Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board meeting (Part 1)	Date: 29 October 2014

Title:	**CQC Quality Improvement Plan**
Item:	**BD/14/180**

Executive Director lead and presenter	**Emma Roberts, Director of Corporate Affairs and Company Secretary**
Report author(s)	**Emma Roberts, Director of Corporate Affairs and Company Secretary**

History:	*Considered by Executive Team on 7/10/2014 and CQC Project Group on 7/10/2014* *Shared with Trust Development Authority for feedback*

This report is for:	
Decision	X
Discussion	
To Note	

The following impacts have been identified and assessed in relation to this report:	
Equality	None identified.
Quality	Identified within action plans.
Privacy	Identified within action plans.

Executive Summary of key issues

This report presents, for Board endorsement, the Quality Improvement Plan which has been produced in response to the Care Quality Commission review of the Trust.

The Trust participated in the wave 2 pilot of mental health trust inspections, and the inspection took place in June 2014. Subsequently, the CQC shared their report detailing areas of good practice; compliance actions and enforcement requirements (amounting to four warning notices).

The report also summarises the project governance arrangements in place surrounding the CQC action plan, the quality assurance mechanisms and the corporate governance systems which will provide the assurance of both actions and evidence and the scrutiny by Committee

of the changes to systems and processes to ensure the actions are embedded. It includes a clear identification of the roles involved and the accountabilities associated. The Board should **consider** this report approving the mechanisms set out above and **endorse** the full plan.

This report addresses these Strategic Priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1. Quality Improvement Plans

Following the CQC's inspection of the Trust in early June 2014 the CQC identified a number of areas where the Trust failed to meet the expected levels within the 5 CQC domains:

- Safe;
- Effective;
- Caring;
- Responsive; and
- Well-led.

This verbal feedback was further consolidated with a formal report outlining areas for improvement, presented at a Quality Summit on 13 August 2014. This report identified clearly the areas of non-compliance.

Action plans have been in development to deliver and assure that the actions have been closed down. These action plans are locality led (Clinical Directors responsible/Accountable), and were initially managed by Liz Bessant, the Acting Deputy Director of Nursing.

The Trust has produced a series of quality improvement plans in conjunction with local commissioners, feedback from the Trust Development Authority and other experts in the field.

The plans have been scrutinised by the Quality and Standards Committee, who have received assurance reports on both the actions undertaken in response to the warning notices, and as part of its locality 'deep dive' assurances in relation to local governance systems and improvements.

The plan attached to this report was submitted to the Care Quality Commission on 27th October 2014, having been approved by the Directors of Operations, Nursing and Medical Director on behalf of the Board.

2. Project Governance

The progress of the action plans has been communicated through the weekly CQC project meetings, reported weekly to ET, and overseen by the Quality and Standards Project Governance Arrangements.

The programme governance arrangements have been further consolidated in October to ensure the trust is best placed to manage the work requirements associated with the quality improvements identified by the CQC. The new arrangements seek to consolidate, in business as usual practices, the management of the quality improvements identified.

2.1. Who does what

Role Title	Name
Programme Sponsor	Kris Dominy, Director of Operations
Programme Board	Executive team
Programme Group	CQC programme Group (meets bi weekly)
Programme Leads	Nursing – Liz Bessant Medical – Rebecca Eastley

	Operations – Kevin O'Connor
Programme Technical Lead	Linda Hutchings – Head of Patient Safety Systems
Programme Support	Programme Management Office Nursing and Quality Directorate Corporate Affairs Directorate

2.2. Project infrastructure

Each locality has its own project, with Clinical Directors taking the role of Project Sponsors, and the Heads of Profession and Practice (in their role as Head of Quality) taking the local lead on all quality improvements.

The Clinical Directors are responsible in every locality for delivery and participation. The Director of Operations will hold them accountable through the bi weekly programme group detailed above.

2.3. Trust-wide Programme Governance

The Quality Improvement Programme comprises a Trust-wide action plan which the Director of Operations will lead on. Each individual action in both the locality and Trust-wide actions on the action plan has a responsible lead and is identified in a Locality Project plan.

The Clinical Director is accountable for their delivery of each action plan element in their locality – they may also have Trust-wide responsibility for a cross cutting issue.

The Programme meeting – held bi-weekly – ensures progress is on track. The meeting is chaired by the Director of Operations, reporting by exception to the Executive Team – where local resolution of an issue is not possible and senior resolution is required.

In the event of escalation, ET will provide advice and require action by a particular timescale.

The three Programme Leads provide support and advice relating to the completion of tasks, and clinical challenge and advice. They are accountable, to their Directors, for the provision of effective nursing, medical and operations oversight.

ET will report by exception (e.g. areas where delivery is not to time) to the Board monthly via a template report. The first such report is in October.

2.4. System wide Programme Governance

In addition to the projects identified within localities, the Trust has also agreed three system wide projects with its commissioners and other stakeholders. These are:

- Capacity Planning
- Workforce
- Learning from incidents

These projects are led by the Operations Directorate, and report to a new group; the Quality Improvement Group. This involves commissioners and other stakeholders alongside trust staff.

2.5. Reporting to Commissioners, the TDA and the CQC

A structure of governance reporting has been agreed with the commissioners, the NHS Trust Development Authority and the CQC. This is important because it ensures that key stakeholders are informed and escalation channels are in place, but that feedback mechanisms are streamlined as far as possible.

Local reporting will take place through local quality and performance meetings with commissioners.

In addition, the Clinical Quality and Performance Meeting for all the Trust's commissioners will continue to take place once a month, and will provide an opportunity for update and escalation of issues.

In addition, a Quality Improvement Meeting has been introduced, Chaired by Lead Commissioner Liam Williams. This group will sit above the CQPM outlined above, and will monitor system wide progress around the Trust quality improvement plans and the three system wide associated projects outlined above.

This ensures that the Trust, the commissioners and NHS England (as commissioners) may be held.to account.

The Trust Development Authority will participate in this monthly meeting, to advise and gain assurance. In addition, the CQC will be invited to attend as appropriate.

Finally, two weekly telephone calls between the Trust, the TDA and the CQC are in place to ensure prompt and frequent follow up of issues raised at the Quality Improvement Meeting. These meetings will be recorded as appropriate.

The Director of Operations will continue to report assurance to the TDA at the monthly Integrated Delivery meetings.

3. Corporate Governance

3.1. Assurance of Actions and Evidence

The completion of defined actions is fundamental to ensuring that upon re-inspection the CQC is satisfied that the Trust has understood what is required of it and made necessary improvements to ensure patient safety. Whilst staff can confirm they have implemented actions, the Trust Board needs to be assured that there is evidence of this, sufficient to satisfy a re-inspection. The mechanisms for both checking evidence and confirming that this fully and robustly shows that the issue raised has been corrected are therefore fundamental in this process. The procedure for responding to inspections sets out the nature of the response process in more detail (considered by the Quality and Standards Committee in May 2014).

3.2. Quality Assurance

The Head of Patient Safety Systems is the technical lead for the Quality Improvement Plan.

Working alongside the patient safety team, the Corporate Affairs team will further review all physical evidence to ensure evidence logs are complete and demonstrate closing the loop (e.g. a new policy has been written, agreed by SMT, agreed by Committee, then promulgated). Any anomalies or gaps will be discussed with the manager responsible for the action and further evidence obtained. This will ensure that the Trust has a complete log of all evidence which is satisfied supports the completion of actions as it reported them to the CQC.

In addition, the Nursing and Quality Directorate will inspect using agreed methodology to review and assure the effectiveness of practice changes on the ground. This will provide physical evidence and therefore assurance that specific changes have been effected.

In order to ensure the sustainability of these changes, quality assurance mechanisms will continue to be reviewed and refocused, as appropriate, as part of the further iteration of the 'Information for Quality' (IQ) system.

3.3. Quality Visits and Walkarounds

As part of the review of quality assurance mechanisms, the approach to 'walkarounds' and quality visits has been refreshed, building on good practice from other private and public healthcare providers.

A schedule of 'walkarounds' has been agreed for the month of October, which will specifically quality assure the practice changes and ensuring sustainability of changes made in the sites identified in the warning notices.

The Quality Improvement Visit methodology is being revised and the new style visits will start on November 1st. These will involve a wider cross section of staff, stakeholders and commissioners.

The trust is implementing 'action weeks' which will see a focus on particular areas raised through the quality improvement programme. For example, a focused look at 'environment or 'documentation,

In addition, taking learning from other NHS Trusts, a more comprehensive, annual quality inspection methodology is being introduced, which will an even wider group of staff and stakeholders. This will take the form of a mini CQC Inspection trustwide, known as a 'Week in Focus'. This will ensure the trust remains 'inspection ready' at all times.

3.4. Scrutiny

3.4.1. Board Committees

The role of the Committee is *to seek assurance relating to the proper performance of the systems and processes of governance.*

The Quality and Standards Committee will assure the elements in the action plan identified to it. These will be areas where changes to policy and systems are required as a result of compliance actions from the CQC and the Committee will seek to test the rigour of the systems and processes on behalf of the Board.

ESEC will review elements relating to changes to staff recruitment, retention, training and development.

The Audit and Risk Committee will review both the governance mechanisms and the assurance mechanism outlined, and agree this paper. The Committee will also receive the report of the Internal Auditors in relation to their internal audit of the assurance of this programme.

3.4.2. Board Oversight

The Board will review, by exception, progress in achieving the compliance actions at each of its meeting. This will ensure the Board is appropriately accountable to the public for both transparency in undertaking the actions but also in reporting progress.

It will receive reports from committee chairs relating to system and process assurance considered at each Committee.

Finally, as part of its Monthly Digest, the Board will receive a one side 'progress dashboard' identifying RAG rated progress against actions.

3.5. Communications

A bi-weekly cascade has been introduced Trust-wide for staff and other key stakeholders. This will provide immediate updates to internal staff and other stakeholders in relation to the activity and its progress, and cascade 'FIVE KEY MESSAGES' aligned with the CQC Domains.

Support to tailoring individual communications plans in localities will be provided by the Communications team and wider Corporate Affairs Directorate.

Core briefings and other support to service user and carer groups will be provided in each locality as required and the Trust-wide Involvement Group will consider service user engagement and involvement through the quality improvement programme.

Briefings will also be provided to commissioners and other external stakeholders regularly through the networks identified above.

Existing media relationships will be employed to share progress and ensure transparency on the part of the general public and trust members.

Stakeholders	How will they be kept informed?
Staff	Managers - email - Project meetings Team Meetings Bi weekly cascade
External Stakeholders – CCGs/Commissioners	Performance meetings CQPM Quality Improvement Group
External Stakeholders - Service Users, Carers, Members, the public	Trust-wide Involvement Group Service user and Carer meetings, Trust-wide Core briefings to members Members newsletter Board minutes and summary of issues
Programme Board (Executive Team)	Escalation and exception reports from the Director of Operations
Board	Reporting from Board Committees Monthly reporting Dashboard of project grip
Committees	Exception reports and consideration of assurance mechanisms
TDA	IDM Meetings Quality Improvement Group Telephone meetings
CQC	Regular updates Meeting the deadlines for completion of Warning Notices Re-inspection

	Telephone meetings

3. Recommendation

The Board should consider the report and **approve** the mechanisms set out above.

The Board should **consider** the actions in train and note the mitigations to ensure safe services in areas where full compliance requires lengthier inputs.

The Board should **note** the assurance mechanisms in place and affirm its confidence in the robustness of the framework.