

Cover page			
Meeting	Trust Board		
Agenda Item No.	<i>To be added by meeting administrator</i>		
Paper Title	Approval of Quality Improvement Plans		
Date of meeting	4 th April 2019		
Date paper was written	26 th March 2019		
Responsible Director	Simon Wright		
Author	Christian Adams, SaTH PMO		
Executive Summary			
<p>At the 7 February Trust Board an update was provided on the progress that was being made to develop the composite Quality Improvement Plan ("QIP"), to address the findings highlighted in the November 2018 Care Quality Commission ("CQC") Inspection Report. The approach adopted was detailed in the Trust's 28-day response to the CQC, previously shared with the Board.</p> <p>The Trust has now developed the QIP in line with the approach and timeline advised to the CQC. The draft Must Do plans along with examples and evidence of delivery have been shared with the CQC, NHS Improvement ("NHSI"), Clinical Commissioning Group ("CCG") and other stakeholders through the February and March Safety Oversight and Assurance ("SOAG") meetings. Draft Should Do and Well-led plans have similarly been developed and are ready to share and enter into the delivery phase.</p> <p>The focus has moved towards embedding the delivery processes that have been developed alongside the plan. The Trust is also aiming to build upon the momentum that has been generated through engagement with staff.</p> <p>The purpose of the paper is to:</p> <ol style="list-style-type: none"> 1. Inform and provide assurance to the Board on the completeness, robustness and fitness for purpose of the Trust's composite Must Do, Should Do and Well-led operational QIP and the journey taken to develop them. 2. To inform and seek approval for the Must do and Should Do QIP delivery trajectories. 3. Inform and provide assurance to the Board on the arrangements that have been put in place to monitor and manage implementation. 4. Note the next steps to further embed and evidence delivery of continuous improvement ahead of a CQC re-inspection and beyond. 			
Previously considered by	<p>Must Do, Should Do and Well-led plans have been considered and agreed by the Improvement Steering Groups and the Executive Continuous Improvement Board established in the QIP governance structure.</p> <p>The Must Do QIP plan has been reviewed and considered by external stakeholders and regulators through the February and March SOAG.</p>		
The Board is asked to:			
<input checked="" type="checkbox"/> Approve	<input 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
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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
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Link to strategic objective(s)	<p><i>Select the strategic objective which this paper supports</i></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> <p><input type="checkbox"/> HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities</p> <p><input checked="" type="checkbox"/> LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions</p> <p><input checked="" type="checkbox"/> OUR PEOPLE Creating a great place to work</p>
Link to Board Assurance Framework risk(s)	<p>RR 1204 If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage</p> <p>RR 561 If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards</p> <p>RR 668 If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients</p> <p>RR 423 If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve</p> <p>RR 859 Risk to sustainability of clinical services due to shortages of key clinical staff</p>

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

Main Paper

Situation

At the 7 February Trust Board, an update was provided on the progress that was being made to develop the integrated QIP to address the findings highlighted in the November 2018 CQC Inspection Report. The approach adopted was detailed in the Trust's 28-day response to the CQC, previously shared with the Board.

The Trust has developed the QIP in line with the approach and timeline advised to the CQC (**Figure 1**):

- Our staff have identified 256 root-cause issues underlying the **79 Must Do findings** identified in the CQC Inspection report. Detailed plans are in place to resolve every one of these root causes. The plans were completed in February and **delivery has been operationalised**.
- 142 root-causes have been identified and plans developed to address the **91 Should Do findings**. It is proposed that delivery be operationalised from 1 April.
- A detailed diagnostic has been undertaken to support the development of a **comprehensive improvement plan** to address the Trust's Inadequate rating in the CQC **Well Led domain**.
- A **programme management framework has been designed and put in place** to oversee, manage and report delivery against the Integrated QIP. This has built upon the governance arrangements that were previously proposed and agreed.
- **Two fortnightly delivery cycles have already been undertaken** with 12% of the Must Do root causes having been closed.

Figure 1: Stage in reached in development of QIP



The Trust's **draft plans and evidence of delivery have been shared with the CQC, NHSI, CCGs** and other stakeholders through the February and March SOAG meetings and are subject to ongoing scrutiny.

The Trust is now in a position to formally conclude the plan development phase and move fully into the delivery phase. Further, consider the ongoing action that is required to continue to embed delivery processes and the continuous quality improvement journey.

Background

The CQC's Inspection Report for the Trust was published on 29 November 2018. The Trust was found to be Inadequate in two domains (Safe and Well-led) and was rated overall as Inadequate. The CQC's 79 Must Do findings describe areas where the Trust must demonstrate improvement. These emanate from breaches of licence conditions and regulations. A further 91 Should Do findings recommend additional areas for improvement.

Section 29A and Section 31 Notice letters were received ahead of publication of the final report in response to urgent concerns identified during the inspection requiring immediate action.

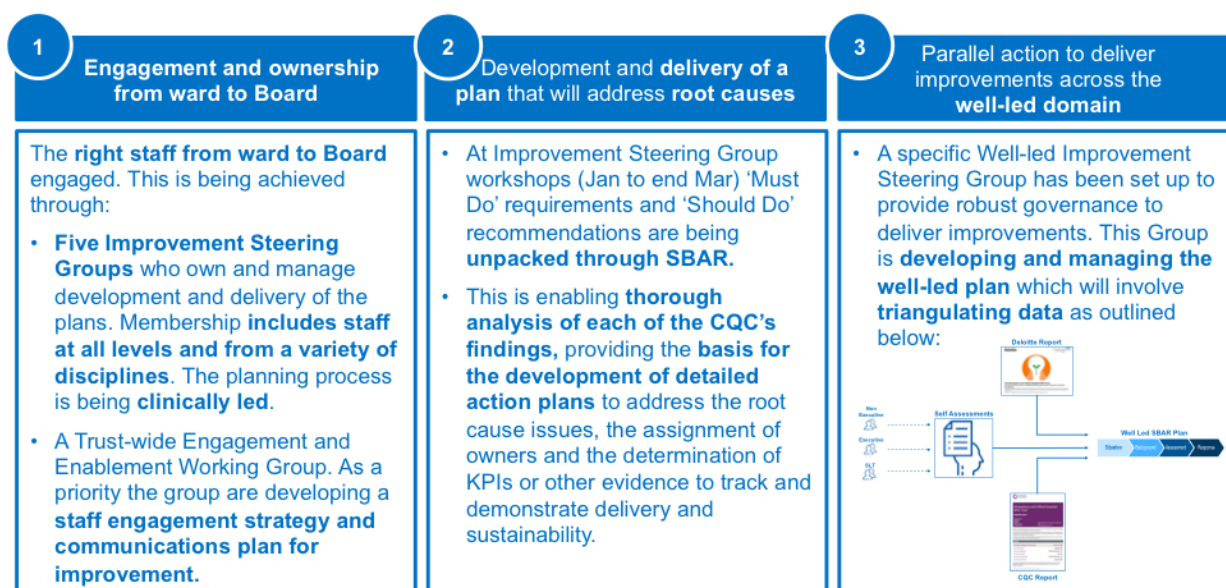
The Trust recognised that delivery of its plan to address the findings of previous CQC inspections had not proved adequate with insufficient progress having been made in demonstrating delivery of the necessary improvements. It determined to take a new and comprehensive robust approach to development of an integrated quality improvement plan to address the CQC Must Do and Should Do findings. This was discussed in the paper presented to the February Board.

The detailed approach, timeline and governance arrangements were set out in the Trust's 28-day response to the CQC sent on 11 January 2019. These have subsequently been shared with NHSI, CCGs and other stakeholders through the February SOAG.

The approach described centred around developing a comprehensive improvement plan using the Situation, Background, Assessment, Recommendation ("SBAR") approach with clear actions, accountabilities and trajectories agreed. Adoption of this approach was intended to ensure the improvements within the plan were developed and owned by the staff who best understood the causes and would deliver the change. This in turn would provide confidence the QIP would be achievable, sustainable and provide a foundation for continuous improvement to take the Trust from Inadequate to Outstanding.

Success was recognised as being dependent upon three factors (**Figure 2**).

Figure 2: Success factors



Central to the governance arrangements described in the 28-day response was the **establishment of five Improvement Steering Groups ("ISGs")** with membership from ward to board. The ISGs are responsible for the development and oversight of delivery of the improvement plans to address each and every Must Do and Should Do finding. Each ISG is chaired by an Accountable Executive. A similar ISG was constituted to develop and manage the delivery of the Well-led plan.

Table 1: Established ISGs

ISG	Accountable Executive	Must Do Findings	Should Do Findings
Women and Children's	Director of Nursing and Midwifery	21	27
Scheduled Care	Medical Director	16	42

Unscheduled Care	Chief Operating Officer	20	9
Workforce	Workforce Director	21	10
Well Led	Chief Executive	1	3
Total		79	91

An **Executive Continuous Improvement Board** was established to oversee development and delivery of the plan and to hold ISGs to account through their Accountable Executives.

The 28-Day response committed to Must Do plans being in place by the end of February and Should Do and Well-led plans being in place by the end of March.

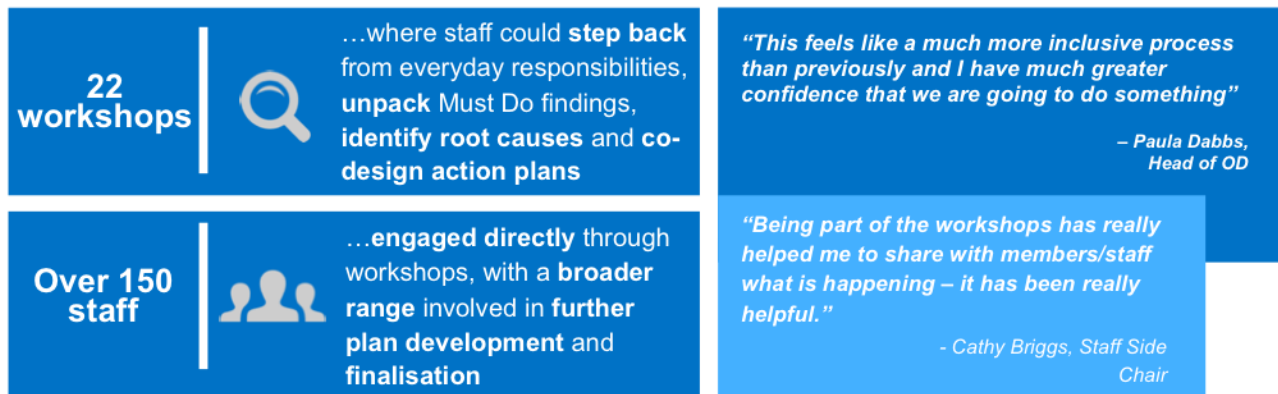
Assessment

1. Development of the Must Do and Should Do QIP

The Must Do and Should Do elements of the QIP have been developed in accordance with the agreed approach.

Staff engagement has been pivotal to plan development and commitment has been demonstrated in both attendance at workshops and through ongoing membership and participation of the ISGs. **Figure 3** provides an overview of staff engagement in the development of the plans.

Figure 3: Staff engagement in QIP development



Detailed Must Do plans and delivery trajectories were signed off by ISGs in February. These were then presented to SOAG in February, allowing for feedback and scrutiny.

Since this time the plans have been live documents, subject to change control, against which delivery is being monitored and managed. Details on change control, evidence collection and reporting arrangements are provided later in this paper.

Outcome Key Performance Indicators ("KPIs") have been developed in respect of each Must Do Root Cause to enable the Trust to determine and monitor the effectiveness of the action taken. Reporting against these will commence in April.

Workshops to develop Should Do plans have been taking place through March. Final plans will be signed-off by individual ISGs with by 1 April. From this date Should Do plans will be similarly operational.

2. Overview of the Must Do QIP and delivery trajectory

Through the unpacking process **264 Root Causes** have been identified relating to the original **79 Must Do findings**. The vast majority of Must Do findings have multiple Root Causes that need to be addressed to fully

resolve the headline finding to deliver sustainable improvement. **Action plans have been developed and resolution dates set in respect of each of the Root Causes.**

The QIP delivery trajectory sees over half the Root Causes being resolved by the end of June and **more than 80% completion by the end of September 2019 (Figure 4).**

When all the Root Causes associated with a Must Do finding have been resolved then the Must Do finding itself is considered to have been addressed. Over half the headline Must Do findings are expected to be fully addressed by the end of August (**Figure 5**).

Completion dates have been determined according to when actions have been completed, whilst outcome KPIs will be used to assess whether these actions have delivered the intended impact. ISGs will continue active monitoring of KPIs to determine whether further action may be required. Note that figures 4 and 5 show the trajectory to December 2019. A small number of Root Causes and thus Must Do findings will be closed post December with all actions being completed by the end of March 2020.

The shape of the trajectory allows for sustainable improvements to be made with realistic achievable delivery dates. More urgent priorities and transactional actions have an earlier completion date and later dates for those that require longer delivery lead times. Delivery timescales have also taken account of the volume of change that it is possible for front line clinical teams to deliver and absorb at one time without adversely impacting their ability to deliver clinical services.

ISGs will be responsible for actively reviewing their plans to determine where opportunities exist to bring delivery dates forwards, or where more time maybe required. The authority to agree to changes in delivery dates rests with the Executive Continuous Improvement Board.

ISGs have been managing delivery against Must Do plans since February. At the March SOAG the Trust was on schedule for resolution of Must Do Root Causes and ahead of trajectory for resolution of Must Do Findings.

Figure 4 - Must Do Root Cause resolution trajectory by month to December 2019

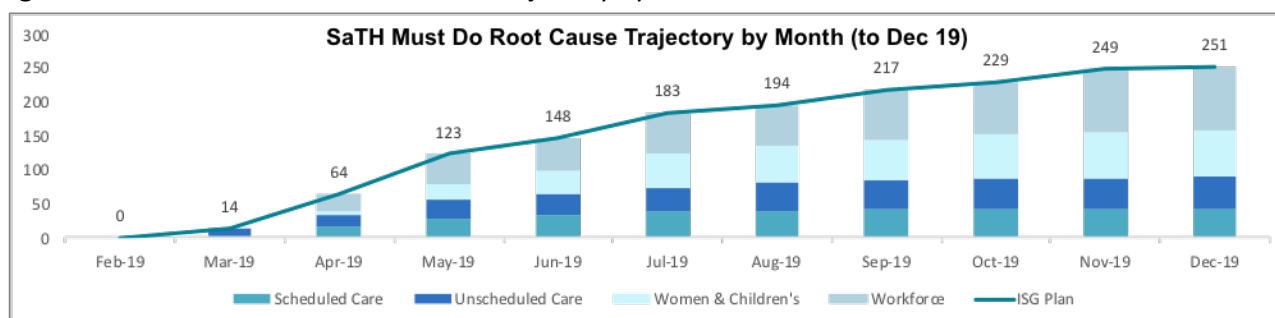
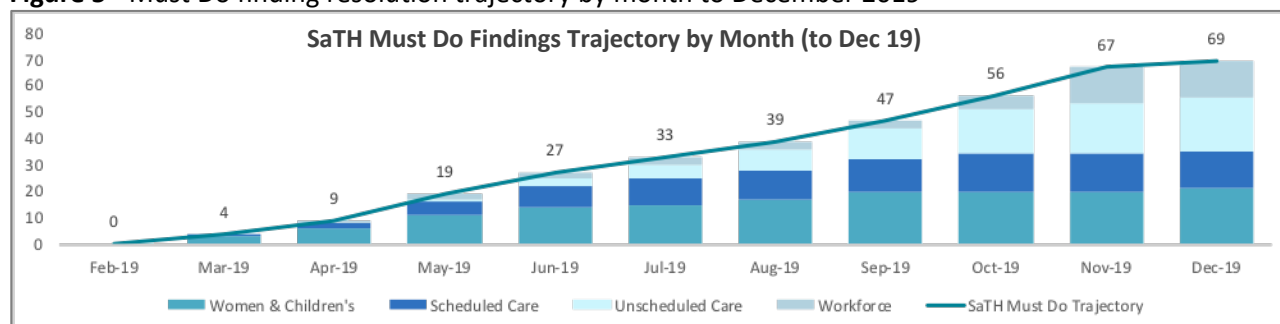


Figure 5 - Must Do finding resolution trajectory by month to December 2019



3. Overview of the Should Do QIP and delivery trajectory

Through the unpacking process 142 Root Causes have been identified relating to the original 91 Should Do findings. There was significant overlap with Root Cause issues identified in respect of MustDo findings. For this reason proportionately fewer additional Root Causes have been identified.

As indicated above, the Should Do unpacking and QIP development phase will conclude on 1 April at which point all ISGs will have approved their plans. From this date the plans will move into change control and delivery.

The Should Do Root Cause trajectory set out in **Figure 6** reflects the draft plans and completion dates.

The Should Do Finding trajectory set out in **Figure 7** reflects the draft plans and completion dates.

Figure 6 - Should Do Root Cause resolution trajectory by month to December 2019

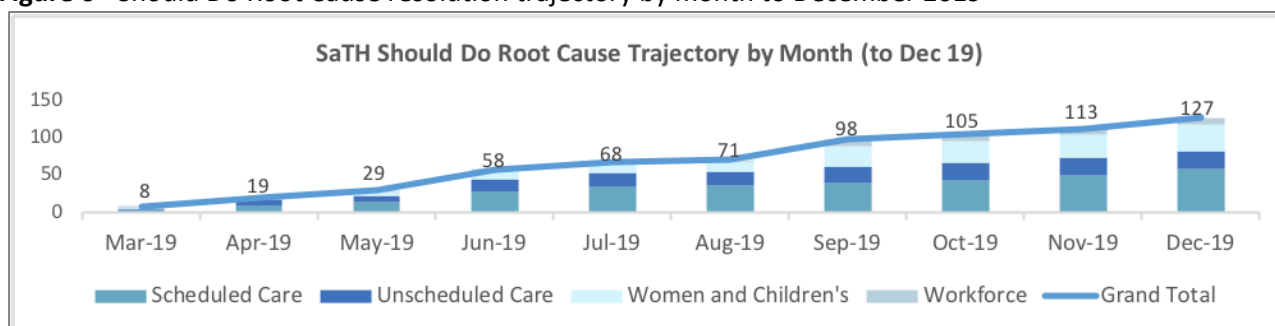
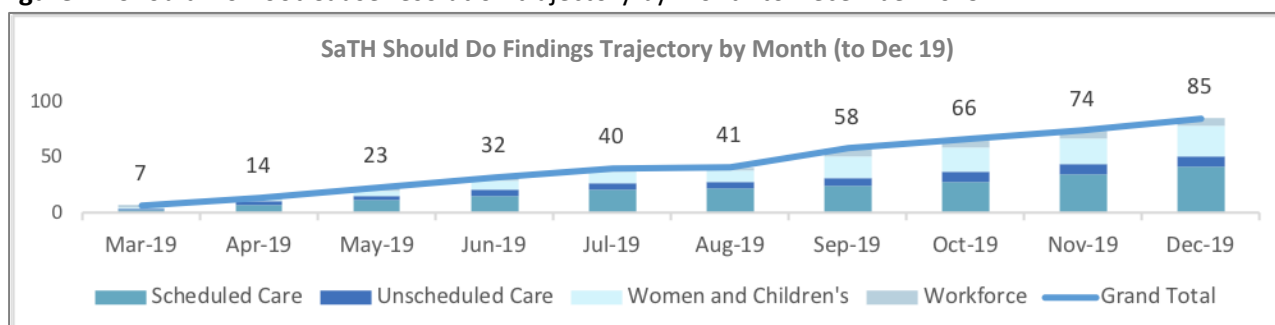


Figure 7 - Should Do Root Cause resolution trajectory by month to December 2019



4. QIP Plans and delivery by Improvement Steering Group

Delivery against the composite QIP is undertaken and managed at an ISG level, with each ISG overseeing delivery against its component element. This section seeks to provide the Board with detail on the component elements of the QIP and progress made in delivery.

4.1 Women and Children's ISG

The Women and Children's QIP addresses the 21 Must Do and 27 Should Do findings relating to maternity services at the Trust. The unpacking process led to the identification of 46 Must Do and 36 Should Do Root Causes. Maternity actions detailed and required in response to the Section 31 notice have been incorporated within the Women and Children's QIP.

10 Must Do Root Causes have been closed. In addition, **four Must Do CQC findings have been closed, above the trajectory of three.** Five of the 10 complete Must Do Root Causes were associated with the Section 31 notice issues.

Front-line staff members of the ISG have presented three examples to SOAG of where action taken in response to Must Do findings has already had a significant positive impact on the quality of services:

Community midwife equipment –

Standardised kit bags and mobile phones have been purchased and all midwives now have the equipment they need to provide care to women in the community

Medical handover high-risk women –

Policy and procedures have been clarified to ensure that all high-risk women receive prompt medical review

Reduced fetal movement –

Guidance has been updated to midwives and women. All women reporting reduced fetal movements now receive medical review in triage

Women and Children's ISG Must Do – Community midwife equipment																																																																											
Must Do finding (MD018): "Ensure that the community midwives are carrying the correct equipment to carry out their work in line with best practice"																																																																											
Women and Children's ISG Must Do – Medical handover of high-risk women																																																																											
Must Do finding (MD019): "Ensure handovers are completed consistently and high-risk women in labour are reviewed by medical staff"																																																																											
Women & Children's ISG Must Do – Reduced Fetal Movement																																																																											
Must Do finding (MD020): "Review the policy on reduced fetal movements (RFMs) so there is a clear and defined pathway for midwives and sonographers to follow"																																																																											
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Front-line staff members of the ED and Medicine have presented three examples to SOAG of where action taken in response to the CQC's findings has already had a significant positive impact on the quality of care that patients receive.

The sepsis escalation pathway has been reviewed and resulted in an improvement in the speed of sepsis treatment.

[illegible][illegible]

The approach taken to addressing the Well-led findings from the CQC has been different to that used for the other quality improvement plans. This is due to the CQC assessment of how 'well-led' the Trust was as a standalone domain as well as within each core service. It was important for the **full leadership team to be**

The process to ensure an aligned baseline position involved:

- All senior leaders and the Board **completing individual self-assessments**, which answered questions against the well-led Framework.
- **Facilitated workshops** at the Senior Leadership Team (“SLT”), Executive and Non-Executive levels in order to come to a common view on the current position.
- A **facilitated workshop** with the **full Board to collectively agree ratings** against each of the CQC Key Lines of Enquiry (“KLOE”) and **priority actions** to take forward.
- **Triangulating the output from the workshops with the information from the CQC Report and Deloitte report findings** and form the initial **well-led improvement plan**.



In order to ensure adequate focus on delivery of each of the areas, Executive Directors have been assigned as overall KLOE owners as well as owners for actions specific to their work area. A **Well-led ISG has now been convened**, which is comprised of **members from across the SLT and Executive Directors**.

The group has now met twice to refine the detail for actions within KLOEs 1-4 which were deemed a priority and will focus on refining the detail of the remainder of the plan in early April. Key themes have emerging from the initial plan development include: strategy (including vision and values) development; staff engagement; and Care Group governance. It is anticipated that smaller working groups involving representation from SLT and Execs will be formed to implement actions within these areas.

Once the final plan has been signed off by the Well-led ISG, fortnightly meetings will be scheduled to monitor progress in line with the Quality Improvement ISGs. Progress and escalations will also be reported to the Continuous Improvement Board. It is planned that each quarter the Board will review progress in Board Development Sessions and **re-assess the Trust's Well-led position** against each of the KLOEs.

6. Monitoring and managing Delivery

The QIPs are operational documents that describe detailed actions, completion dates and KPIs. They are used as live documents to manage and track delivery. The governance tools and processes around delivery of the QIP complement the governance arrangements set out in the February Board paper.

The master QIP documents, change control log and evidence repository are held centrally by the Programme Management Office (“PMO”).

6.1 Fortnightly delivery cycles

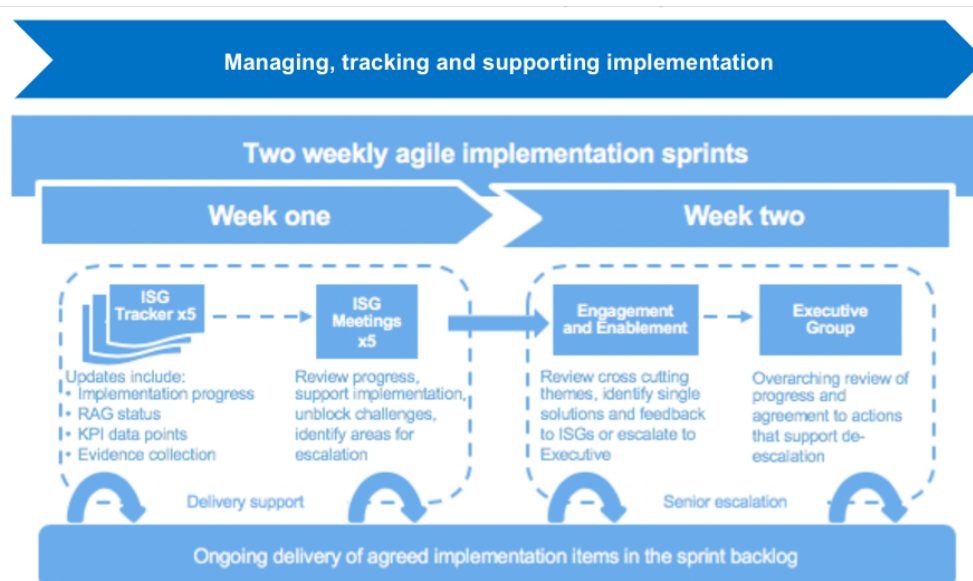
Delivery is managed through fortnightly delivery cycles and monitored against the QIPs agreed by the individual ISGs. **Figure 9** describes the delivery cycle.

Figure 8: Well-led plan

KLIDE ID	Project ID	Action ID	Overall Outcome	Overall KLIDE Rating	KLIDE Key line of inquiry	GOE Prompts	Relevant Leadership Competencies	Map to the Competency Framework	Specific Changes to be Implemented	Action Ownership	Others Responsible	Planned Completion Date
WL1	WL1.1	WL1.1.1	Strategic Alignment	Progressive	Is there the leadership capacity and capability to deliver high quality, sustainable results?	Do leaders have the skills, knowledge, and integrity that they need – both when they are assessed and on an ongoing basis?	Lead and coach others, KLIDE 1: Leadership	There is comprehensive understanding of all issues, including all relevant stakeholders, and the ability to communicate the high levels of expertise and capability needed to deliver sustainable and sustainable plans.				
WL1	WL1.2	WL1.2.1	Strategic Alignment	Progressive	Is there the leadership capacity and capability to deliver high quality, sustainable results?	Do leaders understand the challenges to quality and sustainability, and can they address them?	Develop the team, KLIDE 3: Leadership	Leaders have a deep understanding of issues, challenges and priorities in their actions, and understand and identify actions needed to address them.				
WL1	WL1.3	WL1.3.1	Strategic Alignment	Progressive	Is there the leadership capacity and capability to deliver high quality, sustainable results?	Are leaders visible and appreciated?	Lead and coach others, KLIDE 1: Leadership	Throughout the organization, all at times, leaders are available, visible and accessible (time and energy).				
WL1	WL1.4	WL1.4.1	Strategic Alignment	Progressive	Is there the leadership capacity and capability to deliver high quality, sustainable results?	Are there clear priorities for ensuring sustainable, comprehensive, inclusive and effective leadership, and is there a leadership strategy and program, which includes sustainability planning?	Lead and coach others, KLIDE 1: Leadership	There is a clearly embedded system of leadership development and succession planning which allows the leaders that the leadership presents the diversity of the positions.				

Progress against individual Root Causes is reported by the named Root Cause owner through to the ISG's QIP Manager. Supporting evidence is required to close an action. This is recorded.

Figure 9: Delivery cycle



At their fortnightly meetings the ISG considers progress against individual Root Causes, reviews supporting evidence to determine whether it is sufficient to demonstrate closure and considers requests for escalations or changes to the plan. Progress is then reported to the Executive Continuous Improvement Board through the central Trust PMO.

6.2 Robust change control process

The change control process requires that any material changes to the QIP, including the addition or removal of actions and root causes and requests to change a completion date are escalated to the Executive Continuous Improvement Board. Clear guidance has been determined as to when a proposed change must be escalated. This guidance, **as highlighted by Figure 10**, features as part of a comprehensive reporting and evidence collection guide for our staff.

Figure 10: Change control guidance

Appendix F – Guidance on Change Control

Anytime an amendment is required, a **Plan Manager** must record this change on a **QIP Amendment Log**.

The Master versions of each QIP will be held by the PMO. The PMO will then review the QIP Amendment Log for each area and escalate changes which need executive approval as identified by the rows in orange below.

Change Category	Type of change	Impact on trajectory?	Needs to be escalated to Exec?	Approval required	Comments
Root Cause	Root Cause - change owner	No	No	ISG	
Root Cause	Root Cause - add more detail	No	No	ISG	
Root Cause	Root Cause - add new root cause rate	Yes	Yes	Exec	Where actions need to be added for the extra context to the root cause, these will need to be escalated if the associated completion date needs to change outside the current month.
Action	Action - add action to root cause rate	No	No	ISG	Additional root cause to track, will impact number of root causes reported to SGM.
Action	Action - remove action from root cause	No	Yes	Exec	Actions can't be manipulated to an earlier level in order to ensure dates are met. Explanation can be added to the narrative where required.
Date	Date - within the same month	No	Yes	ISG	e.g. moving the 31 st of the month to the 31 st of the month
Date	Date - later than same month	Yes	Yes	Exec	Will impact root cause trajectory which has been sent to SGM.



For changes highlighted in orange, these should be escalated and approved by the executive board

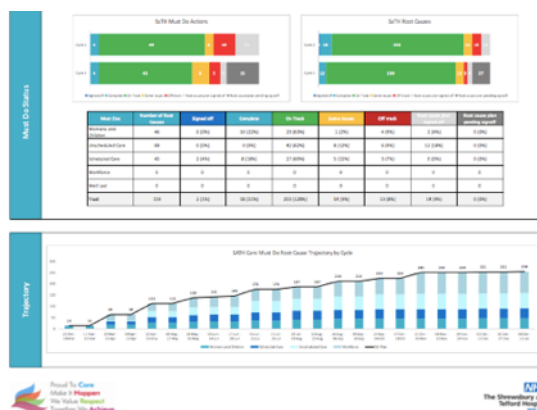
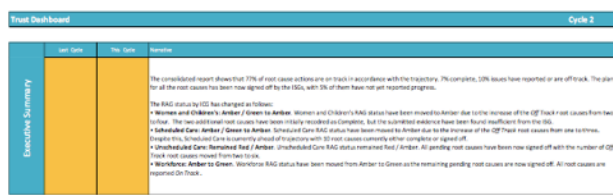


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6.3 Standardised reporting dashboards

Composite and ISG level dashboard reports are produced by the PMO for consideration by the fortnightly Executive Continuous Improvement Board alongside any escalations. Dashboard reports provide an update of progress against trajectory. An example is provided in **Figure 11**.

Figure 11: Reporting dashboard



7. Embedding the Quality Improvement Journey

The composite QIP has been developed and the focus of the Trust is on embedding the approach to ensure that sustainable improvements are realised. This is necessary both to ensure sustainable improvement is demonstrable to our stakeholders (including the CQC), but also as the basis of the Trust's continuous improvement journey.

This section describes the principal areas of action the Trust must consider.

7.1 Embed the SaTH PMO and Continuous Improvement Infrastructure

Standardised programme management tools have been developed to manage and report delivery and two delivery cycles have been completed to date. Comparable experience shows that it can take up to eight delivery cycles to fully embed the methodology with the ISGs, PMOs and the Executive Continuous Improvement Board.

Additional time and attention will be required from the Executive team during this period to ensure that focus is maintained. This will include undertaking a weekly review of delivery until at least the end of June. After this time the review consideration may be taken on stepping down to a fortnightly review undertaken by the Executive Continuous Improvement Board.

During the QIP development phase the Trust PMO function has been resourced through an external consultancy. From 1 April a SaTH Head of PMO will come into post and the transition will commence to a fully SaTH resourced PMO. External support will remain in place until the end of April to ensure a successful transition, including handover of tools and knowledge transfer to take place.

The Quality and Safety Committee will maintain an assurance role to ensuring the infrastructure is in place and fully embedded.

7.2 Address cross cutting themes

During the development of the composite QIP a number of cross cutting themes and improvement opportunities were identified. These are improvements identified within one service, but that require changes to be made by a corporate or clinical support service. These will result in an organisation-wide impact.

Many of these cross-cutting themes are currently overseen through the Unscheduled Care ISG having been initially identified in respect to the Medicine core service.

Further work is required to ensure that there is effective governance in place in respect of these themes, so they receive the appropriate attention and grip, and that improvements are delivered across all clinical services.

The Executive Continuous Improvement Board has undertaken to identify an Accountable Executive to take ownership across these 'corporate' actions. The incoming Accountable Executive will review the potential for the Engagement and Enablement Group to provide support to these.

7.3 Monitor and measure the impact of change

Feedback received through the SOAG has highlighted the requirement to demonstrate the impact that delivery of the QIP is having on the quality of services delivered, patient and staff experience.

Outcome KPIs have been developed for each of the Must Do Root Causes to enable ISGs to assess the impact that the action they are taking is having on resolving the underlying problems. Reporting will commence in April whilst similar KPIs will be developed in respect of Should Do Root Causes.

ISGs will also need to continue to articulate the impact of improvements on patients as part of signing off evidence and closing Root Causes. This may be through the consideration of patient stories to aid understanding of the impact on patient pathways and experience. More specifically, ISGs may wish to consider using patient experience as a discreet KPI.

To ensure the continued focus on outcomes it is recommended that ISGs look to identify a subset of predictive outcome KPIs, for inclusion on their dashboards and onward reporting, that will ISGs and the Executive Continuous Improvement Board to maintain a direct line of sight on the quality of services delivered.

7.4 Engage and communicate with staff

The engagement of staff from ward-to-Board has been pivotal to the development of the QIP. There is a risk that engagement activities will diminish now that the plan is in place. Staff engagement is a key dependency for achieving sustainable embedded improvement. For this reason, staff knowledge and engagement in improvement is a key indicator tested by the CQC during engagement.

The Trust will look to build upon the engagement activities it has already undertaken. The Well-led element of the QIP has identified key actions to support this activity whilst the Enablement and Engagement Group is also undertaking a programme of work. Initiatives that are also underway in direct support of the QIP delivery include: the roll out of People Link Boards, a SaTH app and the identification of Engagement Champions.

There is a role for ISGs to ensure that they frontline staff membership is expanded. In addition, ISGs should proactively communicate the improvement work they are undertaking both to the staff within their immediate service, their patients and the wider organisation. Delivery against both these objectives should be reviewed and tested by the ISGs and Executive Continuous Improvement Board.

7.5 Engage and communicate with external stakeholders

The monthly SOAG is the primary forum for engaging with the Trust's key external stakeholders. However, it is recognised that there is a limit to the breadth and depth of engagement that can be achieved through this forum.

It is acknowledged that there is a need for the Trust to undertake greater proactive engagement on the QIP with its stakeholders, particularly our local CCGs. This will provide mutual benefits, through an opportunity for the parties to fully familiarise themselves with the QIP, challenges, gain assurance and provide constructive feedback.

7.6 Engage and communicate with patients

The local population that we serve are our most important stakeholders. It is of critical importance that our refreshed approach to quality improvement is shared with our patients and the wider public. It is recognised that this must be undertaken in a way that is meaningful and tangible for people that are, or may in the future, use our services.

As a result, communications and engagement with patients will be closely related to the improvements that the ISGs are overseeing. In particular, this will draw on the articulation of benefits through patient stories.

Further opportunities should also be sought to involve our patients more closely in the design and development of improvements, through a co-production approach. This will be considered more fully as our approach to continuous improvement matures through the QIP.

7.7 Prepare for CQC reinspection

The CQC has clear timelines for the re-inspection of core services and the Well-led domain to ensure that required improvements have been made and patient safety is prioritised. Services rated inadequate are inspected on at least an annual basis, those rated requires improvement bi-annually, those rated good at

least every three and a half years and outstanding every five years. The Well-led assessment is undertaken annually.

In practice, this means that the latest date that services rated inadequate could be reinspected is November 2019. At the same time there will also be a Well-led assessment. It is also possible that this could happen sooner, especially if further concerns are raised.

Although the Trust remains 'inspection ready', a process will be undertaken to ensure overall preparedness ahead of the anticipated inspection date. Preparations will begin ahead of the receipt of the Routine Provider Information Request ("RPIR"), that marks the beginning of an inspection. Preparations will be Trust-wide, as opposed to solely focussed on those services rated as inadequate. Core services will be supported to undertake self-assessments; these will 'translate' improvement efforts to the CQC inspection domains. The Trust Central PMO will also collect relevant information in anticipation of the receipt of CQC Data Requests ("DRs"). Typically, a Trust will receive around 300 unique DRs during the course of an inspection.

A full plan of activities leading up to re-inspection will be developed throughout May 2019. This will draw on the experiences of similar organisations that have recently been inspected, as well as the learnings from the 2018 inspection. This will be overseen by the Executive Continuous Improvement Board.

Recommendation

The Trust Board is asked to:

- Consider whether the content of this paper provides sufficient assurance as to the robustness of the composite QIP plans and the arrangements that have been put in place to manage and monitor delivery.
- Approve the composite QIP delivery trajectories that have been set out in respect of Must Do and Should Do findings.
- Agree that delivery continue to be led by the Executive Continuous Improvement Board with assurance through the Quality and Safety Committee.
- Note the principle areas for further work to embed and evidence delivery of sustainable continuous improvement.

