

Cover page	
Meeting	Trust Board
Paper No.	12
Paper Title	Quality Improvement Plan - Report and update on the Trust response to the 2018 CQC Inspection
Date of meeting	7 February 2019
Date paper was written	30 January 2019
Responsible Director	Simon Wright
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Executive Summary	
<p>At the November Board the Chair requested that the NHSI Improvement Director provide the Board an independent critique of the approach and progress the Trust has made to address the concerns highlighted by the CQC following their inspection last year.</p> <p><b>Part A</b> of the paper provides the Improvement Director's report outlining the particular challenges which the Trust has to address and the level of change that this will require.</p> <p><b>Part B</b> outlines the approach now being taken by the Trust and progress made since November 2018.</p>	
Previously considered by	N/A

The Board is asked to:			
<input type="checkbox"/> Approve	<input checked="" type="checkbox"/> Receive	<input type="checkbox"/> Note	<input type="checkbox"/> 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:				
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Responsive	<input checked="" type="checkbox"/> Well-led

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

Equality Impact Assessment	<input checked="" type="radio"/> Stage 1 only (no negative impact identified) <input type="radio"/> Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	<input checked="" type="radio"/> This document is for full publication <input type="radio"/> This document includes FOIA exempt information <input type="radio"/> This whole document is exempt under the FOIA
Financial assessment	No

## **PART A – Improvement Director’s Report**

### **1. Summary Observations**

The Trust was poorly prepared for the inspection by CQC last year. Fundamental issues related to:

- a lack of detailed analysis on the state of readiness of the organisation;
- a poor level of awareness or ownership at a leadership level as to the state of readiness of the organisation;
- a lack of shared ownership of the CQC preparation amongst the Executive, leaving the responsibility with the Director of Nursing, Midwifery and Quality;
- failure since the last CQC report to establish ownership for the actions at an individual, team and care group level, resulting in a lack of focus and drive;
- in the absence of proactive ownership and engagement at a local care group level the approach taken became dependent on centralised management and co-ordination; and
- poor measures of improvement and therefore obfuscation of where improvements had been made and were embedded.

There is no doubting that the organisation did not anticipate the level of concerns described by CQC. Some of the issues highlighted related to fundamental failings in basic standards of care and maintenance of dignity. Following a review in July 2018, the Improvement Director outlined **two key areas of concern** to the CEO and Chair:

1. A lack of connectivity between the Board, Executive and the care groups, resulting in a poorly defined line of sight on key issues relating to quality.
2. Lack of focus on the re-inspection, partly due to the Board being exercised by ED and Maternity driven concerns, resulting in poor preparation and a level of complacency in some parts of the Trust.

Following the inspection the Improvement Director has worked with the Board and Executive to look at an alternative approach to addressing CQC concerns which has resulted in the Board adopting a 'bottom up' strategy.

This has required engaging with staff at all levels and facilitating workshops to help them to own the issues and work out for themselves the measures which would provide confidence that patients are being cared for to the standard required.

The Trust lacked capacity, capability and experience to support the development of an 'integrated improvement plan' at pace. Existing capacity has been supplemented through special measures funding with the provision of additional capability and support to ensure that the Trust takes a consistent and comprehensive approach to develop and deliver a sustainable improvement plan.

### **2. Progress made**

Since the November Board the Trust has:

- embraced an approach to development of the improvement plan based on comprehensive staff engagement and the detailed unpacking of underlying causes;
- identified named individuals to support the ongoing monitoring and development of the improvement plan;
- implemented confirm and challenge ' sessions with care groups to ensure that the measures of improvement are tracked;

- submitted on time their response to the initial report (28-day response);
- established a 'maternity committee' to provide additional independent oversight of maternity issues;
- implemented NHSI chaired system oversight meetings;
- commenced the development of metrics to ensure trajectories are timely and appropriate; and
- attended a Board to Board with NHSI.

### **3. Key challenges**

The **key challenges** the Trust must continue to address are:

- release and leverage the capacity and capability of the senior leadership team to drive improvement;
- increase Trust capability to actively manage the oversight required to deliver a comprehensive plan requiring the development of a PMO;
- refine governance processes to ensure the Board are fully sighted on emergent issues; and
- manage and prioritise significant operational pressures to create the space for quality improvements to be delivered at pace.

### **4. Conclusion**

The Improvement Director believes that the Trust has accepted the concerns highlighted by CQC and developed an approach which will enable them to demonstrate to patients and their wider stakeholders improvements to standards of care which will be sustainable.

The approach outlined requires a higher level of commitment from individual members of the Trust to address poor care, by taking personal responsibility to work towards improved system, process and delivery. The Improvement Director will continue to support the organisation to develop clear evidence of improvement and a sustainable approach which will enable the Trust to regain the confidence of the residents of Telford and Shrewsbury.

## **PART B – Approach and Progress**

### **1. Formal response to CQC**

There is a statutory requirement for providers to respond to a CQC Inspection Report within 28-working days of the publication of the report. The Trust provided its response within the required timeframe, on 11 January.

The 28-day response provided a detailed plan of action that included:

- a timeline of action taken in the 28 working days since publication;
- a schedule of planned activities that were underway to both address findings and develop and implement detailed plans to drive improvement;
- the approach being taken to unpack and address underlying cause to the inspection findings and to ensure staff engagement; and
- the governance framework that has been developed and put in place to ensure and monitor delivery.

An undertaking was made in the response to have plans in place to address the 79 ‘Must Do’ findings identified in the report by Safety Oversight and Assurance Group (SOAG) meeting on 19 February.

An overview of the approach detailed in the 28-day response was additionally provided to the CQC, NHSI, CCGs and partners at the SOAG meeting on 17 January.

In parallel the Trust continues its delivery against the action plan and reporting requirements set out in the Section 29A notice letter issued by the CQC on 17 October 2018 and Section 31 notice letters issued on 5 and 12 September 2018. These were findings identified by the CQC where immediate action was required.

In particular the Trust met its requirement to provide, by 17 January, a formal update to the CQC providing demonstrable improvement against the sub-set of issues identified in the Section 29A letter.

### **2. Approach**

The Trust’s approach is centred around developing a comprehensive improvement plan using the SBAR approach with clear actions, accountabilities and trajectories agreed. We have adapted the SBAR approach, as this is a communication tool that front-line staff will be familiar with:

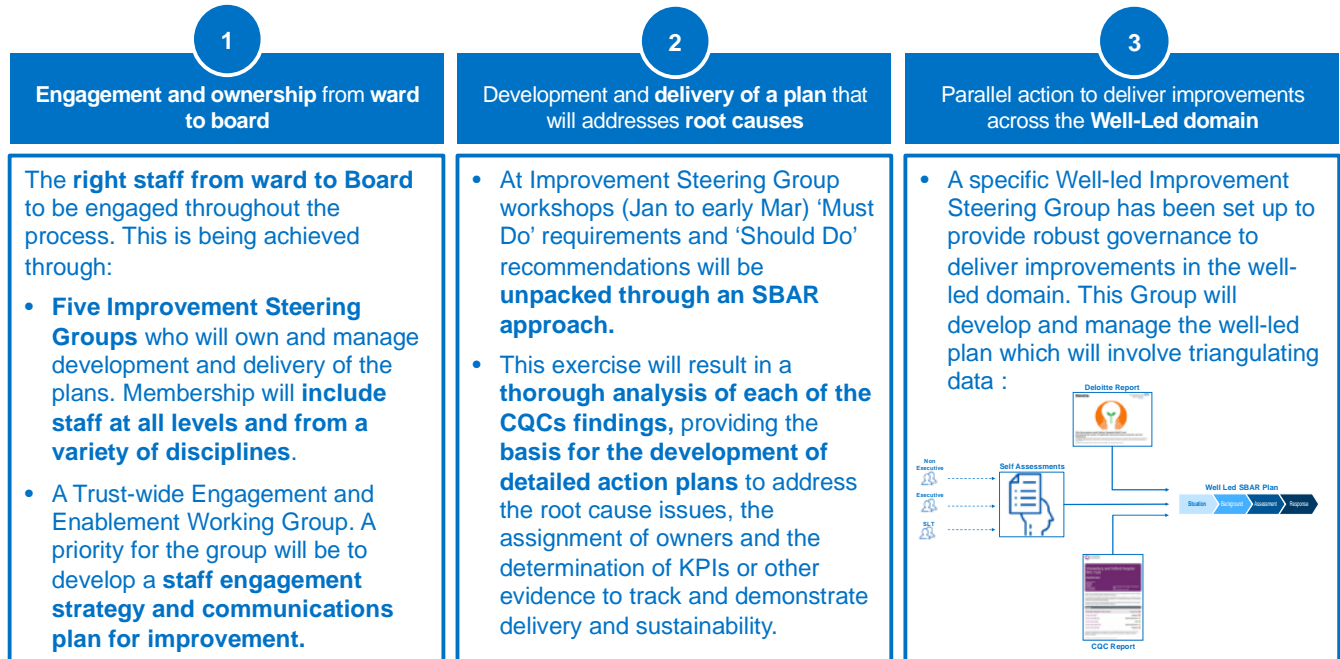
Situation:                   What was the CQC inspection finding?  
Background:                What were the underlying causes of the CQC inspection finding?  
Assessment:                What does success look like? What actions should we take? Who owns these actions? When will these actions be completed by?  
Recommendation:        How will know if we have succeeded?

The resulting improvement plan will be a vehicle for engagement with all staff as well for evidencing our commitment to continuous improvement.

The approach taken will require effort across the teams to take responsibility for and delivery of the improvements. However it is clear that this will provide the organisation with the best possible opportunity to embed improvements and sustain them in to the future.

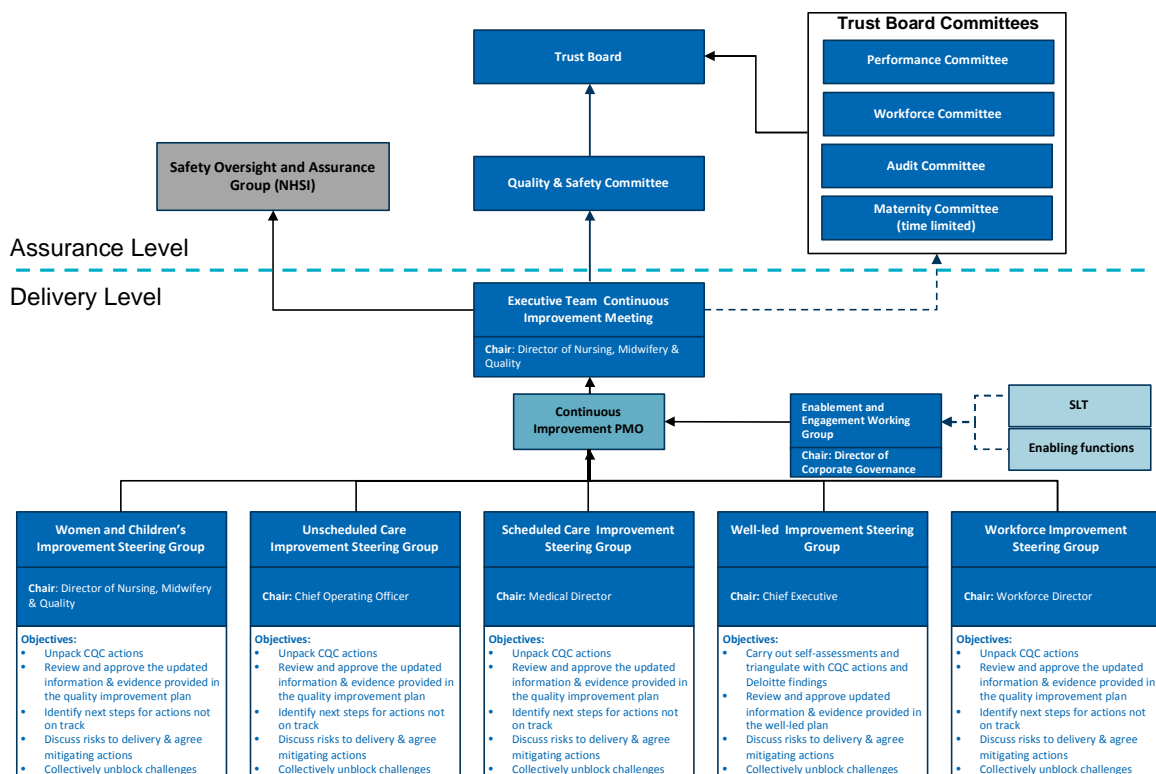
The overall approach adopted by the Trust will **robustly address the CQC actions** as well as put in **place the structure for continuous quality improvement**. Above all it will set the Trust on a solid foundation so that it can rebuild the confidence of regulators, staff and patients in the quality and safety of care it provides.

Success is recognised as being dependent upon three factors:



The agreed governance arrangements to manage the approach and support effective engagement have now been designed and implemented (figure 1).

**Figure 1: Continuous improvement governance structure:**



The approach and detailed plans are detailed fully within the Trust’s 28-day response.

### 3. Progress in development of the Improvement Plan

Rapid progress has been made in the establishment of governance and the delivery of workshops to unpack CQC ‘Must Do’ findings and inform the development of the improvement plan (figure 2).

**Figure 2: Current stage and progress in development of the improvement plan:**



**12 Improvement Steering Group workshops** have been completed. These focused on unpacking the ‘Must Do’ findings using the **SBAR approach**. The **workshops have unpacked all the 79 ‘Must Do’ findings and 4 priority ‘Should Do’ findings** that were subject to a Section 29A notice (figure 3). Action plans have already been provided to the CQC against the findings with Section 29A and Section 31 notices, but the same process for unpacking these findings was followed to ensure that a robust plan is developed (utilising the ongoing work). This has been done to provide assurance that the root cause issues are fully understood and that the actions being taken are appropriate.

**Figure 3: Progress of CQC findings unpacked to date**

Improvement Steering Group Workshop	Completed in Phase 1		To be completed in Phase 2
	Must Do's	Priority Should Do's	Remaining Should Do's
Unscheduled Care - ED	4	2	4
Unscheduled Care - Medicine	13		2
Scheduled Care - End of Life	10		10
Scheduled Care - Surgery	5		8
Scheduled Care - Critical Care	4	2	20
Scheduled Care - Hospital at Night	1		1
Women and Children's	21		26
Workforce - Training	10		5
Workforce - Staffing	10		8
Well-led	1		3
<b>Total</b>	<b>79</b>	<b>4</b>	<b>87</b>

The output from the workshops has been used to develop an improvement plan for each service, with **clear root causes and actions have been identified**. These plans are being validated and signed off by the Improvement Steering Groups, and a final draft will be presented for confirm and challenge at the Executive Continuous Improvement Board on 13 February, ahead of the SOAG meeting on 19 February. The remaining 87 ‘Should Do’ findings will be unpacked in workshops through February and March.

**Well-led self-assessments** have been completed by all non-executive, executive directors and members of the Trust’s Senior Leadership Team. Workshops will have been held to unpack findings with each of these groups, and a triangulation workshop is being scheduled for late February. These sessions will inform the content of the well-led improvement plan.

#### 4. Staff Engagement

The workshops to date have been **very well attended**, with 143 staff attending from all levels and from a variety of disciplines (including consultants, nurses, HCAs, housekeepers, administration, operational management, corporate staff and Executive Directors).

Engagement at the workshops has also been very positive, with feedback from attendees that it **feels like a different and more meaningful approach** to understand how to drive sustainable changes.

An **Engagement and Enablement Group has been established** and is taking the lead on the development and delivery of a staff engagement plan. Development of initiatives such as a SaTH staff app are in progress.

The role of **Staff Engagement Champion** is being developed. Staff Engagement Champions will join each Improvement Steering Group and will take a lead in ensuring continued front-line engagement in the development and delivery of the improvement plan.

#### 5. Next Steps

The immediate next steps in the development and delivery of the improvement plan are:

Activity	Governance	Date
Sign-off of final draft improvement plans for all 79 ‘Must Do’ findings and 4 priority ‘Should Do’ findings	Improvement Steering Groups	6 – 12 February
Confirm and Challenge session	Executive Continuous Improvement Board	13 February
Share detailed draft improvement plans and trajectories with NHSI and CQC	Safety Oversight and Assurance Group	19 February
Detailed draft improvement plans and trajectories considered by Quality & Safety Committee	Quality and Safety Committee	20 February
Fortnightly delivery monitoring and governance cycle commences	Trust PMO / Executive Continuous Improvement Board	27 February
Presentation of draft plans to Trust Board for review and sign-off	Private Trust Board	7 March