, ventilation, painting, signage (IPAC approved) • Separate dedicated waiting area for children with clear signage on use • Revised SOP for booking children to specific slots (communication to staff) at the beginning of the clinic. There will be a daily check by the booker and compliance will be monitored through a dashboard (recognising clinical appropriateness)	• Permanently relocate the Fracture Clinic in the longer term, monitoring compliance for the children's area in the current space • Undertake a review of all children's outpatient facilities to assess compliance with safeguarding requirements • Ongoing audits of new booking SOP to ensure compliance

Area	Actions undertaken	Sustainability plan
Governance *(Lack of systems and processes to ensure evaluation and improvement of services/ Ineffective management of Serious Incidents/ non-compliance with Duty of Candour requirements)*	• Comprehensive review and restructure of the governance function (£400k investment) • Governance improvement programme (informed by the Well Led review) developed with trajectory and includes plan for divisional governance. The Board will receive direct assurance through QEWs whilst the plan is being delivered • The Serious Incidents policy has been revised (with supporting communications to staff) and a live DATIX dashboard has been developed • A process of centralised Incidents Officers has been implemented, communicated to relevant staff by the Medical Director, and supporting training dates are available • The Duty of Candour Policy has been revised to be explicit on requirements and automatic reminders will now be sent to incident handlers (with checklist for compliance). Mandatory training and Induction materials have been updated	• The Ward to Board Governance Project will incorporate the findings of the Well Led Review and standardise the management and reporting of quality governance mechanisms across all divisions and services to the Board • The Trust will re-establish the Clinical Governance Committee in April 18 • Establish a full training and development framework for clinical governance mechanisms including incident management by level of accountability (all staff, clinical management and executive leadership) • Embed systems for learning from incidents through an investigators forum and a patient safety group
Maternity *(Concerns with MEOWS chart completion and audit/ Poor record keeping/ Lack of policy for high dependency women / Concerns with 2nd Maternity theatre processes / Community midwifery – managing emergencies (equipment/ training/transfers of care) / home birth risk assessments)*	• Revised, comprehensive (12 point) MEOWS guideline and chart implemented, with extensive communications to staff, and are being audited daily. Both the guidance and audit methodology have been externally validated • Assessment of evidence undertaken which highlight compliance but issues with documentation process. A new process has been introduced to clearly capture safety observations/checks • Five guidelines for high dependency women, externally validated, implemented and circulated to all staff highlighting key changes • Revised SOP for 2nd Maternity theatre revised following simulation testing / permanent call bell implemented / completion of the WHO safety checklist …(continued)	• MEOWS; the monthly audit process will be built into the Maternity Dashboard reporting framework from end April 2018 and will report through to a newly developed Maternity Governance Group to Divisional Board • Ongoing monitoring of compliance against record keeping • Interim audit against new guidelines introduced to assess compliance and undertake thematic analysis • Medium to long term plan to introduce a different staffing model • Ongoing monitoring in place with manual audit process to be developed into full integrated Theatre Galaxy system • From April 2018 reports will be part of the reporting schedule for the Maternity Governance Group on either a monthly or quarterly basis depending on the safety area concerned

Area	Actions undertaken	Sustainability plan
..(continued)	• WHO manual audits are undertaken on a monthly basis and submitted to the central Theatre team for inclusion in the overall WHO compliance report (improvement shown) • A number of risk assessments undertaken within community midwifery related to managing emergencies (equipment / training/ delayed transfers of care) with results analysed and clear plans developed, where required, for addressing issues; including, training needs analysis more explicit for community requirements, delayed transfer of care monthly report amended to include and analyse all community cases, home birth assessment form introduced	
Surgery *(Lack of systems and processes for risk assessment prior to surgery/ completion of safety briefings/ concerns re RTT performance deteriorating)*	• The updated Theatre Scheduling Policy and its associated appendices covers both theatre scheduling and risk assessment prior to surgery. This is being monitored through the weekly senior managers meeting. Processes have been introduced for more effective scheduling • Draft single Trust wide Policy for 5 Steps to Safer Site Surgery & Interventional Procedures introduced (ratified by end June18) • Morning Huddle standardised across all main theatre sites, with a trial underway in one theatre for all theatre staff to attend (assessing impact on start times) • Our RTT position has deteriorated over the winter and we have a threefold approach: 1) Increasing or releasing existing capacity, 2) development of RTT recovery through to specialty level weekly performance management, with Executive oversight, 3) Harm Review Panel which supports a retrospective harm identification outside of regulatory targets and prospective risk stratification against clinically agreed targets	• A Trust wide Surgical Safe Site Surgery and Interventional Procedures Task and Finish Group with designated senior clinical leadership is being developed to provide oversight across the Trust by the end of April 2018 • A tablet based '5 Steps to Safer Surgery' software solution is in development to reduce administration and increase the opportunity for cultural change • Both Harm Review and RTT recovery processes will occur consistently across all specialties and be reviewed through Divisional performance meetings by Execs • The Board will have oversight of Harm Review and RTT performance within future IPRs from May 2018 • The triumvirate will be supported with increased insight into developing their speciality plans with clear trajectories for plans agreed • This will involve further work on both systems and processes but also organisational development of people to support Trust capability in RTT recovery

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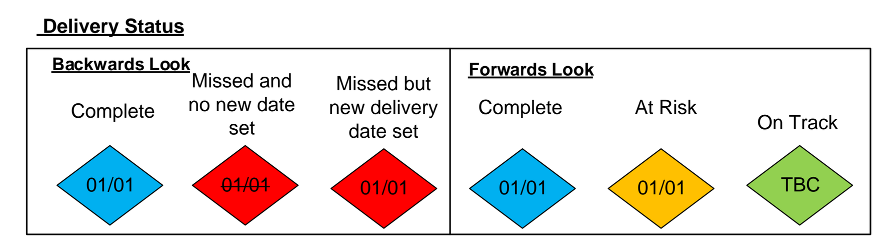
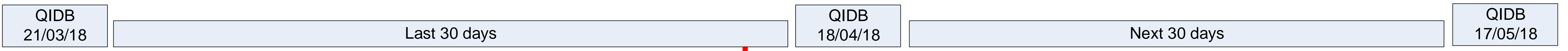
Royal Cornwall Hospital Quality Improvement Programme Plan
30 Day cycles

Version 0.1 (updated 16 April 2018)





Safety Culture

Maternity
- 31/03 – Expert review of high risk inductions in maternity to be undertaken and presented to QA Committee
- 20/03 – Revision of MEOWS chart for change in escalation parameters following approval at Directorate meeting on 14th March 2018
- 05/04 – The 5 clinical guidelines covering HDU obstetric women & deteriorating patient reviewed & approved by Trust Guideline Group
- 20/03 – The SOP for the 2nd theatre to be revised and approved at the directorate meeting
- 26/03 – Call with National Maternity Team
- 30/03 – Timescale for business case & trajectory for implementation of total theatre staff model in maternity services to be outlined
- 30/04 – Quality Assurance Check Stillbirth Review Process
- 30/04 – Diagnostic for maternity patient flow to be completed
- 24/04 – Revise current Maternity Fresh Eyes and CQC Review plan to reflect next three months work in relation to safety culture, governance and patient flow

Safety Culture

ED Safety Checklist
- 30/03 – Finalise ED Safety Checklist for use
- 01/04 – Start implementation of ED Safety Checklist in Majors
- 01/05 – Start implementation of ED Safety Checklist in Resus

Pressure Ulcer Collaborative
- 21/03 – Prepare local team from pilot wards for presenting at National Celebration event
- 08/04 – Collect and confirm baseline data to set improvement trajectory for 2018 /2019
- 30/04 – Roll out adult inpatient record. Admission areas to commence roll out. Ward staff to be visited by Clinical Matrons to be reminded of new patient record roll out.

Ward to Board Framework
- 06/05 – Present revised ward to board KPI's for SRO sign off

Ward Accreditation
- 31/03 – Testing Draft 1 Ward Accreditation Prototype in 1 medical and 1 surgical
- 31/03 – Present finalised framework to clinical cabinet for approval
- 27/04 – Remaining in-patient wards to start ward accreditation process

WHO Safety Checklist
- 30/04 – Draft terms of reference and hold first meeting for Safe Site Surgery & Interventional Procedures Group
- 21/04 – Trial of daily electronic management of Brief / Debrief to commence 3rd April 2018 (WCH) Monthly 5 Steps to Safer Surgery

End of Life
- 31/03 – Complete specification for ward accreditation
- 31/03 – New Treatment Escalation Form to be in place Trust wide
- 31/03 – Monitor compliance with completion of End of Life Documentation
- 22/03 – Participate In Fresh Eyes NHSI End Of Life Review
- 30/04 – Consultation process to be completed for Seven day working.

Safety Huddles & Team Reviews
- 27/04 – Complete Trust wide scoping of Safety Huddle and Team Review process

Safe Staffing
- 26/04 – International Nursing Recruitment Trip to Dubai

Strong Governance

Managing Incidents
- 31/03 – Publish Revised Policies and Procedures for Serious Incidents and Duty of Candour
- 31/03 – Established programme of centralised Investigating Officer allocation reinstated Root Cause Analysis training and refresher training commenced
- 31/03 – Revised Incidents Performance Management Tool and Framework in place
- 31/03 – Duty of Candour targeted guidance education and training plan to improve compliance by Division agreed and initiated
- 29/03 – Duty of Candour Compliance Audit Results presented to QA Committee
- 23/03 – Overdue Incidents and Serious Incidents reduction trajectories agreed and commenced with Divisions
- 16/05 – Revised investigating Officer Training (Phase 1) Completed

Clinical Effectiveness
- 04/05 – Divisional Harm Review Process in Place (Governance)
- 27/04 – Publish Revised Terms of Reference for Harm Review Panel

Risk Management
- 11/05 – Standardised ToR and Agenda for Divisional Governance and Quality and Divisional Performance meetings published

Ward to Board Governance
- 17/04 – Quality Governance sub committee reinstated
- 04/05 – Initial Phase II: Ward to Board Project Meeting
- 17/05 – Ward to Board Governance Project Plan Submitted to QIDB

Patient Experience

Tackling Patient Delay

Ambulatory Emergency Care
- 23/04 – Agree and approve SDEC model
- 20/04 – Update operational policy for AEC/SDEC and distribute

Emergency Medicine
- 16/04 – Complete review of best practice guidance
- 04/05 – Review existing speciality guidance
- 20/04 – Implement improvement plans following review including SOP's
- 27/04 – Review of trial Paediatric cover in ED to understand next steps

Acute Medicine
- 17/05 – Complete 3 month review of Medical Model with all medical specialties including SOP and on-going model

Frailty Management
- 31/03 – Review of job planning to enable pilot change to medical cover (Consultant consistent cover across the week for OPAL cover) **Not implemented**
- 31/03 – Disseminate communications around OPAL criteria
- 30/04 – Frailty model defined – New action plan required. Re-align project milestones to new delivery plan

Implementing SAFER
- 30/04 – Task and Finish Group being set up to explore consistency and approach to EDD (link to SAFER KPI)
- 24/04 – Wave 2 objectives and implementation schedule agreed
- 08/05 – Completion of the action learning set (PDSA) regarding waves 1 and 2
- 07/05 – 8 week concept presentations initiated (12/3/18) led Matron, ECIP Lead and Project Support

Elective Care
- 31/03 – Detailed action plan for reaching co-efficiency score of 1.5 for all patients in place and being monitored

Ophthalmology
- 30/04 – Glaucoma surveillance action plan in place to deliver new imaging system and ensure process is robust in order to increase capacity

Cardiology
- 27/04 – Harm reviews to be completed for all angiogram patients
- 13/04 – Complete Job plan reviews in order to release additional capacity to tackle TOE Backlog
- 06/04 – Trajectories in place for Diagnostics (Echo/ Angio), non admitted RTT and ICD
- 30/04 – Approval for 2nd radial lounge (increase day cay capacity to drive down Angio waits and backlog)
- 01/05 – Implement day case PCI

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Orthopaedic

Outpatients
- 31/03 – Project governance, objectives and sub projects identified
- 31/03 – Identify level 2 KPIs
- 20/04 – Trust wide options for the delivery of outpatient services
- 27/04 – Outpatient centralisation workout with divisional managers to feed options appraisal

Culture & Leadership

Culture & Leadership
- 30/03 – Culture of well-being promoted – Flu Campaign
- 31/03 – Recruiting to second cohort of 12 week University Course for Staff in Healthy Eating, Managing Stress & Increasing Physical Exercise (160 in first cohort)
- 27/04 – Signed off Culture and Leadership Strategy and Plan
- 27/04 – Delivery of a Trust Wide Organisational Development Plan
- 27/04 – Effective and supportive processes for staff to 'Speak Up' in place
- 30/04 – Launch Respecting Each Other - bullying and harassment campaign video

Engagement & Communications

Communication
- 11/05 – Open Team Talk in every clinical division scheduled from March.
- 30/04 – New Staff App launched

Engagement
- 30/03 – First (March) Monthly snapshot staff survey completed
- 30/03 – March Trust Board visit programme underway
- 23/03 – Appropriate interim resource identified to deliver workstream objectives
- 30/04 – April Trust Board visit programme underway
- 30/04 – Resource gaps identified and external recruitment commenced
- 30/04 – Quarterly Senior Leader shift shadowing commences
- 04/05 – Second (April) Monthly snapshot staff survey completed

Currently Here 17th April 2018