EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**29 JANUARY 2015**
SUBJECT:	**PROGRESS AGAINST CQC RECOMMENDATIONS: IMPROVEMENT DIRECTOR'S OBSERVATIONS TO DATE**
REPORT FROM:	**MONITOR IMPROVEMENT DIRECTOR**
PURPOSE:	**Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

This paper summarises the view of the Improvement Director as to the situation of the CQC action plan to date. It also gives an opportunity for the Board to consider the implementation of the plan, and what more should be done. It addresses fact that external stakeholders have a part to play in the success of the Programme.

SUMMARY:

The Paper reflects on: Issues relating to the Action Plan; Programme Management; Communication, and other Issues relevant to a successful Programme, including preparing for a CQC revisit. It also sets out a list of recommendations and a process for agreeing RAG ratings.

RECOMMENDATIONS:

This paper is mostly to assist the Board in reflecting on the position of the CQC Improvement Programme to date. However there is a list of recommendations which the Board is asked to consider accepting. There is also a process listed for information.

NEXT STEPS*:*

The Board may consider the Trust using this paper in other committees including the Improvement Board and Trust's Management Board.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

The Board will need to identify these

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO10: Maintain strong governance structures and respond to external regulatory reports and guidance.

IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:

The Trust's success in implementing the recommendations of the HLIP will be assessed by the Chief Inspector of Hospitals upon re-inspection of the Trust. The results of this inspection will have a significant impact on the future reputation of the Trust.

FINANCIAL AND RESOURCE IMPLICATIONS:

This has been considered in other discussions

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

The Trust is currently in breach of its Licence with Monitor by virtue of being placed in Special Measures.

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A

ACTION REQUIRED:

(a) Discuss and agree recommendations.
(b) To note

CONSEQUENCES OF NOT TAKING ACTION:

The CQC Improvement plan will not be successful. Failure of the Trust to respond in a timely fashion with appropriate information may affect the Trust's rating with Monitor and the CQC.

REPORT BY IMPROVEMENT DIRECTOR RE CQC IMPROVEMENT PLAN

1 INTRODUCTION

1.1 I have now been the Monitor Improvement Director for East Kent for three months. In this time I have: reviewed the findings of the CQC across the organisation, and as the Board knows, I have mostly found similar issues, particularly around staff engagement, bullying and harassment and governance matters; I have also spent time understanding relationships with external partners; I have undertaken the role of ensuring the action plan was appropriate and that programme management was embedded, and that change was being made and I have also given some oversight to the operational performance of the organisation. This paper uses my observations from this work and makes some recommendations regarding the CQC Improvement Plan going into the future.

1.2 The Trust has approached the development of the Improvement Programme with good intention, and the actual programme has structure, reasonable governance, particularly at the higher level of the organisation and some key achievements have been made. The appointment of Dr David Hargroves as the clinical lead is a positive action. However now it is 10 months since the Inspection and 5 months following the publication of the reports, it would be good for the organisation to take the time to reflect again on the reports, the action plan and the programme management structure and governance, to ensure that the outcomes will indeed achieve the improvements which will put right the findings of the CQC in a sustainable manner. In so doing, it is essential to ensure that the improvements required in behavioural change and establishing good practice are addressed comprehensively and not simply by putting right just individual points in the CQC report.

1.3 As I have gone around the Trust, I have found an enthusiasm from many staff members to grab the reports findings and to convert them into actions that will build on what is an organisation with great potential. The Board has a responsibility to make sure that the approach to improvement maximises this opportunity.

1.4 This paper identifies some concerns that I have regarding the opportunity programme gives and makes some suggested recommendations going forwards.

2. ISSUES AND CONCERNS RE ACTION PLAN

2.1 Review of the Plan.

The CQC visit was undertaken over 6 days in March 2014. The team visited all three main sites (William Harvey, Ashford; Kent and Canterbury, Canterbury and Queen Elizabeth Queen Mother, Margate). Following these visits, the Trust received reports in August 2014, which gave an overall rating for the Trust as Inadequate, and consequently, the Trust was ‘put into special measures’. I have reviewed the reports again recently, and have been able to put them in context now I have a much better feel for the Trust. The Board and other members of the organisation should also do this, now ‘the dust has settled’ and much internal reflection has been undertaken.

I have found much in the reports to support what I have heard and seen as I have travelled around the Trust.

2.2 The Action Plan

When tracking the action plan, I have a few considerations:

2.2.1 It approaches the reports recommendations from a very 'technical point of view', each 'Must do' and 'Key Finding' has a separate 'root cause analysis', with linked actions. Whilst this approach ensures that each issue is addressed, the opportunity to reflect on the bigger picture and to ask the question 'what are the overall issues in the Trust that have got us to this situation?' is missed. There are definitely strands which apply across many of the findings, these include leadership; lack of a recruitment and retention strategy and plan; Divisions not having clear corporate accountability and so on.

2.2.2 I do not think that the actions always properly ameliorate the issue found. This is understandable, as there was a need to compile an action plan very quickly, however it is important to review these actions with the staff involved to make sure that the actions will improve the problem and at the same time it would be useful to review the RCA attached to each issue.

2.2.3 The actions are often very specifically related to a particular finding of the CQC in a particular area. As well as ensuring that the particular issue has been sorted, the question should also be asked whether the same or similar issue applies in other parts of the Trust. I often hear 'but the CQC didn't go there', but in the spirit of learning and developing the Trust into a continuous improving organisation, every opportunity should be taken to ask what more and what else should we do?

2.2.4 At the moment the action plan is a list of many specific issues with actions against each one. I believe that all these specific points can be grouped into 5 or 6 themes with headings such as Leadership, Staffing issues, governance and so on. This will help the Trust get the 'Big Picture' in their minds as to what generally has to be different going into the future and will help the Trust and others to understand what the action plan is going to achieve.

2.2.5 The Trust Board and other key bodies should remind themselves at every opportunity that the acid test to the outcomes being achieved is the answer to 'so what is different here?' When reviewing RAG ratings in the plan, rather than a technical 'yes the correct progress is being made, perhaps it should also be asked 'and what difference has it made'? Another Trust in Special Measures has two RAG ratings, 1) Progress against actions and 2) Impact of completed actions (so far). This would allow a much more comprehensive and meaningful assessment of progress when reviewing the actions.

2.2.6 There are over 250 actions in the base plan. This is an enormous number, and is the result of such a wide ranging report over three sites, however a continual challenge should be to try to simplify these whilst at the same time ensuring the actions properly cover the breadth and depth of the whole organisation.

2.2.7 The way the RAG rating works at present reviews each action as having equal significance, and indeed each desired outcome as being equally important in the improvement drive. It may be possible to give weightings to these two areas so that the Trust can put most effort where the most impact will be made, and to explain the nature of the actions and the outcomes to staff and others. This would have to be covered in the RAG rating process if it is implemented.

2.2.8 There is further work to do in identifying how the 'Culture Programme' meshes into the Improvement programme as a whole. This links to the 'Big Picture' points. It is essential that the Board is fully engaged with the Culture programme, and sees it as the main piece of work which supports the action plan itself. There is a danger that the Culture programme and the CQC improvement plan are seen as separate entities, they are not, indeed one is inextricably linked with the other. Close working between both programme managers and a joint communications approach should be adopted.

2.2.9 I am concerned that for many of the action points, there is not a real understanding of what needs to be done to achieve the desired outcomes, and whist theoretically in many cases the completion dates may have been reasonable, I am not sure that with the work programmes being followed they will be met and / or the desired outcome will be achieved. In some cases, I think that the timelines stated for completion may be overly ambitious, in others it is difficult to be sure of the exact final date for completion.

3. ISSUES RE PROGRAMME MANAGEMENT AND GOVERNANCE

3.1 The Programme Situation to Date

The Trust has put much consideration and work into developing a well-constructed programme management structure to ensure the Improvement plan actions are implemented throughout the organisation. This includes having a central programme management office (PMO) staffed with admin support, a full time Programme Manager and a Clinical Lead with a number of Programmed Activities (PA's) available to support the application of the Programme. The Chief Nurse and her team have also contributed much time to Programme management whilst the PMO has been pulled together but they are now able to pull back somewhat and hand over to the PMO. There is an overarching 'Improvement Board' which reports to the Trust Board, and which is responsible for gaining assurance that actions are being implemented in a timely manner, and identify where there are 'blocks' to this achievement, and where appropriate giving support in unblocking them. The High Level Improvement Plan (HLIP) consists of a list of the Must Do's and Key Findings identified by the CQC, which is broken down into over 250 actions found in the action plan. Each Division has taken these actions and applied them within their division. The HLIP statement in turn drive the NHS Choices Submission paper. The Trust has done well in asking internal audit to review the Programme.

3.2 Despite the good findings regarding Programme Management as stated above, there are outstanding issues:

3.2.1 Despite attempts to ensure that the action plan can be tracked from the 'top to bottom' of the organisation, I have not found evidence that this is the case. It is possible to find reasonable evidence of this through the nursing structure, and in most cases the AHP structure, but I have difficulty in identifying this in areas consisting of Doctors and administration staff in all areas.

3.2.2 The CQC Improvement Plan and the Culture Improvement Plan are being governed separately. I believe that they are really two critically interlinked parts of one Programme and although they both report to the Improvement Board, they do not feel as one. They are both inextricably linked, and would probably benefit from sharing the same programme office, with shared communications and Clinical Leadership. The Organisation needs to see both of these drives to be the answer to the CQC reports together, I do not think that is the case at the moment.

3.2.3 The CQC HLIP has executive leads linked to each of the 40 plus statements. This was a good initiative and should have supported the Executive being seen as a team in driving the Improvements. It has not been possible for all of the Execs to find a way to take leadership roles for their designated Statements. I suspect that this is partly due to there being so many themes. I have discussed with the Exec the possibility of grouping the HLIP into 5 or 6 themes each with a designated exec lead, this may help improve the situation.

3.2.4 The RAG rating has proved difficult:

a) There is a lack of understanding that the ratings relate to progress against the action plan timelines, and not the state of the issue itself; (so for instance, recruitment of nurses could be improving, but one of the actions of good practice which would ensure the last few appointments required, had been delayed. Under the present scoring this action could be red, but there were actually more nurses available.)

b) There has been confusion as to who is responsible for the RAG ratings, particularly of the HLIP each point of which is an amalgamation of a number of actions. To give true assurance if the RAG ratings are produced by a number of people (which they necessarily are), there should also be an opportunity for cross checking them;

c) There is no way of showing where improvements are being seen, as the RAG rating system purely reflects the state of the actions themselves, not the outputs.

3.2.5 The PMO struggle to get returns back from leads to ensure the plans can be updated in a timely manner. This in turn results in a rushed approach to getting meaningful plans ready for the Improvement Board, Trust Board and the Monitor PRM. A proposed time table is attached.

3.2.6 Good governance includes that appropriate and meaningful time is spent in reviewing the plans at relevant meetings. This includes Trust Board, Trust Management Board and Divisional Boards. This is not always the case, and each chairman should review this.

3.2.7. Although there has been some work in identifying the risks related to the programme, more is required to ensure that both the risks to the programme and also the risks that the CQC report itself has identified are fully listed and mitigated and linked to the Trust risk register and where required added to the corporate risk register. There should also be an issues log and a change register.

4. ISSUES RE COMMUNICATION

4.1 Communications within the Trust

There is a reasonable sized Communications team in the Trust, who have a number of clear methods of communicating internally which is mostly electronic in nature. External Communications appear less well developed and appear to be more reactive.

4.2 Despite the Comms team having a defined method for internal comms, there are still significant issues when considering the Communications issues related to the Improvement plan. These fall under two headings, firstly the Communication plan which supports the CQC Improvement plan, and secondly any actions which should be attributed to the Communications function in the plan itself.

4.2.1 There is a complication regarding the Communication plan which supports the CQC Improvement Programme in that there is a separate communication section directly related to the Culture Improvement programme, which also has significant communication funding (both for internal and external support). The CQC Improvement programme does not have any designated funding. It would be sensible to review the communications arrangements to ensure that the communications behaviour is linked between both aspects of the Improvement programme which includes the Culture piece.

4.3 I do not believe there has been a review of the direct and indirect effects of the Trusts Communications behaviour in what the CQC found. This included staff who said they felt isolated from the executive through to people who did not know how to access certain policies. Communications has to play a significant part in ensuring that these (and most of the others) are put right. This is an example of where the actions identified may not entirely ameliorate the problem, and others regarding communication should be added. The Trust should probably spend some time considering where its communications behaviour contributed to the CQC's findings (as part of the root cause analysis) and also should develop a communications plan for the CQC Improvement Programme alongside the Culture programme and integrate this work into a Trust wide communications plan for both internal and external use.

5. OTHER ISSUES RE THE CQC IMPROVEMENT PROGRAMME

5.1 I am aware of some other issues which the Trust should consider:

5.1.1 I understand that there are some other action plans within the Trust, although I have not seen them specifically. I would expect that these (such as Francis) would directly link in many cases to the CQC Improvement plan. I have suggested on a number of occasions, that each of the outstanding plans in existence should be reviewed and mapped against the CQC Improvement plan. This will ensure that there is not the case of the same (or nearly the same) issue having a number of slightly different actions. Where there is an issue which is not covered on the CQC plan, this of course should continue to be driven through the original plan. I have frequently heard that there are too many plans in the Trust and that not all of the actions are completed, this method would ensure that the governance set up for the CQC Improvement plan also covers other important action plans.

5.1.2 There will soon be the results of three separate, but linked governance reviews which were commissioned following the CQC visit. There is a risk that these will be treated in isolation, with separate action plans for each which are not directly linked to the CQC Improvement plan. This would be not be ideal, and would run the risk of having too many action plans which may have some slightly conflicting actions and at the same time the Governance would not be within that of the CQC Improvement PMO. It is vital that the results of the three Governance reviews are directly linked to the CQC Improvement plan, this may mean that there is some review of the actions already identified, and some others added.

5.1.2 It is recognised that there are other vital Programmes in existence within the Trust and indeed the success of these are very important in the overall success of the CQC Improvement plan. These include the Clinical Strategy Programme; the A&E and RTT Improvement programmes; CIP programme, the Quality Hub programme and so on. The Trust Board should consider the importance of all of these interlinking and how this will be shown in the annual plan.

6. PREPARATION FOR THE NEXT CQC VISIT

6.1 The Trust knows that it will have a re-inspection from the CQC at some point when it hopes that it will have the ‘special measures’ regime revoked. The Trust should be preparing for this, and indeed by reflecting and acting on the above they will do be working towards this. It is vital that this work starts now.

6.1.1 The Trust should take the opportunity to review the visit itself and consider what could have been done differently next time. It would be possible to gain advice from others who have been successfully inspected, and also from other inspectors.

6.1.2 The Trust should consider creating a team and sub programme to prepare for the next visit. This may include peer reviews across various areas which are shared with the programme board, learning opportunities as previously described and a review of the Communications strategy.

6.1.3 Done well and very soon, the work of preparation will support the improvement work itself, by teams being seen out and about, by rewarding improvements made and identifying areas to be improved, and ensuring that this happens.

7. CONCLUSION

7.1 I am very aware that this paper appears very wordy. Consequently, I have listed a series of recommendations as an attachment. These are intended for discussion, and may need development to ensure that they are appropriate and indeed to consider any others which should be added. These over-arching recommendations will support the programme as a whole, and it is hoped that they will give the glue to what could be said is a fragmented, disjointed approach to what is well intentioned improvement. Many of the recommendations I have suggested would change the way in which the senior team(s) engage with the CQC Improvement Programme so that it changes 'the way things are done around here', rather than achieves a list of specific things which have been sorted (this does still need to be done). If followed as a senior team, the staff in the Trust should be able to see a leadership style which would allow them to say that it does feel different. The Trust will benefit from reviewing how the CQC Improvement Plan and the Culture Improvement Plan work together.

I have not included the need for the Trust to review leadership styles and individual and team behaviours which may have contributed to the situation the CQC identified. This piece of work will be very important but will be best done with the benefit of having the two key governance reviews in reflecting on these important matters.

Appendix 1

RECOMMENDATIONS

1) Members of the Trust Board, Divisional Leads and other significant leaders should re-read the CQC reports and reflect together on the findings.

2) A high level agreement to the questions of 'what does this say at the high level about the Trust?' how did we get here?' and 'what did we do/not do to contribute to this?' should be reached by the above groups together. This should lead to a high level agreement as to how things should be done differently in the future and a statement of what sort of Trust East Kent should be.

3) Consider organising the 'Must Do's and Key Findings' into 5 or 6 key Themes such as Leadership and Culture; Staffing Issues and so on and where appropriate identify high level action plans into which all the relevant sub actions fit.

4) Review the HLIP statements, and ensure that they reflect the consensus views of the CQC reports and have consistent time lines with the sub actions. Theme the HLIP.

5) Review the action plan to ensure that the actions are relevant to the points, allow the issue to be reflected across the organisation and that no actions are missing.

6) At Board and other discussions ask 'what difference has this action made?' Consider a double RAG rating system, one for process and one for outcome so far.

7) Consider simplifying the Action Plan by potentially reducing the number of actions being tracked, or grouping similar actions, or weighting actions so that those with the highest weighting are tracked more than others. Also consider weighting Outcomes.

8) Ensure that there is greater synergy between the CQC Improvement programme and the Culture Improvement Programme. This should include joint working with each PMO and potentially sharing of resources.

9) Continue to track the implementation of the Action plan across the breadth and depth of the Organisation, and test this at times.

10) Ensure that all execs have a greater role in leading the Improvement Drive. (Including the Culture work). This applies to the team approach as well as individuals. Ensure the organisation sees the executives are driving for change.

11) Review the RAG rating system to ensure that it is properly understood and consider a method of showing outcome progress.

12) Introduce a strict timeline for the monthly review of the action plan. Hold leads to account for making returns at the right time.

13) Review the discussions held at each key Board to ensure that there is robust review of the Action Plan.

14) Review the Communications plans and functions between the CQC Improvement Programme and the Culture Improvement Programme to ensure they complement each other with consistency. Provide the CQC Improvement Programme with designated Comms support either directly from the Central comms team; shared with the culture Improvement Programme or separately.

15) Identify communications actions in relation to the CQC report which will improve the situation.

16) Review the communications behaviours and leadership (internal and external) for the Trust as a whole to ensure that it addresses the issues which contributed to the CQC findings going forwards. This includes individuals and teams responsibility as well as reflecting on communications methods.

17) Map all contents of other action plans to the CQC plan

18) Ensure the 3 governance reviews are taken into consideration together and implant the actions into the CQC Improvement Programme.

19) Scope and understand the relationship between other key programmes in the Trust.

20) Prepare for the next CQC visit, including getting support from successful organisations, other inspectors, and peer review which is shared for learning purposes.

Appendix 2

PROCESS FOR AGREEING RAG RATINGS (PREPARED BY PMO)

Process for RAG rating the Detailed Action Plan

Each month, commencing January 2015, David Hargroves and Sharon Cannaby will meet with the identified leads for each of the actions. The meetings, which will be held prior to the Improvement Plan Delivery Board (IPDB), will be used to discuss and, in particular, challenge progress against each of the actions to date.
If actions are reported as delayed, then Leads will be asked to explain the cause of the delay and the actions being taken to address this. The RAG rating will be marked as Red if not started and Amber if started but delayed.
If actions are on track then this will be noted and a RAG rating of Green agreed.
If actions are completed then the Lead will be asked to provide evidence and the RAG rating will be recorded as Blue.
Once all the meetings are complete the detailed action plan will be updated and used to RAG rate the High Level Improvement Plan (HLIP).

Process for RAG rating the High Level Improvement Plan

The RAG rating of each of the Must Dos and Key Findings listed in the HLIP will be calculated using the RAG ratings in the detailed action plan.
The overall RAG rating for each Must Do and Key Finding will be calculated as the mode of the detailed actions with the following exceptions:

- The overall score for each must do or key finding cannot be blue if there are any greens, ambers or reds (as the action is not complete)
- The overall score for each must do or key finding cannot be green if there are any reds (as the action cannot be on track)
- If there is no mode then the relevant Director will be asked to give the RAG rating based on actions to date and known risks.

Example (taken from December 2014)

M26	**MUST DO 26: Review the provision of end of life care to ensure a coordinated approach.** *(From WHH report, actions to be implemented at Trust level)*	GREEN
M26.02*	Review membership and Terms of Reference for the End of Life Board, to include reporting to Clinical Advisory Board	Blue
M26.03	Co- design end of life strategy with the Pilgrims Hospice	Amber
M26.04	Explore opportunities with SEAP and patient watch regarding advocacy and support for relatives and carers at point of discussion of DNACPR and EofL care	Green
M26.05	Continue to gain feedback from relatives via "In Your Shoes" sessions and feedback results to the End of Life Board and trust wide.	Green

* There is no M26.01

In the HLIP dated December 2014, M26 was RAG rated green as the majority of actions relating to this Must Do were RAG rated green.

Process for signing off HLIP

Both the detailed action plan and HLIP will go to the IPDB for sign off before going to the Trust Board.
David Hargroves will present a monthly progress report to the Trust Board.

NHS Choices Plan
The RAG rating of each of the 'Summary of Urgent Actions Required' listed in the NHS Choices Action Plan will be calculated using the RAG ratings from the HLIP. The overall RAG rating for each line will be calculated as the mode of the HLIP actions with the following exceptions:

- The overall score for each summarised action cannot be blue if there are any greens, ambers or reds (as the action is not complete)
- The overall score for each must do or key finding cannot be green if there are any reds (as the action cannot be on track)
- If there is no mode then the Chief Nurse will be asked to give the RAG rating based on known actions to date and known risks.

Example (taken from 13 Jan 2015 NHS Choices submission)
Ensure medications are stored safely and that the administration of all controlled drugs is recorded.

This relates to:
MUST DO 24: Ensure medications are stored safely. RAG rated BLUE on the December HLIP.

MUST DO 25: Ensure the administration of all controlled drugs is recorded. RAG rated Green on the December HLIP.

Therefore the overall RAG rating given to this line on the NHS Choices Plan submitted 13 January 2015 was Green.

Process for signing off NHS Choices Plan
Monthly meetings have been arranged with the Executive Team and Sue Lewis to agree and sign off the NHS Choices Action Plan. Once agreed, the NHS Choices Plan will go to the Chairman for final review before being signed by the Chief Executive and Chairman.

Time line – 2015
The timeline for the actions above has been agreed for the first quarter of 2015 as below.

	January	February	March	April	May	June
Meetings with Leads	7-19 Jan	9-21 Feb	9-21 Mar	6-17 Apr	tbc	tbc
Detailed action Plan complete	20 Jan	24 Feb	24 Mar	21 Apr	tbc	tbc
HLIP complete	20 Jan	24 Feb	24 Mar	21 Apr	tbc	tbc
Improvement Plan Delivery Board	21 Jan	25 Feb	18 Mar	22 Apr	20 May	17 Jun
Trust Board	29 Jan	27 Feb	27 Mar	24 Apr	21 May	26 Jun
Performance Review Meeting with Monitor	4 Feb	18 Mar	15 Apr	20 May	tbc	tbc
NHS Choices submission prepared	2 - 6 Feb	2 - 6 Mar	1 – 3 Apr	tbc	tbc	tbc
Executive meeting re NHS Choices submission	6 Feb	5 Mar	9 Apr	tbc	tbc	tbc
NHS Choices signed by CE and Chairman	9 Feb	9 Mar	tbc	tbc	tbc	tbc
NHS Choices submission (Sue Lewis)	11 Feb	11 Mar	10 Apr	tbc	tbc	tbc

Sue Lewis
20 January 2015