



Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	7 th May 2019	
Agenda Item:	P1-098-19	
Title:	Improvement and Assurance Plan – CQC	
Report prepared by:	Gill Murphy, Associate Director for Improvement	
Executive Lead:	Sheila Lloyd, Director of Nursing and Quality	
Status of the Report:	Public	Private
	x	

Paper previously considered by:	A form of assurance was presented to Integrated Governance committee. This structured report will form the process of reporting going forward.
Date & Decision:	7 th May 2019

Purpose of the Paper/Key Points for Discussion:	<p>The Board is asked to note the progress made against implementation of regulatory actions and recommendations made by the CQC following the publication of their report on 16th April 2019.</p> <p>The aim is to deliver the changes required to address the issues raised by the CQC during the unannounced inspection in December 2018 and 'well-led' review in January 2019. Specifically four regulatory actions requiring immediate action, 14 'must do' actions and 19 'should do' actions.</p> <p>A comprehensive improvement plan has been developed, based on the findings contained in the CQC's report, supported by a robust implementation project plan including:</p> <ul style="list-style-type: none"> • Detailed Project Initiation Document – PID • Standard Operational Procedure - Management of improvement plan(s) following a regulatory visit(s) • Weekly action meetings chaired by Executive lead <p>The trust submitted a detailed report to CQC on 10th May 2019, identifying the immediate actions taken in response to the four regulatory actions.</p> <p>Progress continues on the implementation of the improvement plan with all actions on plan to be delivered.</p> <p>Weekly exception reporting continues through Trust Executive Group, with monthly exception reporting through Board sub-committees and their relevant sub groups.</p>
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Action Required:	Discuss	
	Approve	
	For Information/Noting	X

Next steps required	
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The paper links to the following strategic priorities (please tick)

Deliver outstanding care locally	X	Collaborative system leadership to deliver better patient care	x
Retain and develop outstanding staff	X	Be enterprising	
Invest in research & innovation to deliver excellent patient care in the future		Maintain excellent quality, operational and financial performance	X

The paper relates to the following Board Assurance Framework (BAF) Risks

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	X
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	X
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	X
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	
8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	X

Equality & Diversity Impact Assessment

Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		X
Disability		X
Gender		X
Race		X
Sexual Orientation		X
Gender Reassignment		X
Religion/Belief		X
Pregnancy and Maternity		X

If YES to one or more of the above please add further detail and identify if a full impact assessment is required.



**The Clatterbridge
Cancer Centre**
NHS Foundation Trust

CCC Improvement plan following regulatory visit and
published CQC report April 2019

Progress Update Report

May 2019

Introduction.

The CQC inspect and regulate healthcare service providers in England. Their aim is to get to the heart of patients' experience of care and treatment and they ask all providers the same five questions: are services safe, effective, caring, responsive to peoples' needs and well-led?

The CQC completed an unannounced visit in December 2018 and a 'well led' review in January 2019. The CQC published their final report on 16th April 2019, rating the trust overall as **GOOD**.

This was a change in the rating which was previously outstanding in 2016. This rating was determined by a number of breaches in legal requirements which meant that the Trust was rated as requires improvement in the well led domain, with an overall Trust rating of Good.

Findings

The CQC inspected three of the acute services provided by the trust as part of its continual checks on the safety and quality of healthcare services. They also inspected the well led key question for the trust overall.

Their comprehensive findings described in their report published in April 2019, identified:

Four regulatory requirement notices

Regulation 5 HSCA (RA) Regulations 2014 – Fit and proper persons: Directors

Regulation 17 HSCA (RA) Regulations 2014 – Good Governance

Regulation 18 HSCA (RA) Regulations 2014 – Staffing (BLS / ILS training)

Regulation 12 HSCA (RA) Regulations 2014 – Safe Care and Treatment
(ID / safety checks)

14 'must do' actions:

8 – Trust wide

4 – Medicine services

2 – Diagnostic services

19 'should do' actions:

12 – Trust wide

2 – Medicine services

4 – Diagnostic services

1 – Outpatient services

Further details of all actions required is described in Appendix 1

As stipulated by the CQC the trust submitted a detailed report on the immediate actions taken in response of the four breaches of regulations on 10th May 2019.

Improvement plan

Following initial feedback from the CQC, following their visits in December 2018 and

January 2019 and to support the implementation of the recommendations described in the final CQC report, the trust invested in a project manager to provide expert project management knowledge and skills and support the development of an improvement plan.

A detailed Project Initiation Document (PID) is in place together with a detailed SMART action plan, monitored through a weekly meeting chaired by the executive lead. This plan is accessible, on a shared drive, by all leads

Further to this a Standard Operational Procedure (SOP) has been developed – *Management of Improvement Plan(s) Following Regulatory Visit(s)* to further support staff, strengthen systems and processes and maintain good governance and assurance (Appendix 2).

Progress to date

All actions to regain compliance relating to the four regulatory requirement notices have been completed. Audit plans are in place to ensure improvements have been embedded and will be reported through the Audit Committee.

Table 1 Status of 'must' and 'should' do actions

	Compromised / significantly off track	Experiencing problems/ off track but recoverable	On track	Completed
Regulatory Actions* (4)	-	-	-	4
Must do actions (14)	-	1	11	2
Should do actions (19)	-	3	14	2

*Please note the regulatory actions were a composite of all actions overall

Table 2 Summary of three actions – experiencing problems / off track but recoverable

Action	Summary
Must do – BLS/ILS/ALS training levels	An action to attain compliance in staff trained at a level of at least 90% is complete. The outstanding action relates to the education and governance committee approving the agreed competency levels which will allow the trust to ensure the appropriate capacity is in place to maintain this compliance. This is planned to be approved at the meeting w/c 3 rd June 2019.
Should do- Equality and Diversity	The Equality and Diversity strategy is in development and once approved will be supported by a robust action plan.
Should do – Equality and Diversity	The Equality and Diversity group will then identify a timeline for implementation and deliver CQC recommendations and national guidance .

Should do- Safety Culture	An external safety review is planned for the Hematology Oncology directorate, commissioned by the MD. The trust has invested in an Associate Director for Improvement to support development and implementation of an 'Improvement Journey' based on The Health Foundation Learning Report published May 2019. The trust is already working in partnership with AQUA implementing actions to improve patient safety, utilising best practice methodology. A plan of monthly 'patient safety' walkabouts by the Consultant leads for patient safety is in place, using a 'human factors' approach to engage with staff and patients across the trust. This forms part of the clinical quality strategy planned to be presented and approved at board in June 2019.
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Assurance

Internal assurance is provided through the relevant sub-committee to the board and their individual sub groups. All actions have the relevant executive lead to support implementation and following completion a formal 'sign off' process is in place. Formal audits are planned to support actions / changes in practice being embedded. Internal 'CQC Mock inspections' will continue, as will walkabouts by Non-Executive, Governor and Executive colleagues.

External assurance is provided by commissioners through formal reporting at the 'Quality Focus' – monthly contract review meetings. MIAA have been engaged to complete formal governance audits, reported through the audit committee. The CQC will continue with their engagement visits and will expect to see evidence of improvement against their recommendations. This report, following receipt by the board, will be shared with commissioners, CQC engagement lead and our NHSI quality lead.

Trust Wide Procedure The Clatterbridge Cancer Centre NHS Foundation Trust	Procedure Number: OTWOIMPRO Version:1.0 Page 1 of 3 Written by: Gill Murphy Approved by: Sheila Lloyd Date Approved: 10 th May 2019 Review Date: May 2022
SOP: Management of the Improvement plan(s) following a regulatory visit	

Version History

Date	Version	Author name and designation	Summary of main changes
3.5.19	1.0	Gill Murphy - Associate Director for Improvement	New document

1. Background

This SOP is in place to support staff to manage the improvement plan following the CQC visit in December 2018, and January 2019 and any subsequent regulatory visits to CCC.

2. Purpose

The SOP is to ensure a robust SMART action plan is in place and all leads (executive, management and operational) are fully aware of their roles and responsibilities to ensure implementation of recommendations are completed and embedded across the organisation.

3. Other Related Procedures

None

4. Scope

This SOP is to support the process implemented to ensure all recommendations following a regulatory visit are reviewed, actions identified, implemented, completed and sustained to ensure the organisation meets the Health and Social Care Act 2008, associated regulations and any other legislation identified to be in breach of.

Trust Wide Procedure The Clatterbridge Cancer Centre NHS Foundation Trust	Procedure Number: OTWOIMPRO Version:1.0 Page 2 of 3 Written by: Gill Murphy Approved by: Sheila Lloyd Date Approved: 10 th May 2019 Review Date: May 2022
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5. Procedures

The management of the improvement plan(s) will be:

Owned by:	Director of Nursing & Quality (DoN&Q) on behalf of the Board
Supported by:	Project Management Office (PMO)
Operationally managed by:	Clinical Governance Manager – Regulation (CGM-R)
Overseen by:	Improvement Plan Assurance Group (IPAG)

The improvement plan will be implemented in partnership with clinical leads and teams using SMART methodology.

The improvement plan will be available to designated staff, to access on a shared drive. All leads will be required to manage their actions and escalate to the relevant manager and /or executive if the action is off track.

All leads will be required to update open actions on a weekly basis by 12 midday on a Wednesday (on plan will suffice if no specific detail is required or copy and paste current position. The weekly update box **must not** be left blank as this will be considered as not reviewed)

The PMO and CGM-R will then lock down the plan and pull together and exception report for that week.

The exception report will be shared with executive, management and operational leads by 12md on a Thursday.

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The IPAG will review and action the exception report as required, escalating any concerns of non- compliance to the Executive team.

The IPAG will review the risk register and agree if a new risk is required following the meeting.

The PMO will provide support to leads to familiarise themselves with the document, how to update, upload evidence and manage their risks as required.

A monthly highlight report will be completed by the PMO and CGM-R and submitted to the following committee's for assurance:

- Integrated Governance Committee
- Quality Committee
- Trust Board of Directors

Once an action is complete the action lead will present evidence to the DON&Q or designated other, to close the action.

Any audits required as a result of a recommendation / action will be agreed and managed through the clinical audit committee / MIAA audit cycle.

The Clatterbridge Cancer Centre Improvement Plan

Ref.	Theme	Dept	Must do / should do	Requirement and actions	RAGB	Exec lead	Start date	End date
D1	Dementia / DoLS / AN	Trust wide	Must do	Dementia: The Trust must ensure that it has appropriate governance arrangements for the dementia strategy. Regulation 17	B	DoN	02/01/19	12/04/19
D2	Dementia / DoLS / AN	Trust wide	Must do	DOLS: The Trust must ensure that Deprivation of Liberty Standards are recorded within patients records. Regulation 17	G	DoN	11/03/19	22/03/19
D3	Dementia / DoLS / AN	Trust wide	Should do	Additional needs: The Trust should ensure its systems and processes ensure it has oversight of patients with additional needs. Regulation 17	G	DoN	29/03/19	30/06/19
T1	Training	Trust wide	Must do	Staff training : The Trust must ensure it has an effective system to record staff training completion. Regulation 17	G	DWOD	01/01/19	30/06/19
T2	Training	Trust wide	Must do	Staff competencies: The Trust must ensure all staff have relevant competencies allocated to them and an effective system to monitor them. Regulations 17 &18	G	DWOD	01/01/19	31/07/19
T3	Training	Trust wide	Must do	BLS/ILS/ALS training levels: The Trust must ensure there is always enough suitably qualified, competent and experienced staff with relevant levels of life support training (including basic life, immediate life support and advanced life support) deployed within the service at all times. Regulation 18	A	DOps DWOD	01/01/19	12/04/19
T4	Training	Medicine	Must do	BLS/ILS :The service must ensure that there are sufficient numbers of suitably qualified staff with basic life support and immediate life support training on each shift in each area. Regulation 18(1)	G	DOps	01/01/19	12/04/19
T5	Training	Medicine	Must do	Staff competencies: The service must ensure that there are sufficient numbers of suitably competent staff on each shift in each clinical area. Regulation 18(1)	G	DOps/MD	01/01/19	12/04/19
T6	Training	Trust wide	Should do	Staff training: The Trust should consider how it can enable all staff to access training and development opportunities. Regulation 18	G	DWOD	29/03/19	30.09.19
T7	Training	Trust wide	Should do	Development opportunities: The Trust should consider developing a documented talent map or succession plan.	G	DWOD	29/03/19	30.09.19
T8	Training	Outpatients	Should do	Resuscitation training: The service should train all eligible staff in resuscitation training as soon as possible.	G	DOps	29/03/19	30/06/19
R1	Risk	Trust wide	Must do	Risk :The Trust must ensure that all risks are assessed, recorded on the risk register at the right level and mitigated appropriately in a timely way. Regulation 17	G	CE	29/03/19	31/05/19
R2	Risk	Medicine	Must do	Risk Mitigation : The service must ensure that where risks are identified, mitigation is put in place in a timely manner. Regulation 17 (2)	G	CE	29/03/19	31/05/19
R3	Risk	Diagnostics	Must do	Risk Mitigation: The Trust must ensure that where risks are identified, mitigations are put in place in a timely manner. Regulation 17(2b)	G	CE	29/03/19	31/05/19
G1	Governance	Trust wide	Must do	Fit & Proper persons: The Trust must ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role. Regulation 5	G	DWOD	11/03/19	31/03/19
G2	Governance	Trust wide	Should do	Complaints: The Trust should ensure it continues to address its action plan in relation to complaints. Regulation 16	B	DoN	29/03/19	30/06/19
G3	Governance	Trust wide	Should do	Mortality review of deaths within HO service: The Trust should consider how non executive directors can gain oversight of information in relation to deaths within the haemato-oncology service. Regulation 17	B	MD	29/03/19	30/06/19
G4	Governance	Trust wide	Should do	Governance: The Trust should ensure that minutes and action logs clearly outline items discussed and actions. Regulation 17	G	CE	29/03/19	30/06/19
G5	Governance	Trust wide	Should do	Governance: The Trust should ensure that it implements a revised governance structure. Regulation 17	G	CE/DoN	29/03/19	30/06/19
G6	Governance	Trust wide	Should do	Governance: The Trust should ensure that staff understand and can describe the governance systems and processes. Regulation 17	G	DoN	29/03/19	30/06/19
G7	Governance	Medicine	Should do	Governance: The service should continue to build on existing relationships with external providers to maintain oversight and governance of patient pathways and staff training.	G	DOps	29/03/19	30/06/19
G8	Governance	Diagnostics	Should do	Governance: The service should continue to build on existing relationships with external providers to maintain joint oversight and governance of patient pathways.	G	DOps	29/03/19	30/06/19
G9	Governance	Trust wide	Should do	Action plans: The Trust should consider using specific, measurable,attainable,realistic and timely principles in action plans.	G		29/03/19	30/06/19
G10	Governance	Medicine	Should do	Treatment pathways :The service should ensure there is set criteria for accepting referrals for treatment pathways.	G	DOps	29/03/19	30/06/19
G11	Governance	Trust wide	Must do	Strategy implementation monitoring: The Trust must ensure that their systems and processes ensure that implementation of the new strategy can be appropriately monitored. Regulation 17	G	CE	29/03/19	31/03/19
E1	Equality & Diversity	Trust wide	Should do	Equality & Diversity: The Trust should continue to work on equality and diversity including oversight of their workforce demographic.	A	DWOD	29/03/19	30/06/19
E2	Equality & Diversity	Trust wide	Should do	E&D : The Trust should consider developing Staff / Patients groups for those with protected characteristics.	A	DWOD	29/03/19	30/06/19
S2	Safety	Diagnostics	Must do	ID/Safety Checks :The service must ensure that relevant identification and safety checks are completed prior to initiating exposure to radiation and that images are reported on in a timely manner so that patients care and treatment is not subject to undue delay. Regulation 12 (2a)	B	DOps	29/03/19	31/05/19

Ref.	Theme	Dept	Must do / should do	Requirement and actions	RAGB	Exec lead	Start date	End date
S3	Safety	Diagnostics	Should do	Radiation regulations: The service should continue to increase awareness and understanding of the application of relevant radiation regulations.	G	MD	29/03/19	30/06/19
S4	Safety	Diagnostics	Should do	Safety culture: The service should consider how to improve safety culture within the service.	A	DoN/MD	29/03/19	30/06/19
S5	Safety	Medicine	Must do	Storage of records: The service must ensure that records are securely stored. Regulation 17 (2c)	G	DOPs	29/03/19	31/05/19
O1	Other	Trust wide	Should do	Haemato-oncology Service: The Trust should continue developing the integration of the haemato-oncology service.	G	DOPs	29/03/19	30/06/19
O2	Other	Diagnostics	Should do	workforce : The service should continue with plans to build capacity within the radiologist workforce.	G	DWOD	29/03/19	30/06/19

RAGB Key

Red = Compromised or significantly off-track. To be escalated / rescheduled
Amber = Experiencing problems - Off track but recoverable
Green = On track
Blue = Completed
White = Not yet due to start

Role abbreviations key

CE	Chief Executive
MD	Medical Director
DoN	Director of Nursing
DDoN	Deputy Director of Nursing
DWOD	Director of Workforce and Organisational Development
DDWOD	Deputy Director of Workforce and Organisational Development
DOPs	Director of Operations
ADoG	Associate Director of Governance
ADoQ	Associate Director of Quality
HoIPC	Head of Infection Prevention and Control
GM	General Manager