Report Cover Sheet

Report to:	Board of Directors
Date of the Meeting:	26th June 2019
Agenda Item:	P1-0125-19
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:	Report presented to Quality Committee as form of assurance on progress to date.
Date & Decision:	12th June 2019

| Purpose of the Paper/Key Points for Discussion: | 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.

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.

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:
- 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

The trust submitted a detailed report to CQC on 10th May 2019, identifying the immediate actions taken in response to the four regulatory actions. An engagement meeting with the CQC is planned 25th June to discuss the trust improvement plan.

Progress continues on the implementation of the improvement plan with **all actions on plan to be delivered**.

Weekly exception reporting continues through Trust Executive Group, with monthly exception reporting through Board sub-committees and their relevant sub groups. |
|---|---|

Action Required:	Discuss	
	Approve	
	For Information/Noting	X

| Next steps required | |
| | |

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.

Progress Update Report

June 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

As stipulated by the CQC the trust submitted a detailed report on the immediate actions taken in response of the four breeches of regulations on 10th May 2019. No formal feedback has yet been received but an engagement meeting with the CQC is planned 25th June 2019 to discuss the trust improvement plan.

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.

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)	-	-	12 ↑	2 ↔
Should do actions (19)	-	-	16 ↑	3 ↑

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

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. To date five formal 'sign off' meetings have taken place with action leads to formally close completed actions as required evidence was presented and approved.

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 CEO and DON met with commissioning colleagues on 4th June 19 to present and discuss the trust improvement plan. The CCG were supportive of progress made and offered to attend a future weekly Quality Improvement Assurance Group (QIAG) to offer further assurance. The CQC will continue with their engagement visits and will expect to see evidence of improvement against their recommendations. The next planned visit is scheduled for 25th June 19 when they have requested to review the trust improvement plan. This report, following receipt by the board, will be shared with commissioners, CQC engagement lead and our NHSI quality lead.