



Report Cover Sheet

Report to:	Board of Directors	
Date of the Meeting:	25 September 2019	
Agenda Item:	P1/174/19	
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:	Monthly paper which is presented through IGC, Quality Committee and Board
Date & Decision:	Integrated Governance Committee - 02.09.19 Quality Committee – 11.09.19

Purpose of the Paper/Key Points for Discussion:	<p>The committee 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) • Monthly 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. An engagement meeting with the CQC took place on 25th June to discuss the trust improvement plan. Positive feedback was received. The next engagement meeting is planned for 9th September 2019.</p> <p>Progress continues on the implementation of the improvement plan with 5 should do actions off track with recovery plan in place to deliver by end September 2019.</p> <p>At the weekly meeting on 6th July 2019, the DON and members agreed for the meetings to revert to monthly as such good progress has been made. This update follows the meeting which took place on 23rd August 2019.</p>
---	--

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.



The Clatterbridge
Cancer Centre
NHS Foundation Trust

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

Progress Update Report

September 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 breaches of regulations on 10th May 2019. No formal feedback has yet been received but an engagement meeting with the CQC took place on 25th June and positive feedback received. A further engagement meeting is planned 9th September 2019 to discuss the trust improvement plan and present evidence to support compliance to Regulation 18 HSCA (RA) Regulations 2014 – Staffing (BLS / ILS training)

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 monthly 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 (23 August 2019)

	Compromised / significantly off track	Experiencing problems/ off track but recoverable	On track	Completed
Regulatory Actions* (4)	-	-	-	4
Must do actions (14)	-	-	3 ↓	11 ↑
Should do actions (19)	-	5 ↓	3 ↓	11 ↑

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

Table 2 Summary of ‘off track’ actions and recovery plans.

Action	Must or Should do	Recovery plan by end of September 2019
Governance: The Trust should ensure that minutes and action logs clearly outline items discussed and actions. Regulation 17 Provide risk management training for staff	Should do	Training planned 18 th September 2019
Governance: The Trust should ensure that it implements a revised governance structure. Regulation 17 Develop education plan for staff	Should do	Plan in place to develop information slides as part of induction pack to describe governance structure, systems and processes in place for escalation and action through committees
Equality & Diversity: The Trust should continue to work on equality	Should do	WRES and WDES action plans for submission to board in September

<p>and diversity including oversight of their workforce demographic.</p>		<p>2019.</p> <p>E&D Strategy for submission to Workforce and OD committee in September 2019.</p>
<p>Radiation regulations: The service should continue to increase awareness and understanding of the application of relevant radiation regulations.</p> <p>Develop programme of continuing education and awareness</p> <p>Develop audit to assess understanding</p>	<p>Should do</p>	<p>The radiology department have instigated a safety review, supported by outside colleagues</p> <p>The TOR are (amongst other actions) to review and provide assurance that relevant radiation regulations are adhered to, a programme of understanding is in place and level of understanding is assessed.</p> <p>This review is planned for September 2019</p>
<p>Workforce : The service should continue with plans to build capacity within the radiologist workforce.</p> <p>To establish a project to develop a clinical fellows programme for radiologists to support recruitment opportunities</p>	<p>Should do</p>	<p>Project Initiation Document (PID) in place.</p> <p>Directorate require support to lead this project going forward</p>

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. To date 22 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. Plans are in place to present supporting evidence to compliance to Regulation 18 HSCA (RA) Regulations 2014 – Staffing (BLS / ILS training) at the Quality contract meeting in September. MIAA have been engaged to complete formal governance audits, reported through the audit committee. An engagement visit with CQC is planned for 6th September 2019 and again plans are in place to present supporting evidence to compliance to Regulation 18 HSCA (RA) Regulations 2014 – Staffing (BLS / ILS training). This report, following receipt by the board at the end of September, will be shared with commissioners, CQC engagement lead and our NHSI quality lead.

Planning for future regulatory visits

It is expected that the CQC will visit within the next few months to conduct a well led visit.

The associate director for improvement is working with teams to ensure 'we are ready every day and any day' to accept any regulatory body.

It is expected that a provider information return (PIR) will be requested by the CQC prior to the visit. The clinical teams are in the process of collating this data a part of their business as usual, feeding through meetings structures to provide assurance in accuracy. The CQC will as a matter of course want to see evidence to support change in practice following implementation of their recommendations following their visit in December 2018, and January 2019.

Any concerns in providing data will be escalated accordingly through committee structures with executive oversight for their specific action areas.