SUMMARY REPORT		
TRUST BOARD (IN PUBLIC)	5 July 2018	Agenda Number: 9

Title of Report	**Quality Improvement Programme update**	
Accountable Officer	Kate Shields, Deputy Chief Executive	
Author(s)	Programme Management Office	
Purpose of Report	**Quality Improvement Programme update**	
Recommendation	The Trust Board is recommended to: Receive the revised Quality Plan Scope	
Consultation to Date	Presented at: Quality Improvement Delivery Board 21/06/18 Quality Assurance Committee 26/06/18	
Signed off by Executive	Kate Shields, Deputy Chief Executive	18/06/2018
Reviewed by Executive Team	Quality Improvement Delivery Board TMG	21/06/2018 20/06/18
Reviewed by Board Committee (where applicable)	Quality Improvement Delivery Board	21/06/2018
Reviewed by Trust Board (where applicable)	Trust Board	05/07/18
Date(s) at which previously discussed by Trust Board / Committee	Monthly update to Board routinely provided	
Next Steps	Trust Board to receive routine updates	

The Quality Improvement Update Includes:

- An executive summary of progress being made across all of the Workstreams within the Quality Programme since the 31st of May 18. It also outlines the areas for continued focus over the next 30 day planning cycle highlighting some areas of challenge.
- To support this summary the Programme plan on a page illustrates a RAG rated view of delivery milestones across the Programme from May until the end of July 18 outlying what has been completed and what remains outstanding for delivery in July.
- The Programme Level 1 KPI Dashboard outlines the performance of the Programme against the key project metrics for May 18. Trending arrows are included to provide a comparative view against April 18 data.
- The Annex provides a project update for Cardiology, Ophthalmology and the Governance Workstream outlining current progress and remaining challenges.

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Quality Improvement Programme
Executive Summary

NHS
Royal Cornwall Hospitals
NHS Trust

Progress being made

Tackling Delay:

- SAFER (series of interventions to ensure patients are discharged in a timely manner) Wave 4 (6 further wards) has been launched however the audit for assessing triggers requires rescheduling
- The completion of the Speciality level RTT recovery plans has shown a small increase to 79.2% for the 18 week pathway with list validation aiding this position.
- The outsourcing of the Angiogram backlog has been agreed and will commence from the 18/06/18 however a deadline for completing these should now be set.
- In support of Orthopaedics the Constantine Ward refurbishment is now complete and opened on the 11/06/18 and funding has now been agreed for SMH to enable the creation of side rooms.

Strong Governance:

- The Governance 're-set' continues with now daily reports and twice weekly meetings with Divisions which has reduced the incident backlog and maintained performance resulting in a 70% reduction in the total number of incidents since the March 18 baseline.
- Further to this the revised approach is now on track to deliver the closure of all overdue incidents by the end of June 18. The appointment of IOs has also reduced from an average of 13 days in April and 6 in May with a set trajectory of 2 days for June 18.
- A revised Divisional Reporting cycle has been agreed with the SRO and COO and will be operational for July 18 ensuring that performance information is reviewed in a 4 week cycle.

Safety Culture

- Ward Accreditation is progressing well with 6 Wards undergoing accreditation in the last 2 weeks and an overall percentage of 60% complete for May 18 – All Wards are now programmed and GLU has gone from bronze to silver in six weeks.
- ED Safety Checklist for May is on trajectory with 61% completion despite the challenges in ED with flow over the last month.

Maternity

- NHS Resolutions baseline assessment presented to board.
- National Maternity Team initial visits completed with positive feedback received. They will provide support to the LMS and community which will be included in the overall maternity plan once agreed.

Comms and Engagement

- Staff engagement with the Programme is continuing to improve and the Comms team has undergone a refocus in resource in order to prioritise Programme engagement with a communication and engagement plan now in place for every project.
- Respecting Each Other Campaign video launched.

Culture and Leadership

- Anti Bullying Respecting Each Other Video launched.
- Initial FMLM Workshops being held with Clinical Leaders.

Continued focus

Tackling Delay:

- Project priorities and aims will be revisited on the Outpatients and Frailty projects to develop 30/60/90 day plans for continued delivery which should be presented and agreed at QIDB 02/07/18
- Risk and Coefficient management will be a continued focus for the Ophthalmology project and must now be incorporated into the plan for delivery. The Speciality Harm review SOP will be developed and the approved proposal to move the booking team back into the Division with supported intensive training will now be actioned at pace. capacity recovery, operational stability and follow up management is the focus.
- An executive level meeting on the 13/06/18 agreed a phased approach by priority specialties (dermatology, ophthalmology, urology and cardiology) for Harm Review where prospective Harm Reviews should be completed. A new process for streamlining the number of retrospective reviews of 52/52 breaches was also agreed, which will help to ensure that retrospective reviews are completed in a timely manner

Strong Governance:

- Additional resource has been brought into support the correct recording and reporting of DoC compliance and to improve DoC performance management. Successful management of overdue incidents has freed capacity to focus on the improvement of 24-72 Hour identification and reporting of Serious Incidents.
- A Revised Divisional governance accountability and reporting framework will be instilled following a baseline assessment with revised quality governance performance indicators proposed by 01/07/18.
- Ongoing monitoring is required to assess progress for the wider programme against the immediate priorities.

Safety Culture

- Risk Assessment prior to Surgery will be managed via this workstream moving forwards and the execution of the now completed EOL plan will now start to improve the quality of care.
- Once all Wards have been accredited an evaluation will take place regarding how best to develop accreditation further across the organisation.
- The Workstream will continue to ensure that project plans and milestones ensure delivery to agreed timescales and a revised ward to board framework will be published alongside ward accreditation.

Maternity

- The MEOWs guideline is being reviewed via NHSI following a further CQC query, however compliance remains high at 99% for May 18 and there have been no deterioration incidents.

Comms and Engagement

- A revised Trust board and Senior leaders attendance approach at safety huddles will be devised and reviewed.
- The new Staff App is planned to go live on the 22/06/18 which will provide a valuable alternative channel to staff engagement

Culture and Leadership

- The draft Culture and Leadership Strategy and Plan will undergo review at the People and OD Committee on the 19/06/18 prior to submission to the Trust Board
- Senior Organisational Support is being secured and a Band 5 Organisational Development Administration lead is being recruited to support the Workstream in planning and delivery

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Programme Level 1 KPI Dashboard

Royal Cornwall Hospitals NHS Trust

Safety Culture

- 100% of staff trained in ED Safety Checklist (82%)
- 95% Patients Overall in Majors, Resus & Paediatrics have a completed ED Safety Checklist by December (61%)
- 100% in-patient wards (including maternity and ED) undergo ward accreditation by (30/06/18) (60%)
- Who Surgical Safety Checklist Compliance (99.95%)
- Number dying at place of choice (86.11%)

Maternity

- No adverse incidents related to emergencies in the community (1)
- Compliance with documentation standards (MEOWS) (99%)
- Compliance with documentation standards (All) (92%)
- Mandatory Training Compliance in Acute Maternity Staffing (88.7%)

Strong Governance

- Number of incidents investigated and closed within 20 working days (324)
- 24 Hour Divisional Clinical Review from identification of potential SI received (5%)
- All decisions on SI classification recorded on STEIS within 48hrs (0%)
- 60 Working Days Final report submitted to Commissioners (61%)
- Evidence Duty of Candour completed (21%)

Tackling Patient Delay

- Average number of speciality Outliers (29)
- Time to decision within 180 minutes (65.7%)
- Average length of stay of Frailty patients (5.2 days)
- **NOT LIVE** 100% of required harm reviews completed
- Critical Care Flow - Out of hours Discharges (adults) (5)
- Cortical Care flow - Delayed Discharges >24hrs (5)
- RTT 18 weeks (79.2%)
- RTT Number of 52 week waits (226)
- Theatre list confirmed by operative Surgeon (67.4%)

Culture & Leadership

- Vacancy rate (All staff) (11%)
- Retention rate (87%)
- Time to complete grievances (7 Weeks)
- Sickness rate (3.35%)

Engagement & Comms

- 51% of staff will say that “Communication between senior managers and staff is effective (28%)
- 51% of staff will be able to name 3 successful Trust Improvement projects. (50%)
- 51% of staff will say that “Senior Managers act on staff feedback” (28%)
- 51% of staff will say that they have been to an engagement event or meeting on Trust Improvement programme. (31%)

Key:

⇧ Positive change

⇩ Negative change

Red = 12 Amber = 7 Green = 11	Movement since last report: Improved = 18 Worsened = 9 Unchanged = 3

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Annex A

Quality Programme – Project Deep Dives

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Cardiology Update
QIDB 21/06/18

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Situation

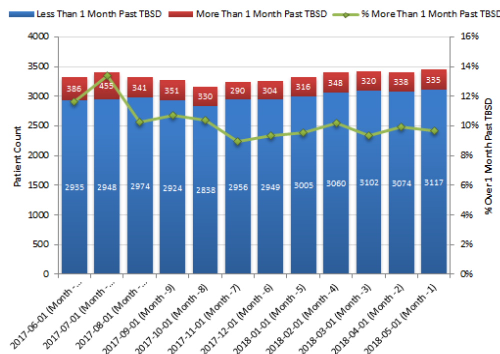
- In April 2017 Cardiology were placed in internal special measures following concerns that there was a significant risk that new, follow up and elective patients were not able to get access to timely appointments. These concerns were echoed by the CQC.

Background

- Three substantive consultant vacancies not filled
- Mismatch in outpatient demand and capacity
- High levels of elective cancellations due to emergency demand on bed capacity
- Bottlenecks in diagnostic services have significantly lengthened patient wait times to start treatment

Today: Continued Areas focus

Follow up pending list: Patients +1 month past TBS date



RTT incomplete admitted pathway: MTD 63.7%

2018-Feb	1617	523	67.7%
2018-Mar	1654	568	65.7%
2018-Apr	1576	606	61.5%
2018-May	1534	557	63.7%

First out-patient appointments

Month to date			
Cardiology patients	<18 weeks	>18 weeks	% under 18 weeks
Totals	301	4	98.70%

April 2017 – 80% of patients booked within 18 weeks.

Recovery can be seen in certain key areas and ongoing action will support this. Elective capacity continues to be a focus

Recovery Plan

RTT Recovery

- Recruited to three substantive consultants **(started March 18)**
- Additional consultant position currently advertised **(June 2018)**
- Outsourcing angiography backlog to Duchy commencing **18th June**
- Second radial lounge approval 11th May and will reduce elective cancellations. Expected delivery **September 2018**
- CTCA implementation meeting scheduled **6th June 18**. Model will reduce elective demand, predicted at 34 patients per month
- Investment approved for Cardiac Physiology and heart function team to reduce dependence on consultant activity (nurse and physiology led services) which will release consultant PA's that will be reallocated to outpatient and elective activity. Posts out to advert during **June 2018**.
- Negotiations are ongoing to re-locate EP/ablation activity
- Additional capacity continues to be provided for patients identified as high risk awaiting complex device/pacemakers procedures. Trajectory on track to recover position by **July 18'**
- Continuing to source additional outpatient clinics to reduce wait times for new and follow up appointments until the 10th consultant recruited.
- Discussions ongoing with CCG and Duchy to provide collaborative working towards development of a single Cardiology service for patients across Cornwall, first step reviewing quick wins which includes Duchy increases outpatient capacity.

Harm Reviews

- Waiting list stratification continues for high risk patients
- Following publication of the Trust wide Harm Review SOP, Cardiology are currently working on linking the current desktop review to ensure it fulfils the harm review criteria
- Vetting proforma implemented June 17' process revised May 2018 to improve turnaround times
- Volume analysis complete which enables team to prioritise cohorts of patients for harm reviews

Summary:

All recovery plan actions are focused on improving patient pathways, tackling long waits and delivering a sustainable service. These align and look to address the concerns outlined by the CQC.

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Ophthalmology Update
QIDB 21/06/18

NHS Royal Cornwall Hospitals NHS Trust

Situation

- CQC (2017) concerned that Ophthalmology were not managing the risk of patients effectively. 4 SI's through the year
- In month rises for follow up's March, April and May
- Patient Co-efficient has increased risk of patients >1.5 target
- Admitted pathways +18 weeks is a concern for patient safety

Background

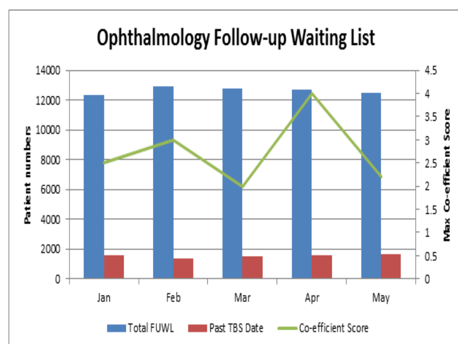
- Ophthalmology booking team changes and loss of dedicated resource for FU has impacted on the ability to maintain co-efficient traction
- Demand across all specialities continues to rise
- Theatre and consultant capacity for elective activity
- Additional clinic availability limited

Actions in progress (June focus)

- Follow up audits underway to establish patients suitable for discharge and or potential harm.. Outputs to inform any required changes to reduce risk and follow up list additions
- Harm review speciality SOP's is progressing with clinical input
- Fail safe officer position progressing with JD drafted
- Ophthalmology booking team proposal approved (to move back into division). Necessary actions being worked through
- Outsourcing options to action elective backlogs identified. Costs, timing and capacity being assessed
- Backfill for lost clinical capacity. Adverts out to post & ops teams proactively working to minimise clinic/elective cancellations through agency

Challenges

Coefficient & FU backlog:



RTT incomplete admitted

2018-Jan	1557	276	82.3%
2018-Feb	1538	348	77.4%
2018-Mar	1522	376	75.3%
2018-Apr	1555	406	73.9%
2018-May	1535	421	72.6%

Key areas of focus for recovery

Specialty	Total	>18 weeks	Booked	non booked	% not booked
Cataracts	887	342	112	230	67.3%
Ocular Plastics	52	9	6	3	33.3%
VR	77	34	5	29	85.3%

Booking team changes and managing impact to service remain a focus
The coming months will focus on capacity recovery, operational stability and follow up management

On-going risks:

1. **Capacity:** Five clinical positions have been lost (Locum consultant, fellow & specialty grades) This provides further challenge on clinic availability and extended waits for patients
2. **Booking team:** Loss of knowledge and experience within current booking team provides risk to the speciality. Mitigation is the booking team proposal which has been approved however, team would be new and would require intensive training
3. **Surveillance clinics:** Capacity constraints hinders the ability to provide the levels of reviews required and there is a risk backlogs will grow. Options to increase surveillance clinics cannot currently be facilitated

Summary: The focus actions are centred around stabilisation for the service and to address the immediate capacity challenges. Cap and demand plans continue and expected July

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Governance Recent Improvements
QIDB 21/06/18

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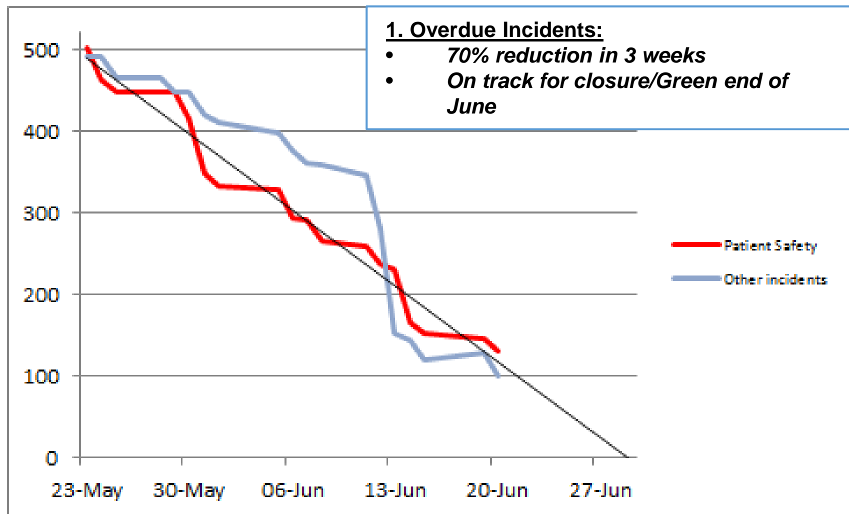
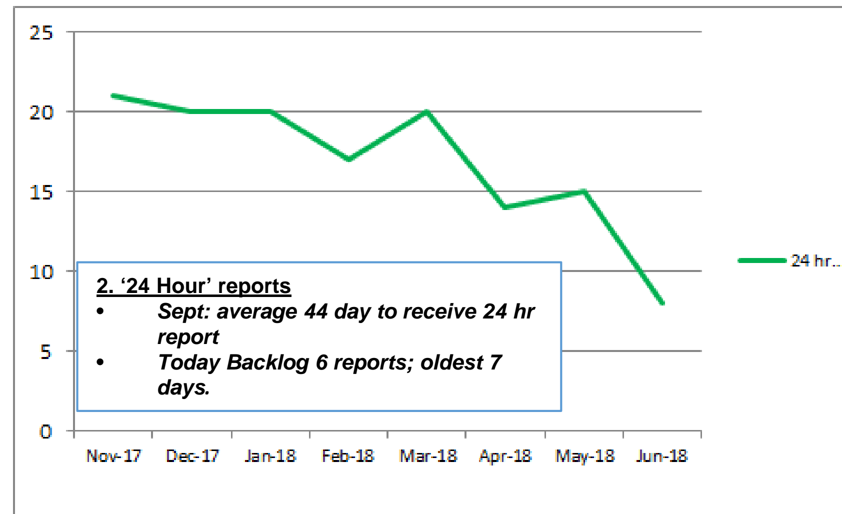
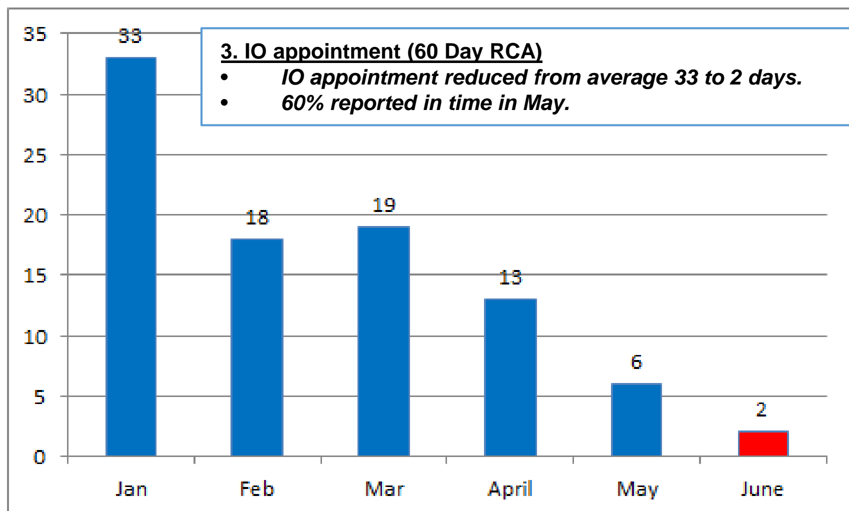
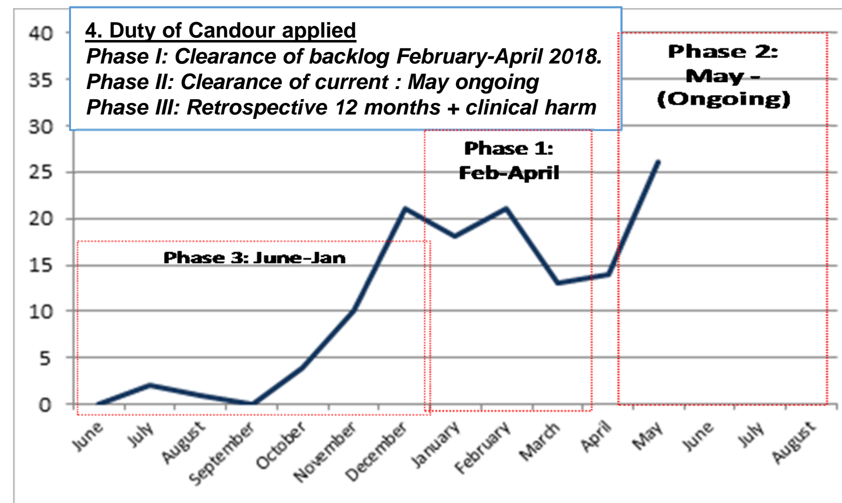








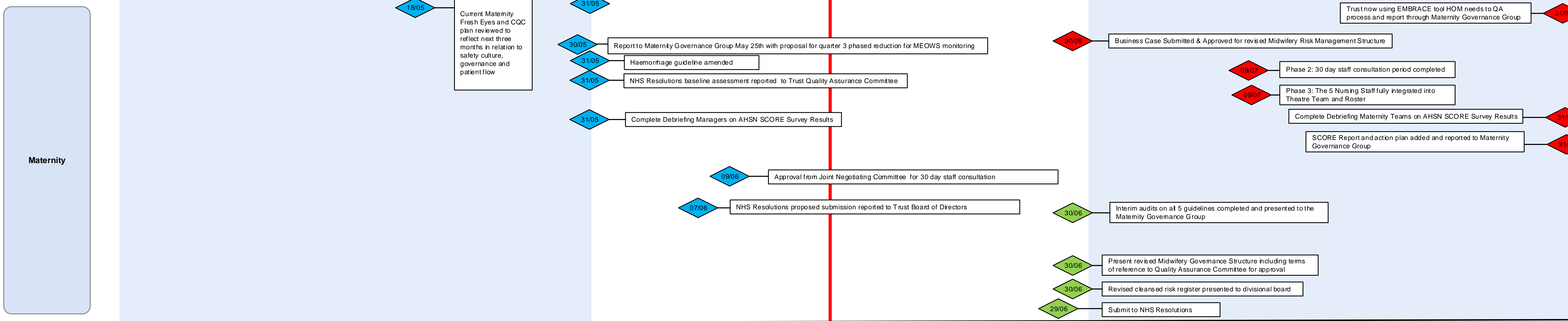
Royal Cornwall Hospital Quality Improvement Programme Plan
30 Day cycles

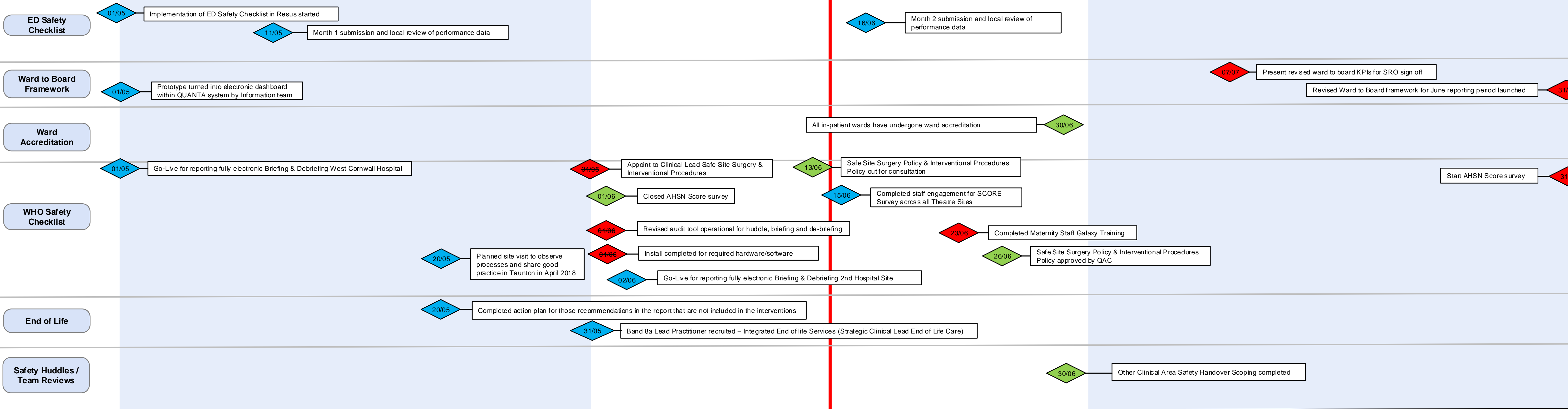
Version 0.4 (updated 15 June 2018)

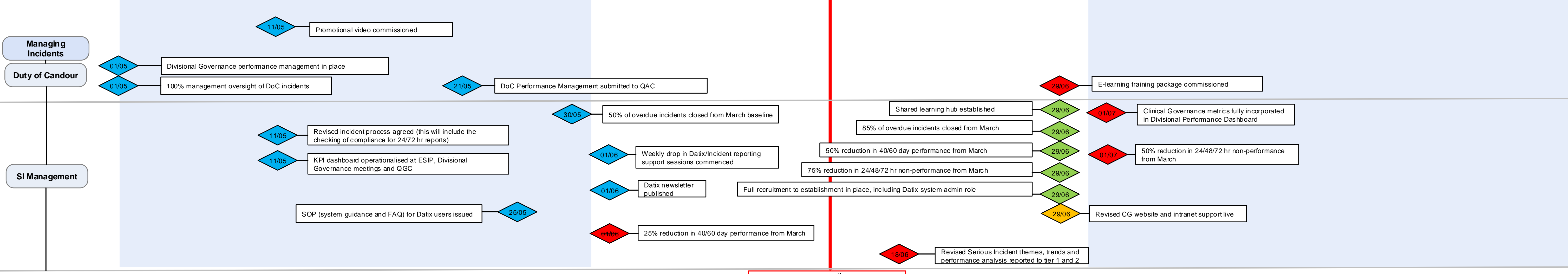
Delivery Status

Backwards Look			Forwards Look			
Complete	Missed no new date	Original Date Missed	Complete	At Risk	On Track	Original Date Missed
01/01	01/01	01/01	01/01	01/01	01/01	01/01

QIDB 31/05/18 | QIDB 21/06/18 | QIDB 02/07/18 | QIDB 18/07/18







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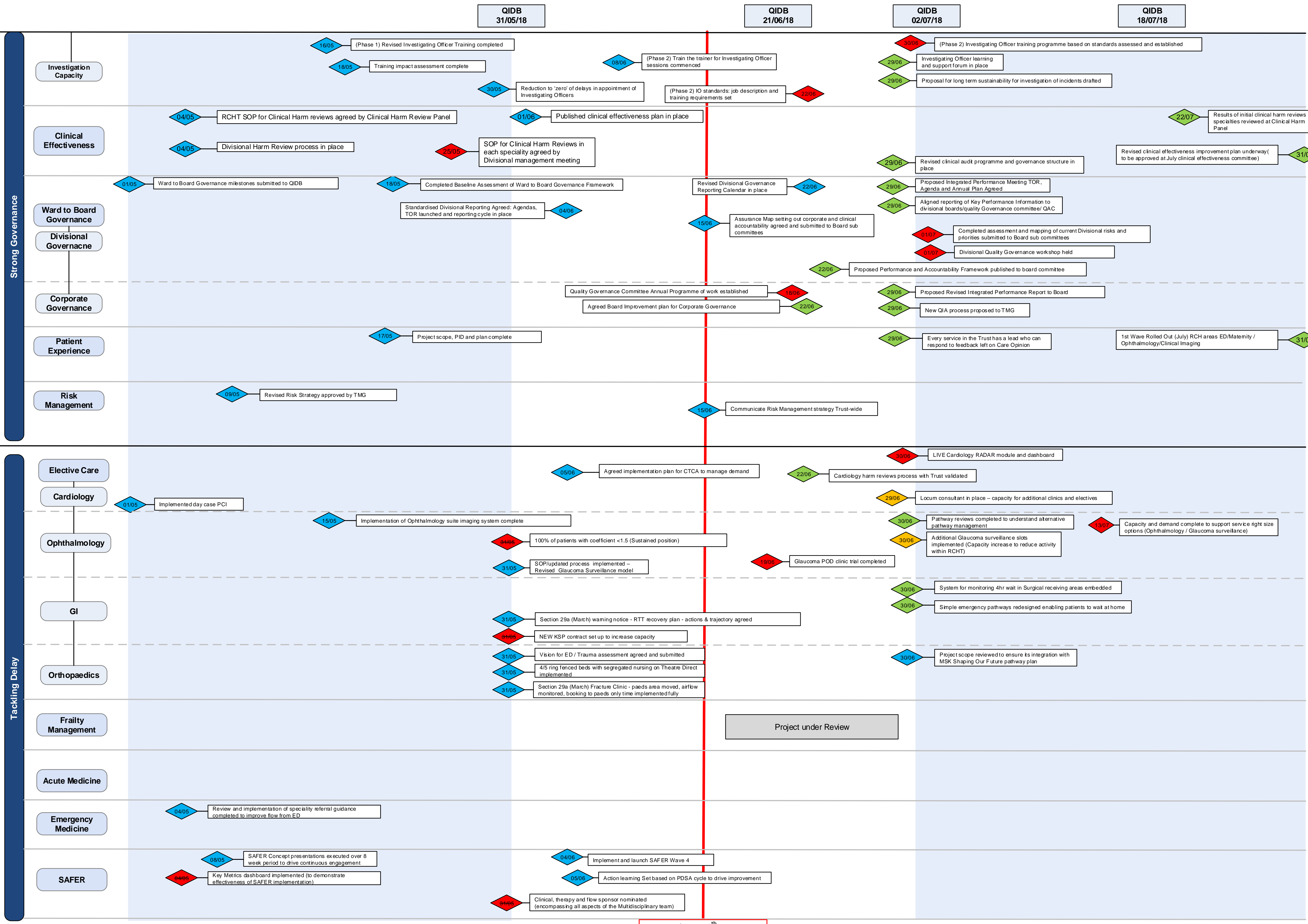

QIDB 31/05/18
QIDB 21/06/18
QIDB 02/07/18
QIDB 18/07/18
Strong Governance
Investigation Capacity
16/05 (Phase 1) Revised Investigating Officer Training completed
18/05 Training impact assessment complete
30/05 Reduction to 'zero' of delays in appointment of Investigating Officers
08/06 (Phase 2) Train the trainer for Investigating Officer sessions commenced
(Phase 2) IO standards: job description and training requirements set 22/06
30/06 (Phase 2) Investigating Officer training programme based on standards assessed and established
29/06 Investigating Officer learning and support forum in place
29/06 Proposal for long term sustainability for investigation of incidents drafted
Clinical Effectiveness
04/05 RCHT SOP for Clinical Harm reviews agreed by Clinical Harm Review Panel
04/05 Divisional Harm Review process in place
25/05 SOP for Clinical Harm Reviews in each speciality agreed by Divisional management meeting
01/06 Published clinical effectiveness plan in place
29/06 Revised clinical audit programme and governance structure in place
22/07 Results of initial clinical harm reviews in specialties reviewed at Clinical Harm Panel
Revised clinical effectiveness improvement plan underway(to be approved at July clinical effectiveness committee) 31/07
Ward to Board Governance
Divisional Governacne
Corporate Governance
01/05 Ward to Board Governance milestones submitted to QIDB
18/05 Completed Baseline Assessment of Ward to Board Governance Framework
Standardised Divisional Reporting Agreed: Agendas, TOR launched and reporting cycle in place 04/06
Revised Divisional Governance Reporting Calendar in place 22/06
15/06 Assurance Map setting out corporate and clinical accountability agreed and submitted to Board sub committees
29/06 Proposed Integrated Performance Meeting TOR, Agenda and Annual Plan Agreed
29/06 Aligned reporting of Key Performance Information to divisional boards/quality Governance committee/ QAC
01/07 Completed assessment and mapping of current Divisional risks and priorities submitted to Board sub committees
01/07 Divisional Quality Governance workshop held
22/06 Proposed Performance and Accountability Framework published to board committee
Quality Governance Committee Annual Programme of work established 18/06
Agreed Board Improvement plan for Corporate Governance 22/06
29/06 Proposed Revised Integrated Performance Report to Board
29/06 New QIA process proposed to TMG
Patient Experience
17/05 Project scope, PID and plan complete
29/06 Every service in the Trust has a lead who can respond to feedback left on Care Opinion
1st Wave Rolled Out (July) RCH areas ED/Maternity / Ophthalmology/Clinical Imaging 31/07
Risk Management
09/05 Revised Risk Strategy approved by TMG
15/06 Communicate Risk Management strategy Trust-wide
Tackling Delay
Elective Care
Cardiology
01/05 Implemented day case PCI
05/06 Agreed implementation plan for CTCA to manage demand
30/06 LIVE Cardiology RADAR module and dashboard
22/06 Cardiology harm reviews process with Trust validated
29/06 Locum consultant in place – capacity for additional clinics and electives
Ophthalmology
15/05 Implementation of Ophthalmology suite imaging system complete
31/05 100% of patients with coefficient <1.5 (Sustained position)
31/05 SOP/updated process implemented – Revised Glaucoma Surveillance model
19/06 Glaucoma POD clinic trial completed
30/06 Pathway reviews completed to understand alternative pathway management
30/06 Additional Glaucoma surveillance slots implemented (Capacity increase to reduce activity within RCHT)
13/07 Capacity and demand complete to support service right size options (Ophthalmology / Glaucoma surveillance)
GI
30/06 System for monitoring 4hr wait in Surgical receiving areas embedded
30/06 Simple emergency pathways redesigned enabling patients to wait at home
31/05 Section 29a (March) warning notice - RTT recovery plan - actions & trajectory agreed
31/05 NEW KSP contract set up to increase capacity
Orthopaedics
31/05 Vision for ED / Trauma assessment agreed and submitted
31/05 4/5 ring fenced beds with segregated nursing on Theatre Direct implemented
31/05 Section 29a (March) Fracture Clinic - paeds area moved, airflow monitored, booking to paeds only time implemented fully
30/06 Project scope reviewed to ensure its integration with MSK Shaping Our Future pathway plan
Frailty Management
Project under Review
Acute Medicine
Emergency Medicine
04/05 Review and implementation of speciality referral guidance completed to improve flow from ED
SAFER
08/05 SAFER Concept presentations executed over 8 week period to drive continuous engagement
04/05 Key Metrics dashboard implemented (to demonstrate effectiveness of SAFER implementation)
04/06 Implement and launch SAFER Wave 4
05/06 Action learning Set based on PDSA cycle to drive improvement
31/05 Clinical, therapy and flow sponsor nominated (encompassing all aspects of the Multidisciplinary team)
Current here 15th June 2018

QIDB 31/05/18 | QIDB 21/06/18 | QIDB 02/07/18 | QIDB 18/07/18

Tackling Delay

Outpatients

- 04/05 – Outpatients centralisation discussion with Directorate managers to develop options held
- 18/05 – Current resource delivering outpatient services across the Trust confirmed
- Project PID (Scope and Aims) under Review
- 19/06 – Agreed ToR and priorities at SoF Outpatient Leadership Event

Risk Assessment Prior to Surgery

- 17/05 – Revised draft of Pre-Operative Risk Assessment report submitted to Divisional Board for information and action
- 31/05 – RCA data from theatre scheduling policy breaches incorporated into the pre operative risk assessment report
- 30/06 – First draft of revised and condensed theatre scheduling policy completed
- 30/06 – Commence testing of pre operative assessment software
- 30/06 – 100% of routine elective lists reviewed by the surgeon at day 7

Same Day Emergency Care

- ~~25/05~~ – Dashboard to maximise opportunities for same day emergency care implemented
- 01/06 – Evaluation of the new model completed through QI approach
- 01/06 – Workforce competencies and Training Needs Analysis completed
- 30/06 – Workforce model completed and recruitment/role redesign approved

Harm Review

- 31/05 – Template for reporting clinical harm reviews distributed to all specialties
- 07/06 – Data input tool for clinical harm reviews in place
- 22/06 – Dates by which 'desktop' reviews will be completed and agreed by each specialty
- 22/06 – RCHT level plan for clinical harm reviews across all 13 specialties established
- 29/06 – Results of initial clinical harm reviews in specialties presented at Clinical Harm Panel
- 29/06 – Initial desktop reviews completed and reported by clinicians through divisional governance structure
- 29/06 – Report on progress of clinical harm reviews prepared for presentation at Quality Assurance Committee and Trust Management Group

Critical Care Flow

- 01/05 – Incident reporting via Datix for all delayed and overnight discharges since SOP implementation completed
- 03/05 – Root cause analysis (Datix) reporting to ITU business meeting and head of patient flow commenced
- 17/05 – All metrics communicated via monthly Governance meeting to drive improvement actions
- 25/05 – Investment request submitted to increase bed capacity
- 29/06 – Safer patient flow bundle adapted and implemented

RTT

- 30/05 – Assurance mechanism for RTT set, agreed and implemented
- 30/05 – Detailed Speciality level plans completed and signed off at Divisional Boards (30 day position)
- 30/06 – RTT Performance reviewed against trajectory and all plans updated (60 day position)

Culture & Leadership

Culture & Leadership

- 04/06 – Anti Bullying Respecting Each Other - bullying and harassment campaign video Launched
- 05/07 – Culture and Leadership Strategy and Plan signed off by Board

Engagement & Comms

Workstream

- 04/06 – Communication and Engagement plan in place for every Project
- 18/06 – Long term resource gaps identified and external recruitment commenced

Communications

- 11/05 – Open Team Talk in every clinical division scheduled from March. Only one open session in April due to senior annual leave commitments – however session videoed and circulated to all staff
- 22/06 – New Staff App launched. (Awaiting final amends and IT security clearance - Pilot commenced)
- 29/06 – New intranet launched to enhance comms and engagement
- 29/06 – New TV screens launched
- 29/06 – Communications activities reviewed and amber trajectory for KPI achieved

Engagement

- 04/05 – Second (April) Monthly snapshot staff survey completed
- 08/05 – Quarterly Senior Leader shift shadowing commenced
- 21/05 – Chairman/Deputy CEO weekly listening sessions commenced
- 29/06 – Review of Trust Board / Senior leaders engagement programme and amber trajectory achieved
- 01/07 – Trust Board / Senior leaders attendance at safety huddles scheduled

Current here 15th June 2018