APPENDIX 3

NHS
Medway
NHS Foundation Trust

CQC Action Plan

MARCH 2020

Our Medway

Best of care
Best of people

Contents

Executive summary

Medway NHS Foundation Trust comprises a single-site hospital based in Gillingham, Medway Maritime Hospital, serving a population of more than 424,000 across Medway and Swale who rely on the hospital and community services we provide each year. With over 4,400 dedicated staff, we are one of four acute hospital trusts in Kent and Medway.

High quality care is one of the Trust's five strategic objectives set out within our Quality Strategy. The strategic priorities within our Quality Strategy aim to provide consistent high quality care, with an emphasis on continuously improving the safety, quality and experience and ensuring that the care patients receive is evidence based and reliable. Designing quality into every aspect of our services will support the achievement of our quality goals and are a key component of the Trusts quality improvement plan.

Quality at the Trust is defined by the domains of:

- services are safe,
- effective
- person-centred
- while promoting better health and well-being.

To achieve a culture of high quality care we have incorporated five enablers which run through our Quality Strategy:

- An inspirational vision of high quality care
- Clearly aligned goals at every level
- Employee engagement
- Continuous learning and quality improvement
- Team working, cooperation and integration.

A message from James Devine, Chief Executive

As Chief Executive, I see every day the positive impact we have on patients and the communities we serve. This is down to the 4,400 staff who work across our hospital and many community services.

I joined the Trust in 2017 and, while the challenges we face are immense, I am confident we have the skills and desire to make Medway brilliant – and ultimately put us in a position to deliver Best of Care, Best of People.

I have been struck by how much goodwill there is locally, and among the communities we serve, for Medway to succeed. This includes our patients, but also the many partner organisations we work with; this inspires me, and re-emphasises the importance of delivering the improvements we want to make.

Great organisations never think they have reached their goals – they always want to strive to continually improve care. This is the type of organisation I want us to be here at Medway.

This document represents our response to the inspection findings in an action plan aimed at addressing the 'must do' and 'should do' actions. This action plan forms part of the High Quality Care pillar of the Trust's improvement plan aimed at delivering care that is safe, effective and person centred.

Thank you

James Devine
Chief Executive

About the CQC action plan

The plan is the Trust's response to the inspection findings published in the CQC report in April 2020.

The first 12 months of this action plan responds to and will focus on delivery of the 24 must dos and the19 should dos. This plan provides the progress to date and details of the actions the Trust has been taking, in responding to the concerns raised following the inspections and sets out the planned improvement work.

This includes priority areas such as:

- Infection prevention and control
- Nursing standards and practices
- Escalation procedures and processes to ensure patient safety, including the opening and use of escalation areas/wards
- Governance and assurance processes in place to assure ourselves and others of a safe standard of care
- A demonstration of the leadership understanding of the significance and seriousness of the concerns raised
- Clear improvement planning with named leads, timescales, milestones and objective measures to achieve the improvement identified.

While priority is placed on delivery of the immediate concerns and the must do and should do actions, the focus and approach will ensure that the changes implemented are embedded into practice to ensure changes are sustained. The approach and methodology taken will include:

- Building upon the improvements made to date in addressing the immediate concerns raised by the CQC implementing, embedding and sustaining changes which will make the biggest impact in improving the quality and experience of care.
- Involving, and empowering frontline teams to identify, lead and implement changes that will demonstrate improvement
- Having a simple set of measures for improvement to demonstrate impact.

CQC inspection findings December 2019/January 2020

CQC inspection December 2019 / January 2020

During December 2019 the Care Quality Commission (CQC) undertook a planned and two unannounced inspections of the Trust in six Core Services.

The following table indicates the dates of when the CQC inspections occurred at the Trust.

Inspection Visit	Date of inspection
Core Service Inspection involving the following five areas: • Emergency Services • Surgery • Critical Care • Children & Young People • End of Life	3,4,5 December 2019
Unannounced Inspection (medical care core service)	16 December 2019
Well Led Inspection	15 & 16 January 2020
Unannounced Inspection	29 January 2020

Following the unannounced inspection on 17 December 2019 the Trust received a Letter of Intent, Section 31 possible Enforcement notice under the Health and Social Care Act. This related to the findings from the CQC unannounced inspection on the 16 December 2019. The formal letter of intent raised concerns in relation to the care of patients within Dickens Ward.

In responding to and addressing the concerns raised, the Trust immediately developed an action plan. This included providing a detailed response to the CQC on the immediate actions the Trust had taken to address the safety concerns and provide assurance that the quality of care the Trust provides to the patients is our number one priority.

Dickens ward was an escalation ward with patients primarily placed there who were deemed 'medically fit for discharge' (patients who no longer required acute hospital care but may have required additional care, such as rehabilitation, before being safely discharged).

In January 2020 the Trust took the decision to close Dickens Ward and in doing so the Chief Executive and Chief Nurse ensured that patients were safely transferred to an alternative ward or discharged from the hospital.

The Trust worked together with the support of our partners in the community and our commissioners to ensure patients who were fit to go home or to a community setting were able to do so in a timely way.

After closure of the ward the CQC did not issue the Trust with the Enforcement Action Section 31 of the Health and Social Care Act (Letter of Intent).

On 19 December 2019 the Trust received a Section 29A Warning Notice under the Health and Social Care Act 2008.

Trust ratings from the CQC 2019/20 inspection

On 30 April 2020, the Care Quality Commission (CQC) published its inspection report for Medway Maritime Hospital following visits to the Trust in December 2019 and January 2020. The CQC disappointingly found a number of significant issues that resulted in an overall rating of 'Requires Improvement' for the services we provide.

Summary and full CQC reports can be found on the CQC website: https://www.cqc.org.uk/provider/RPA

Our ratings for Medway NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency care Services	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020
Medical Care (Including older peoples care)	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Requires improvement ↓ Mar 2020	Inadequate ↓ Mar 2020	Inadequate ↓↓ Mar 2020	Inadequate ↓↓ Mar 2020
Surgery	Requires improvement →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020
Critical Care	Good ↑ Mar 2020	Good →← Mar 2020	Outstanding ↑ Mar 2020	Good ↑ Mar 2020	Outstanding ↑↑ Mar 2020	Outstanding ↑↑ Mar 2020
Maternity and Gynaecology	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Services for Children and Young People	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement ↓ Mar 2020
End of Life Care	Good →← Mar 2020	Good →← Mar 2020	Good →← Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020	Good ↑ Mar 2020
Outpatients	Good Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Diagnostic Imaging	Requires improvement Jul 2018	N/A	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall trust	Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020	Requires improvement →← Mar 2020

Our overall rating for Medway Foundation Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Mar 2020	Requires improvement ↓ Mar 2020	Good →← Mar 2020	Requires improvement →← Mar 2020	Inadequate ↓ Mar 2020	Requires improvement →← Mar 2020

CQC inspection report findings December 2019 / January 2020

In responding to the findings and publication of the report it is important to acknowledge the successes and achievements as well as the areas that require focused improvement work to address the concerns.

Positive findings

- The trust had implemented recruitment and training initiatives to address the lack of medical and nursing staff which meant staffing levels met national guidelines in most areas.
- The services provided mandatory training in key skills to all staff and checked staff completed it. Overall, the majority of staff completed this training.
- The trust employed staff competent to perform their roles and ensured they maintained competency in specialist areas. Most staff had a completed appraisal and met the trust target of 85 per cent for appraisal completion.
- Doctors, nurses and other healthcare professionals generally worked together as a team to benefit patients. They supported each other to provide care.
- Patients, families and carers were generally positive about the care received and we observed compassionate and courteous interactions between staff and patients. In some areas there was a strong, visible person-centred culture. Staff took time to interact with people who used those services and those close to them in a respectful and considerate way, despite pressures in the services.
- Critical care service leaders had an inspiring shared purpose, strived to deliver and motivated staff to succeed. The service had comprehensive and successful leadership strategies to ensure they delivered and developed the desired culture.

Areas for improvement

- The CQC inspection report identified 24 ‘must do’ actions and 19 ‘should do’ actions.
- Action the trust MUST take is necessary to comply with its legal obligations and indicates a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust received a Section 29A Warning notice and seven Requirements notices in response to breaches of the following regulations in a number of core services:
- Regulation 10 – Dignity and Respect
- Regulation 12 – Safe care and Treatment
- Regulation 13 – Safeguarding service users from abuse and improper treatment
- Regulation 14 – Meeting nutritional and hydration needs
- Regulation 15 – Premises and Equipment
- Regulation 17 – Good Governance
- Regulation 18 – Staffing
- Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or improve services.

Developing our CQC action plan

As a result of the core service and well led inspection 2019/20 and in responding to the findings, this CQC action plan has been developed under the leadership of the Chief Nurse, supported by the Associate Director of Quality and Patient Safety. The action plan is subject to robust monitoring arrangements internally by the Quality Panel.

Our CQC action plan is not just a response to the Care Quality Commission's (CQC) Inspection report of April 2020. It also includes the actions that we feel are necessary to provide the communities we serve with safe, effective, and person centred care.

High Quality Care is Medway's fifth core strategic objective set out within the Quality Strategy.

The strategic priorities within the Quality Strategy aim to provide consistent high quality care. The emphasis is on continuously improving the safety, quality and experience of care and ensuring that the care patients receive is evidence based and reliable.

Quality Strategy Domains

- **Safe** – We will learn when things go wrong and reduce the incidence of hospital acquired harm, creating a culture of safety.

- **Effective** – We will ensure the right patient is in the right place receiving the best of care and their care is safely transferred between care providers. This will be based on evidence based best practice.

- **Person Centred Care** – Patients, carers and families will be listened to and supported to meet their needs. Best experiences of care for every person – 'doing with' and not too patients, families and carers.

Leadership and governance oversight of the CQC action plan

The Chief Nurse established the Quality Panel in January to oversee delivery of the immediate actions and the phase one action plan.

Quality Panel aims

- Oversee delivery of the strategic CQC action plan relating to findings from the announced and announced CQC visits and related enforcement notices under Section 29a and Section 31 Letter of Intent.
- Oversee actions related to recovery plans, progress on delivery and hold people to account.
- Tracking and reporting progress both externally to CQC and internally to the Chief Executive, Executive Team and to the Quality Assurance Committee (QAC), a sub-committee of the Trust Board.
- Attendees are divisional leaders, corporate and senior owners of actions and executives as invited.
- The panel has the delegated authority of the Executive Group.

The panel membership includes Executive Leads, Divisional Management Teams, Governance colleagues and external partners.

Our leadership, governance and oversight arrangements of the CQC plan are to ensure the right people take the right actions at the appropriate time.

Phase 1 action plan

In January 2020 all actions originating from the inspection findings, letter of intent Section 31 and 29a Warning notices issued by the CQC were combined into one single central overarching action plan known as the phase one action plan. Delivery of the immediate actions and the action plan was overseen by the Quality Panel chaired by the Chief Nurse.

Phase two CQC action plan

The next phase of our improvement journey has begun with the development of the CQC action plan which will be overseen by the Quality Panel, chaired by the Chief Nurse.

The tracking and monitoring of progress against delivery of the ‘must do’ and ‘should do’ actions will use a standard measure of assessment for each action using a red, amber, green or ‘RAG’ rating system. This will ensure a consistent approach to the tracking and reporting of the overall plan within the Trust and with external partners.

Governance and oversight

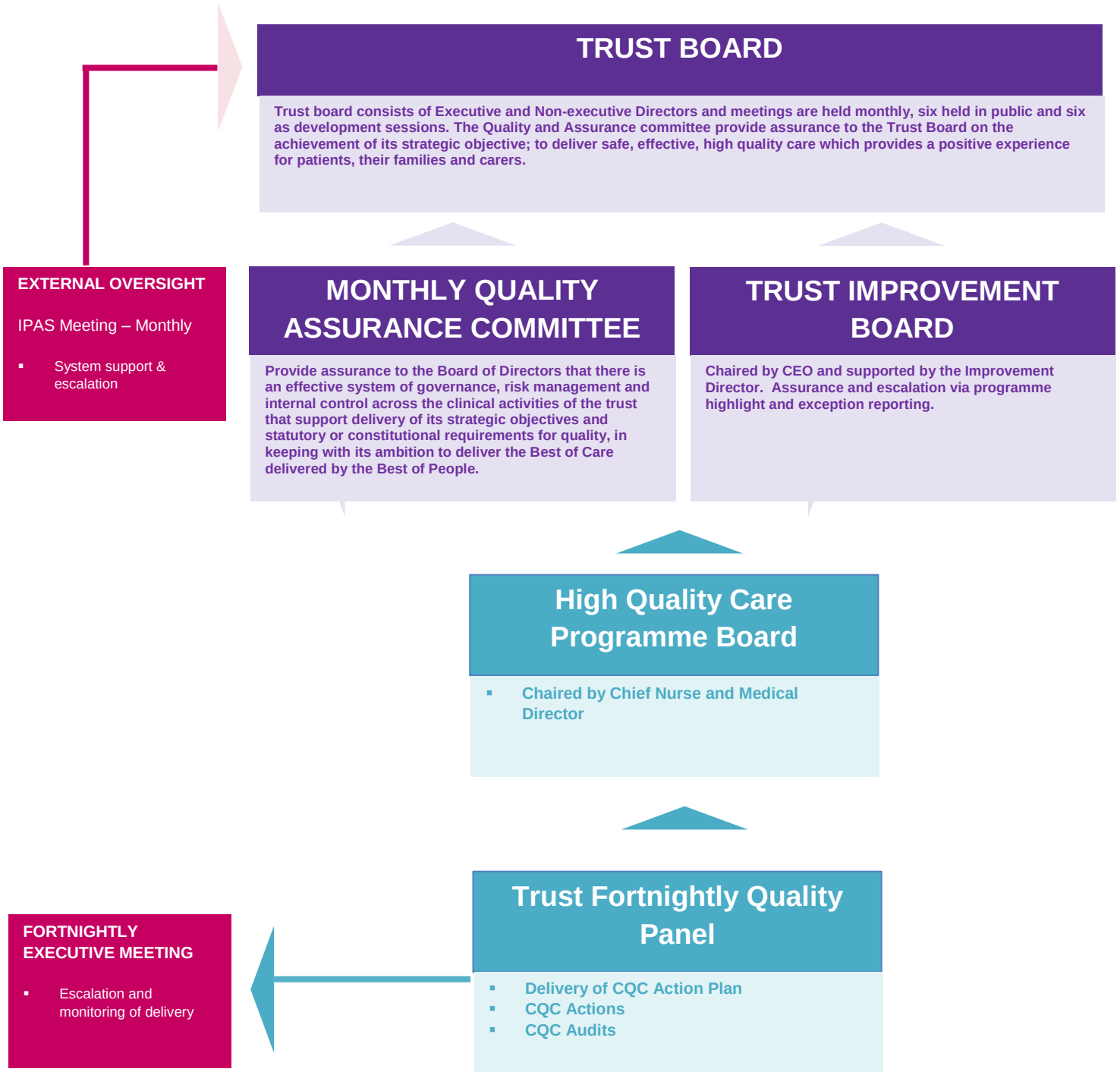
The Quality Panel will continue to meet fortnightly to monitor and oversee the delivery of the CQC action plan and will report progress into the High Quality Care Board (HQCB). The HQCB is one of five programmes that sit within the overarching Trust Improvement Plan.

The following Divisional and organisational groups and committees will also be expected to monitor and track progress against delivery of the CQC action plan

- Divisional Governance Board
- Divisional Management Team
- Trust Infection Prevention and Control Committee
- Health and Safety Committee.

Executive Directors will oversee their operational owners, providing a formal report to the Quality Panel using a standardised template, which will be quality reviewed by the Central Quality Team with a quality assurance assessment of the evidence provided prior to formal reporting to the panel.

Governance structure



Implementing our CQC action plan

The delivery of our CQC action plan will maintain and build on the progress to date in addressing the inspection findings and will ensure the actions will lead to measurable improvements in the quality and safety of care for our patients. Where relevant we will involve patients in the design and delivery of our services so that we better understand what matters to them.

The Chief Executive is ultimately accountable for the implementation of the CQC action plan. The Chief Nurse provides the executive leadership and oversight for the action plan and the Medical Director provides executive leadership for Infection Prevention and Control and will support the Chief Nurse with the delivery of High Quality Care.

This plan will be led by our staff; clinical, operational and corporate services, who will work together to ensure we implement the changes and actions and demonstrate improvements in the safety and quality of patient care.

The Trust is also working closely with NHS Improvement/England through an Improvement Support Director who is supporting the Trust with the implementation of the Trust's Improvement Plan.

To give confidence to our stakeholders, staff and patients that we are making continued improvements, this action plan is underpinned by improvement milestones and metrics to ensure that we can effectively track, monitor and demonstrate progress.

Our plan involves fundamental improvements to services, systems, and processes to ensure we deliver and ensure that we embed and sustain the changes in practice.

CQC action plan Delivery Framework

PROGRAMMES	WORKSTREAMS	PROJECTS			
SAFE & EFFECTIVE CARE	FUNDAMENTALS OF NURSING STANDARDS QUALITY & CARE (MD06, 11, 22, SD04, 06, 07, 08, 17, 18, 19)	Reclaiming Nursing Landscape - Nursing & Midwifery	Pressure Damage	Patient Risk Assessments	
	INFECTION PREVENTION CONTROL (MD01)	Infection Prevention Control			
	CLINICAL SKILLS (MD08, MD24,SD02)	Clinical Skills			
	SAFEGUARDING MCA/DOLS (MD05,WL29)	Safeguarding / MCA / DOLS Compliance	Improvements to Process and Quality		
	COSHH (MD03, MD23)	COSHH Safety			
	EOLC (SD13,SD14,SD15)	EOLC Training	Access to EOLC Specialist		
	SURGERY (SD09)	WHO Checklist			
FLOW & CLINICAL TRANSFORMATION	UNPLANNED CARE (SD01)	ED Majors Patients	Discharge & Process MFFD		
	ACCESS & FLOW (MD02, MD10, MD12, MD14, MD16, MD17)	RTT Performance	Patients in Recovery & Theatre Flow	MSA	Right Patient Right Ward
QUALITY, RISK AND GOVERNANCE	COMPLAINTS MANAGEMENT (SD03)	Improvement to process, Quality & Response Rate			
	INCIDENT MANAGEMENT (WL27,28, 34, 35, 36, 37)	Learning from Deaths	Establish & Sustain Best Practice	Improvement to process, Quality & learning for SI's & Never events	
	CLINICAL RECORDS (MD13, MD19)	Safe, Secure Storage of Records			
	RISK AND CORPORATE GOVERNANCE (MD20,SD16,WL11, 20, 21,25,30)	Corporate Governance	Data / IQPR		
ESTATES & INFRASTRUCTURE	ESTATES & INFRASTRUCTURE (MD04, 07, 15, 18, 21, SD10, WL12)	Estates Strategy	Improve Environment for staff and Patients	Cleaning and Waste Management	
ENGAGEMENT & LEADERSHIP	EXECUTIVE LEADERSHIP (MD09, WL01,02,03,04, 05, 06, 07, 09, 13, 14, 15, 18, 19, 23, 24, 26, 31)	Medical Leadership	Nursing Leadership		
	ENGAGEMENT & CULTURE (SD05, WL10, 16, 17, 22, 33)	Recruitment & Development	Executive Development		
		Exec / Senior Management Engagement	Staff Engagement	Staff Development	

Fundamental Nursing Standards and Quality of Care

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Leads: Karen McIntyre and Simone Hay, Divisional Directors of Nursing

Aim:

- To ensure all patients consistently receive high quality, safe, effective and person-centred care and are not put at risk of avoidable harm.
- To promptly identify changes in a patient's condition and take appropriate action.
- Where relevant ensure all risk assessment and care plans are completed and that local and nationally agreed tools are used.

Standards of care in nursing are important because they recognise the trusted role that a nurse plays. These standards are considered the baseline for quality care.

Inspectors found:

- Services did not audit the National Early Warning Score (NEWS2) tool to ensure compliance.
- Staff did not always complete risk assessments for each patient on admission and arrival to a ward using recognised tools.
- The children's unit was at times taking patients up to the age of 19 and 20 years
- In Medical Care staff did not fully and accurately complete patients' fluid and nutrition charts where needed.
- In Surgery the service did collect safety thermometer data; however, we did not see it displayed on wards or departments.
- On McCulloch ward we saw nine patients did not have their call bell within reach.
- Children's services did not use a nationally recognised tool to monitor children and young people at risk of malnutrition
- The children's unit did not follow the Royal College of Nursing (RCN) guidance for Standards for assessing, measuring and monitoring vital signs in infants, children and young people
- Areas missing within the pre-written care plans used within Dolphin ward. Staff did not complete all care plans on admission and they were dated a few days after the patient had been admitted onto the ward. Evidence found that fluid balance and cannula insertion charts had not been fully completed.

We will:

- MD06 Ensure that risks to patients are identified, documented and regularly reviewed to ensure patients are safe from avoidable harm.
- MD11 Ensure that systems and processes are established and operated effectively to enable the trust to assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity.
- MD22 Ensure there is a clear policy as to the maximum age of young people admitted onto the unit and complete a risk assessment for a young person above the age of 17 admitted onto unit.
- MD23The trust must ensure the doors to the kitchen area on the children's

ward are kept closed at all times and only staff should be able to access the kitchen

- SD04 Ensure that risk assessments are updated, specifically in relation to nutrition and hydration.
- SD06 Ensure that the Planned Care Division monitors compliance with the national early warning score tool.
- SD07 Ensure patient safety information is displayed for patients and visitors to see.
- SD08 Ensure all patients have their call bell within reach.
- SD17 Patients should be assessed by a paediatric dietician and nutritional assessments in place for all patients.
- SD18 Ensure that there is record patient's height and weight on admission to the ward
- SD19 Ensure all staff complete all care plans, assessments and charts in patient records.
- Implement quality and safety Boards on every ward
- Put in place a Ward to Board Quality Standards Improvement and Assurance Framework
- Ensure compliance with risk assessments and fundamentals of nursing care
- Implement a programme of nursing standards audits across the Trust
- Implement a bi-weekly Matrons Quality report to Heads of Nursing/ Midwifery
- Implement a monthly Heads of Nursing/ Midwifery Quality report to the Divisional Directors of Nursing
- Agree the role of perfect ward to support assurance audits
- Implement a monthly Chief Nurse standards quality report from Divisional Directors of Nursing
- Implement the principles of nursing practice setting out what everyone, from nursing staff to patients, can expect from nursing.
- Where relevant ensure all risk assessment and care plans are completed and that local and National agreed tools are used.
- Ensure NEWS 2 audits achieving 90% compliance of audit undertaken
- Ensure robust governance and processes are in place to proactively manage risk assessments.

We will be using a range of indicators to measure this including:

Indicator	Successful when we achieve
Compliance with Nursing Quality audits Year 1 Year 2	 85% 95%
Timely completion of patient level risk assessments and care planning, including the use of 'turn charts'	90%
NEWS 2 audit compliance and appropriate actions taken	90%
Develop and implement a policy as to the maximum age of young people admitted onto the unit and complete a risk assessment for a young person above the age of 17 admitted onto unit	July 2020
Quality Boards will be visible on every ward	August 2020
A Paediatric Dietician will be recruited	September 2020
Nutritional risk assessments will be undertaken for all paediatric In-patients	90%
All patients will have a call bell within reach.	100%
Implement the Royal College of Nursing (RCN) guidance for Standards for assessing, measuring and monitoring vital signs in infants, children and young people	July 2020
Nursing care plans, assessments and charts within the paediatric ward will always be held within in patient records.	90%
All patients (adult and children) who require fluid balance monitoring will have this completed accurately	90%

Infection Prevention and Control

Executive Lead: David Sulch, Medical Director

Operational Lead: Ian Hosein, Director of Infection Prevention and Control

Aim:

- To reduce hospital acquired infections and prevent the spread of infections within the Trust. As part of our everyday duty of care to ensure that no harm is done to patients, visitors or staff.

Inspectors found:

- The service did not control infection risk in line with best practice. Staff did not use equipment and control measures to protect patients, themselves and others from infection
- Staff routinely did not always clean their hands, use personal protective equipment correctly, such as gloves and aprons, manage linen or were bare below the elbows (BBE) in clinical areas in line with trust policy and national guidance.

We will:

- MD01 Ensure all staff are compliant with infection prevention and control practices and procedures, including hand hygiene, and correct use of personal protective equipment PPE.
- Introduce a practical Mandatory Training module to complement the current e-learning module, with each to be taken once every two years.
- Update and implement the existing Infection Prevention and Control Improvement Plan
- Ensure all senior medical leaders undertake ward reviews focused specifically on infection prevention and control in their areas.
- Ensure PPE and BBE audits are undertaken by the Infection Prevention and Control Team.
- Implement the IPC champion initiative Trust wide
- Ensure that IPC audit/assessments and Post Infection Reviews are completed in a timely manner.
- Ensure robust governance and processes are in place to proactively manage IPC processes.
- Ensure that the actions in the IPC Improvement Plan are delivered on time, and that assurance is subsequently obtained to demonstrate that the actions have had the desired effect.

We will use a range of indicator measure this including:

Indicator	Successful when we achieve
Hand Hygiene Audit compliance	**95%**
IPC Improvement Plan – Actions completed and assurance given according to declared timescales	**100%**
Update and implement the Trust IPC improvement Plan	**July 2020**

Clinical Skills

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best and Kevin Cairney Divisional Directors of Operations

Aim:

- Embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training
- Ensure staff complete paediatric life support training

Inspectors found:

- In medical care the 85% target was met for one of the nine mandatory training modules for which medical staff were eligible.
- Paediatric life support training was below the trust target of 85% in children's and young people's services
- In urgent and emergency care
  - 85% target was met for four of the ten mandatory training modules for which medical staff were eligible.
  - 85% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.
  - 85% target was met for two of the four safeguarding training modules for which medical staff were eligible.

We will:

- MD08 The trust must embed an effective system to ensure the service meets the trust targets for mandatory training, including safeguarding training to protect vulnerable adults and children and young people from harm and abuse.
- MD24 Ensure all staff complete paediatric life support training.
- SD02 The Emergency service should ensure that staff are compliant with mandatory training and improve compliance in safeguarding and Mental Capacity Act training
- Monitor compliance of mandatory training via Trust Workforce Reports.
- Achieve 85% compliance in paediatric life support training

We will be using a range of indicators to measure this including:

Indicator	Successful when we achieve
Compliance for all clinical skills training, including safeguarding adult and children, Mental Capacity Act for all relevant staff	**85%**
Paediatric Life support training	**85%**
An effective system for monitoring compliance with mandatory training will be embedded	**July 2020**

Safeguarding

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Bridget Fordham, Head of Safeguarding

Aim:

Patients will be protected from avoidable harm and abuse and statutory safeguarding requirements will be met.

- All staff will receive training on how to recognise and report abuse at the level expected of their roles, as set out by the intercollegiate documents and be able to apply it in practice.
- All staff will understand how to protect patients from abuse and will engage in the necessary safeguarding processes to remove or reduce risk of abuse or neglect.
- Patients will be protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.
- Safeguarding champions will be developed across the Trust, supporting the embedding of safeguarding practices in all areas.

Inspectors found

- The trust failed to notify the Care Quality Commission of safeguarding incidents, where the police had been called.
- Areas around medical care services were unlocked and contained cleaning products hazardous to health, which could be accessed. This is a safeguarding matter however actions pertaining to the safety of products are addressed through COSHH.
- Patients were regularly being brought from the emergency department to wards and placed in a corridor while waiting for their allocated bed to become available and those patients could not call nursing staff for help or have access to drinks. This will be monitored via the Access and Flow one pager.
- Staff did not change patients' positions regularly to reduce the risk of pressure damage. This will be monitored via the Fundamental Nursing Standards and Quality of Care one pager.
- We received information that showed the senior leadership team were aware of the issues on Dickens Ward, including those we identified. These issues had been raised with the senior leadership team in June and July 2019

We will:

- MD05 Ensure that systems and processes are established and operated effectively to prevent abuse of service users.
- The Chief Nurse will commission a Trust wide review of safeguarding
- Ensure that there are robust policies and procedures in place to support and inform staff.
- Ensure that people who use our services are at the centre of safeguarding and are protected from discrimination.
- Ensure that staff have received up-to-date training in all safeguarding subjects, including Prevent and MCA, at levels appropriate to role.
- Ensure that safeguarding adults, children and young people at risk is given sufficient priority in the Trust by ensuring that there are strong governance and reporting structures in place.
- Ensure that staff will take steps to prevent abuse or discrimination that might cause avoidable harm, responding appropriately to any signs

or allegations of abuse and work effectively with others, including people using the service, to agree and implement protection plans.

- Longer term, ensure that there is active and appropriate engagement in local safeguarding procedures and multiagency working such as the Kent and Medway Safeguarding Adults Board, Medway Safeguarding Children's Partnership and the Kent Safeguarding Children's Partnership, PREVENT Boards, MARAC and Community Safety Partnerships
- Ensure that Safeguarding supervision is available for all staff involved in safeguarding cases across the Trust.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Implement systems and processes to prevent abuse of service users	**Sept 2020**
Compliance for safeguarding adult and children training	**85%**
Updated policy and procedure	**Annually with regular review for changes in national policy**
Commission a review of safeguarding	**July 2020**

COSHH

Executive Lead: Gary Lupton, Executive Director of Estates and Facilities

Operational Lead: Paul Norman-Brown, Head of Health and Safety and Compliance

Aim:

- To ensure that premises used by the service provider for the care of patients are safe to use for their intended purpose.
- Ensure that all staff are aware of the need to keep hazardous substances secure and the where relevant all cupboards and doors must be locked to prevent the public from accessing hazardous materials, such as blood and body fluids and chemicals.

Inspectors found:

- Hazardous substances and waste were not stored in line with regulations. Not all areas of the hospital were secure.

We Will:

- MD03 Ensure all substances hazardous to health are stored and managed in line with regulations.
- Ensure that all cleaning cupboards, linen stores, sluice rooms and kitchens where relevant are secure.
- Ensure all COSHH products are stored securely
- Ensure education and training is in place informing, instructing and training employees about risks and precautions to be taken
- Ensure that the Trust as an effective procedure and policy
- Ensure effective monitoring/auditing of COSHH compliance is in place

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
All substances hazardous to health are stored in line with regulations	90%

End of Life Care

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Julie Murray, Associate Director of Nursing

Aim:

- Continue to improve the experience for patients and their loved ones at the end of their life.
- Improve compliance with End of Life Care training.

Death and dying are inevitable. The quality and accessibility of this care will affect all of us. Personalised care at end of life will result in a better experience, tailored around what really matters to the person.

Inspectors found:

- End of life care staff said their current arrangement for medical cover worked however a dedicated specialist palliative care consultant would help the service continue improving.
- The service provided training for ward staff in end of life care however, over the past year this had been more limited than the service would have liked.
- The service provided end of life care training in the trust wide induction programme so that all staff had at least an outline of end of life care.
- It is felt due to pressures on the trust as a whole this resulted in a poor attendance at training sessions for end of life care.
- The trust had link nurses and link clinical support workers for end of life care on each ward. Link staff would like more formal training to be able to support their wards more effectively.

We Will:

- SD13 Improve greater access to a specialist palliative care consultant.
- SD14 Improve the capacity for delivering end of life care training for staff across the trust.
- SD15 Increase staff attendance at end of life care training courses.
- Ensure all relevant staff are prepared to care for patients at end of life
- Develop and implement a Trust end of life care education and training plan
- Reduce variation and inequalities in end of life care
- Improve outcomes and patient experience for patients at end of life
- Ensure the care people receive, reaching the end of their life, is aligned to their needs and preferences.
- Implement a Trust wide EOL Steering group and work with partners across the system to improve end of life care taking a whole system approach
- Ensure delivery of excellent end of life care
- Monitor compliance of mandatory training via Trust Workforce Reports
- Monitoring compliance with EoLC training for staff across the Trust.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
SLA in place for palliative care (post currently vacant)	**August 2020**
Develop and implement EoLC Training plan	**August 2020**
The service will maintain its risk register, so it reflects when risks were last reviewed	**May 2020**
Compliance for EoLC training	**85%**

Surgery

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best, Divisional Director of Operations and Simone Hay, Divisional Director of Nursing

Aim:

- To apply the WHO checklist recommendations and the full checklist process and a standard operating process. This will be clinically led and will be overseen via the Divisional governance process.

Inspectors Found

- Audit data provided from the briefing and de-briefing stages of the WHO Safer Surgery Checklist only showed data collected from October 2019.

We Will:

- MD20 - Introduce systems and processes to proactively identify and address risks to the service.SD09 Ensure compliance with the briefing and de-briefing stages of the World Health Organisation Safer Surgery Checklist.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
The **briefing and de-briefing stages of the World Health Organisation Safer Surgery Checklist** will be consistently applied	**100% compliance**
Observational Audit of WHO checklist practice	**100%**
Review systems and process for identifying risk	**August 2020**
Review and update risk register	**August 2020**

Unplanned Care

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Lead: Kevin Cairney, Divisonal Director of Operations

Aim:

- We aim to reduce the delay for patients who are on admitted pathways in the emergency access pathway. Through a combined programme of work with partners and within the Trust we aim to reduce the aggregated patient delay from decision to admit (DTA) to admission for all medical, surgical and mental health pathways. This will be through the effective use of assessment areas and non-admission pathways, taking full advantage of the Same Day Emergency Care (SDEC) and short stay assessment models at the Trust. We aim to enhance the offer of our SDEC so this runs 12 hours a day, seven day a week. We also aim to move all our receiving teams to the Emergency Department (ED) to work alongside the ED team when reviewing patients for admissions; this will improve patient quality and safety in decision making for admission and will reduce the delay for a decision to admit.
- We aim to ensure the endoscopy unit has the correct numbers of staff to avoid staff working extra hours.

Inspectors found

- During our inspection, multiple patients were receiving treatment, trying to sleep or waiting within the majors waiting area.
- We observed one patient had been in the majors waiting area for over 20 hours and another for 14 hours awaiting specialist review.
- Patients had spent the night in the 'majors lite' waiting room sat on a chair beneath bright hospital lighting.
- The endoscopy unit had 17 members of staff (15 whole time equivalent). This included 14 registered nurses and three clinical support workers. The planned number of staff in the endoscopy unit had not always been achieved, which led to staff having to work extra hours. Staff classified the extra hours worked as 'time off in lieu', however staff reported they had not been able to take back any time, due to the unit being continually short staffed. We looked at the extra hours accrued by 14 of the 17 nursing staff, which ranged from 30 minutes to 27 hours 15 minutes and totalled 169 additional hours that staff had worked. We also noted the senior sister for the unit had worked an additional 70 hours. Working excessive hours can have a detrimental effect on staff physical and mental well-being.

We will:

- SD01 The service should consider how to reduce the length of time patients wait in the majors waiting area, awaiting specialist review or admission.
- SD05 The service should ensure that there are sufficient numbers of appropriately skilled staff to keep patients safe from avoidable harm
- The service will review how best to reduce the length of time patients wait in the majors waiting area, awaiting specialist review or admission.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Reduce the length of time patients wait in majors area awaiting specialist review for admission	July 2020
DTA to admission	**<2 hours**
SDEC usage (7 day services)	**30-40 pts per day**
Triage to referral time	**<1 hour**
Use of Clinical Decision Unit	**20-30 per pts per day**
There are sufficient number of appropriate skilled staff to keep patients safe from avoidable harm	**October 2020**

Access and Flow

Executive Lead: Harvey McEnroe, Chief Operating Officer

Operational Leads: Benn Best and Kevin Cairney, Divisional Directors of Operations

Aim:

- Improve the quality of services provided to patient and outcomes for patients by ensuring that delays in the elective and emergency access pathway are addressed through improvements in discharge planning across all inpatient areas, reduction in the delay of admission and improvements in the use of day case.
- By effectively leading this work we will ensure that we reduce harm and improve patient experience, specifically in the areas of Mixed Sex breaches and improvements in patient dignity, which is one of the biggest drivers for flow improvement.

Inspectors found

- Patients are sharing sleeping accommodation with others of the opposite sex. We requested the trust's standard operating procedure for using recovery as an area for escalation. The policy recognised that by nursing patients in a recovery, that patients remain in a mixed sex area, and curtains around bed space to remain pulled if patient prefers and safety allows. The trust has reported no mix sex breaches for the last 12 months for this area. Patients' dignity and respect was compromised when in recovery overnight because of the other patients recovering from surgery in the same room.
- We looked at the patient flow policy (June 2019), which says that patients transferred to Dickens ward should be discharged from there on the day or within 48 hours. All patients admitted to Dickens ward should be 'medically fit for discharge' (MFFD). On the day of inspection, we found patients that had been on Dickens ward for two weeks.
- From October 2018 to September 2019, the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently worse than the England average.
- Between September 2018 and November 2019, 418 patients were in recovery after midnight. The trust target was zero.
- Between September 2018 and November 2019 theatre utilisation for the day surgery theatres was 75% which was less than the trust target of 85%. In the same period, the average theatre utilisation for main theatres was equal to the trust target of 85%.

We Will:

- MD02 Ensure we meet the Department of Health and Social Care's standard on eliminating mixed sex accommodation, except where it is in the overall best interests of the patient or reflects the patient's choice.
- MD10 Ensure we have an effective system to ensure only clinically suitable patients were cared for in the escalation areas.
- MD12 Ensure it has effective systems and processes to assess

and monitor the risk of harm to patients because of waiting times from referral to treatment and arrangements to admit, treat and discharge patients.

- MD14 ensure that all reasonable steps are being taken to improve the quality of service, specifically in relation to access to treatment and waiting times.
- MD16 Ensure that all reasonable steps are being taken to improve the quality of service, specifically in relation to access to treatment and waiting times.
- MD17 The trust must consider ways to improve patient flow within theatres and recovery.
- SD11 Patient discharges should not be delayed once they are deemed medically ready to transfer to a ward.
- SD12 Out of hour discharges should be avoided in line with the Guidelines for the Provision of Intensive Care Services, 2015.
- Monitoring of Mixed Sex Accommodation Breaches month by month including trajectory
- Graphical and numerical data showing trust performance against constitutional standards.
- Monitoring of Recovery Breaches month by month including trajectory
- Monitoring of Access Performance targets (eg four-hour waits, RTT and theatre utilisation)

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Eliminate MSA	Zero variance against trajectory
Avoid patients staying overnight in recovery	Zero variance against trajectory
Effective systems and processes to assess and monitor the risk of harm to patients because of waiting times from referral to treatment and arrangements to admit, treat and discharge patients will be in place	July 2020
Patient discharges from theatre will not be delayed once they are deemed medically ready to transfer to a ward	June 2020
Out of hours discharges from Critical Care areas will be avoided	Zero variance against trajectory
Use of day case.	20% improvement
MFFD	<30
Time from Decision to Admit to admission	<2 hours
RTT standard	8Ph

Complaints Management

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Philip Kemp, Associate Director of Quality and Patient Safety

Aim:

- Place the patient first and ensure the Trust has a patient friendly complaints process which complies with national guidance.
- Ensure that complaints are responded to in a timely manner, investigated thoroughly and that feedback effectively and systematically for and learning from complaints informs improvement in patient experience.
- Take a person centred approach to complaints management

Patient experience is positive when staff give care that is compassionate, involves patients in decision-making and provides them with good emotional support

Inspectors found:

- From September 2018 to August 2019, the trust received 147 complaints in relation to medicine at the trust (19.3% of total complaints received by the trust). The trust took an average of 35 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be closed within 30 working days.

We Will:

- SD03 the Unplanned Care Division should implement an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy. Identify a way to process complaints that improves quality and effectively responds within agreed timeframes
- Undertake a Trust wide review of complaints management across the Trust
- Put the patient first and take a patient friendly and person centred approach to complaints management
- Implement real time patient feedback
- Ensure real time patient experience and feedback is displayed on all wards and clinical areas
- Improve our systems and processes to ensure the Trust has an effective and efficient complaint management service
- Analyse and triangulate complaints data with other quality measures.
- Create a culture of ensuring lessons are learnt from complainants feedback and this is used to improve services
- Ensure that there is evidence to demonstrate that practice has changed following complaints
- Patients are given information about the range of ways they can provide feedback

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Undertake Trust wide review of complaints management	**September 2020**
The Unplanned Care Division will have an effective system to respond to patient complaints in compliance with timelines set in the trust's complaint policy, including identifying a way to process complaints that improves quality and effectively responds within agreed timeframes	**September 2020**
Patient feedback is displayed on all wards	**September 2020**
Evidence is available to demonstrate changes from lessons learnt and how services have improved	**November 2020**
Compliance with 40 working day complaint response for all amber complaints	**85%**

Incident Management

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Cherrell Taylor, Head of Patient Safety

Aim:

- To ensure that learning from incidents is implemented to reduce the risk of reoccurrence and that lessons and learning is disseminated and shared across the Trust.

- Identifying incidents, recognising the needs of those affected, examining what happened to understand the causes and responding with action to mitigate risks remain essential to improving the safety and quality of patient care in Medway.

Inspectors found:

- There was minimal evidence of learning and reflective practice.
- There was limited assurance that incidents were being reported at all or in a timely manner.
- Evidence demonstrated incidents were not being responded to in a timely way and there was a large backlog of incidents which had not been reviewed.
- There was sporadic innovation or service development, limited application of improvement methodologies, and improvement was not a priority among staff and leaders.

We Will:

- WL27 Embed the Serious Incident Management process, including Never Events, to implement a learning and improvement framework.
- WL34 Implement a process of learning and reflective practice from incidents/never events
- WL35 Ensure incidents are reported in a timely manner and responded to promptly
- WL36 Ensure a process is in place to address the incident backlog and monitor and sustain this going forward. Improve analysis of incidents to allow for thematic analysis and identification of recurrent themes
- Develop and implement a Serious Incident and learning framework aligned to national policy by October 2020
- Review current practice and establish minimum standards for low and high level incident reporting and distribution, with improved communication to staff
- Ensure timely investigation of incidents and ensure that the quality of investigations is of a high standard and meets nationally recommended principles
- Design systems to support the needs of those affected from patient safety incidents
- Ensure patients and families are offered the opportunity to participate in SI investigations or share their story and experience
- Take a risk based proportionate approach to investigation of patient safety incidents
- Ensure lessons and learning is disseminated across the Trust
- Ensure all actions from serious incident investigations are completed with evidence provided

- Facilitate a programme of staff forums to share lessons and learning from incidents, investigations and near misses
- Ensure there is a robust process in place to support analysis of incidents and develop thematic divisional reports to inform improvement actions
- Implement a training programme in serious incident investigation management to ensure the Trust has a highly skilled investigation team within the Trust

The following actions appear within the well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

- WL37 The executive team must take a proactive approach to innovation and improvement

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
The Serious Incident Management process, including Never Events, to implement a learning and improvement framework will be embedded	**September 2020**
A process of learning and reflective practice from incidents/never events will be implemented	**July 2020**
Incidents will reported in a timely manner and responded to promptly	**July 2020**
A process is in place to address the incident backlog and monitor and sustain this going forward	**May 2020**
Analysis of incidents to allow for thematic analysis and identification of recurrent themes will be improved.	**June 2020**

Clinical Records

Executive Lead: Gurjit Mahil, Deputy Chief Executive

Operational Lead: Karen Persad, General Manager

Aim:

- To ensure patient care is not impacted by storage, completion or accessibility of clinical records.
- To ensure that staff meet the quality standards so we are able to support safe and effective care.

Inspectors found

- Patients medical care records were stored in trolleys with locks; however, they were found not locked during the inspection. On the surgical assessment unit, 18 sets of patient records were found in an unlocked office. On the post-operative care unit, pre-assessment unit Pembroke ward and McCulloch wards records were within trolleys, but the trolleys were unlocked. In addition, on McCulloch ward records were found left on top of and next to the trolley.

We Will:

- MD13 Ensure that medical records and confidential patient information are stored securely to ensure patient confidentiality.
- MD19 Protect our patients by ensuring that records relating to the care and treatment for each patient are kept securely and are an accurate and complete record
- Ensure records are accessible to authorised staff in order that they may deliver, to people, care and treatment in a way that meets their needs and keeps them safe.
- Identify areas of non-compliance for clinical record storage and barriers to compliance
- Review capacity of corporate secure record storage facilities
- Review the audit process for clinical records to improve the quality of clinical records
- Identify training needs for clinical groups and identify feedback forums to support learning
- Agree national and local quality standards so we can track our performance
- Develop action plan for remedial action at area level to enable compliance
- Review the temporary notes process.
- Link in with the Digital strategy for EPR.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Medical records and confidential patient information are stored securely to ensure patient confidentiality.	90%
Records relating to the care and treatment for each patient are kept securely and are an accurate and complete record	90%

Risk and Corporate Governance

Executive Lead: Gurjit Mahil, Deputy Chief Executive

Operational Leads: Gemma Brignall and David Seabrooke

- **Aim:** To handle risk throughout the organisation through effective systems and processes that are used and understood by our staff.
- To ensure that information is provided to our Board to assure them we are operating effectively and our patients and staff are being well cared for.

Inspectors found:

- The risk register did not accurately reflect all the risks we identified.
- The service monitored a range of performance and outcome measures each month. However, we could not always see where action had been taken to address poor performance.
- The End of Life care services risk register showed that one of the three risks had not been reviewed since 2016; however this we did see that this risk that related to staff training had been discussed at the service governance meetings.

We Will:

- MD20 - Introduce systems and processes to proactively identify and address risks to the service. This is address through the Surgical Project page.
- SD16 The service should maintain their risk register, so it reflects when they last reviewed risks. This is address through the End of Life Care project page.
- Continue to monitor compliance with the risk management policy
- Review all risk register controls and RAG ratings
- Introduce a refreshed version of the Trust Integrated Quality and Performance Report (IQPR) will be available at the May 2020 Board.
- Arrange for regular executive review of risk registers will commence from April 2020. Enable the Board to confirm its current risk appetite at its May 2020 meeting
- Organise monthly executive corporate risk register review meetings first meeting on the 17th of April 2020. The group is to provide oversight to the Executive Group about the effectiveness of corporate compliance and risk management arrangements. Divisional teams will also be required.
- Commence a review of the Board Assurance Framework
- Undertake a review of the Corporate Governance Team Structure

The following actions appear within the well led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality improvement Plan.

- WL11 Review of IQPR
- WL20 Ensure there is a process in place for the board to receive risks/issues and reports on significant information
- WL21 Ensure emerging themes and trends from top risks are presented to the board
- WL25 Ensure corporate risk register is presented to the board on a monthly basis
- WL30 Ensure information used in reporting and performance management is accurate, valid, reliable, timely and relevant

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
WL11 Review of IQPR	**June 2020**
WL20 There is a process in place for the board to receive risks/issues and reports on significant information	**July 2020**
WL21 Emerging themes and trends from top risks are presented to the board	**June 2020**
WL25 Ensure corporate risk register is presented to the board on a monthly basis	**June 2020**
WL30 Information used in reporting and performance management is accurate, valid, reliable, timely and relevant	**Sept 2020**

Estates and Infrastructure

Executive Lead: Gary Lupton, Executive Director of Estates and Facilities

Operational Lead: Paul Vidler, Deputy Director of Estates and Facilities

Aim:

- To address issues with the estate and facilities services to ensure patient and staff safety

Inspectors found

- There were no key coded or swipe access doors to access places other than the paediatric section within the urgent and emergency care department. This meant unauthorised personnel could access all areas.
- Flooring, walls, fixtures, and fittings were not intact on some of the wards visited.
- The trust did not meet National Specifications for Cleanliness in the NHS regarding the frequency of audits in theatres.
- Equipment was not always stored in a way to minimise the risk of cross infection.
- Staff in theatres did not always clean equipment after patient contact to ensure it was safe to use.
- Staff did not always dispose of body fluids quickly to minimise the risk of cross infection.
- The hospital did not have a dedicated paediatric operating theatre or recovery area.
- The design of the medical high dependency unit did not follow national guidance.

We Will:

- MD04 Ensure access to the adult emergency department is restricted to only those authorised.
- MD07 Ensure the flooring and walls on medical wards (Wakeley and Arethusa) meet the Department of Health and Social Care Health Building Note 00-09.
- MD15 Ensure they meet with the national specifications for cleanliness on the frequency of cleaning audits carried out in all high-risk areas.
- MD18 Ensure waste is handled in line with national guidelines – relating to Phoenix ward as used disposal gloves in waste bin. Staff understanding of waste segregation. MD21 Ensure children in recovery are not placed next to adults with only a curtain for privacy. Paediatric Strategy currently being developed by Planned Care
- SD10 The service should make sure the high dependency unit meet the minimum bed space dimensions as recommended in national guidance. Part of clinical strategy.
- We will use competent persons to devise and implement compliant solutions for the ‘must do’ actions, and will address the ‘should-do’ and ‘would-like to do’ actions as far as is reasonably practicable.

The following action appears within the Well Led section of the CQC Inspection Report and will be addressed by the Trusts Overarching Quality Improvement Plan:

- WL12 The trust must ensure there is a current Estates Strategy

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Physical and administrative controls in place (two stage strategy is currently being implemented)	Access control system i commissioned and staff
Refurbishment of Wakeley and Arethusa Wards' floors and walls	Works completed and signed off.
Compliant cleaning audits process in place for theatres	Three months continual audit history
Correct waste segregation in Phoenix Ward	85% staff trained and successful compositional waste audit
Adequate segregation between adults and children in place	Physical or administrative separation achieved
Options appraisal to be undertaken to meet standards in HDU	**Options appraisal completed and considered**

Executive Leadership

Executive Lead: James Devine, Chief Executive

Supported by Ian Renwick, Improvement Director

Aim:

- To ensure our current and future Executive Team and Board are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

We Will:

- WL01 All Executive leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL02 The Trust must ensure there is stability in the Executive leadership team
- WL03 Executive leaders must ensure they are able to identify risk and issues described by staff
- WL04 Ensure a programme of board development is in place
- WL05 The Trust must ensure they recruit a company secretary
- WL06 Ensure Non-Executive Directors have a good understanding of their roles and responsibilities
- WL09 Ensure all staff are aware of trust strategies and how their role contributes to achieving the strategy
- WL14 Ensure Executive Team complies with the Trust culture of fairness, openness, transparency, honesty, challenge and candour.
- WL15 Ensure visibility of the Executive Team
- WL19 Ensure the Executive Team are aware of the significance of the regulatory requirements of care and their duty to report significant incidents to the CQC
- WL20 Ensure there is a process in place for the board to receive risks/issues and reports on significant information
- WL23 Ensure Gemba Walkabouts are effective and identify where poor-quality care is being delivered. Ensure results are acted upon and evidenced
- WL25 Ensure corporate risk register is presented to the board on a monthly basis
- WL26 Ensure Executive Team and senior leaders are aware of the process of escalating risks onto the corporate risk register
- WL27 Ensure that the Trust embeds the serious incident management process, including Never Events, to implement a learning and improvement framework
- WL30 Ensure information used in reporting and performance management is accurate, valid, reliable, timely and relevant
- WL31 Ensure data or notifications where required are consistently submitted to external organisations
- WL37 The Executive Team must take a proactive approach to innovation and improvement

- Board effectiveness assessment completed internally by the Trust on a yearly basis and three-yearly by an external accountancy firm
- Ensure Board Development Programme in place

Medical Leadership

Executive and Operational Lead: David Sulch, Medical Director

Aim:

- To ensure our current and future medical leaders are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

We Will:

- WL01 All medical leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL14 Ensure that all medical staff adhere to a Trust culture of fairness, openness, transparency, honesty, challenge and candour
- WL28 Ensuring a consistent approach across specialities from learning from deaths
- Development of the Clinical Engagement Strategy with a specific focus on how organisational structures can empower and enhance clinical leadership
- Implantation of Leadership Development Programme
- Reorganise operational structure to ensure that each Division, Care Group and speciality has a single named clinical lead
- Review the results of the recent Medical Engagement Scale exercise and address accordingly
- Develop Clinical Advisory Groups for all critical Trust committees
- Facilitate leadership training both externally and internally for key medical leaders

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Completed and approved Clinical Engagement Strategy	**July 2020**
Medical leadership development programme and strategy	**August 2020**
Review of medical leadership within organisational structure	**June 2020**
Introduction of Medical Cabinet and refresh of Clinical Council	**May 2020**
Relaunch internal professional standards	**June 2020**
There will be a consistent approach across specialities from learning from deaths	**July 2020**

Nursing Leadership

Executive Lead: Jane Murkin, Chief Nurse (Interim)

Operational Lead: Katy White, Director of Nursing Quality and Professional Standards

Aim:

- To ensure that the Trust has in place highly visible experienced, empowered, knowledgeable, confident, competent and compassionate nursing and midwifery leaders at all levels, and across all wards, departments, care groups and divisions.
- To ensure that the Trust has nursing and midwifery leaders who can inspire and effectively lead our nurses to deliver consistently high quality care to patients and their loved ones.

Inspectors found:

- Not all nursing and midwifery staff have completed the necessary competency training for their roles.

We will:

- MD09 Ensure nursing staff are appropriately skilled and competent to carry out their roles, to provide safe care, in the medical care.
- WL01 All Nursing leaders must have the necessary experience, knowledge, capacity and capability to lead effectively.
- WL07 Launch and implement the Reclaiming Nursing Landscape
- WL13 The trust must ensure there is a current Patient Experience Strategy
- WL18 Ensure patients are referred to by name and not bed numbers or clinical conditions
- WL24 Ensure visibility of Senior Nursing Staff on wards
- WL26 Ensure senior nursing leaders are aware of the process of escalating risks on to the risk registers
- Design and implement a Ward to Board Nursing and Midwifery Assurance Framework
- Design, develop and implement a Nursing Strategy
- Strengthen nursing and midwifery leadership across the Trust
- Renew the reputation of our profession
- Commission and implement a Matron leadership development programme
- Commission and implement a Heads of Nursing leadership development programme
- Implement a Matron unique identifier uniform to support visible leadership
- Ensure all our nurses, midwives and care support staff have a voice and are empowered and enabled to be heard
- Implement a programme of senior nurse forums
- Have a workforce that is fit for the future through the development of a nursing and midwifery workforce, education and training plan which includes roll out of the care certificate for nursing and midwifery support staff
- Continue to implement the Ward Managers Leadership for Quality & Patient Safety programme for all Ward Managers across the Trust
- Revise the Matron and Head of Nursing job descriptions

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Develop a programme of education and training to ensure all nursing and midwifery staff are appropriately skilled for their role	**September 2020**
Commission and develop leadership programmes for all levels of nursing and midwifery staff in leadership roles	**November 2020**
Implement Reclaiming the Nursing Landscape	**March 2020**
Develop a patient experience strategy	**Sept 2020**
Revisit the 'not just a number campaign'	**July 2020**
Review the senior nursing and midwifery management structure	**Sept 2020**
Roll out of training programme to develop senior nursing and midwifery staff on identifying, recording, managing and escalating risks	**August 2020**
Senior leaders will have ward visits built into their job plans	**July 2020**

Engagement and Culture

Executive Lead: Leon Hinton, Executive Director of HR & OD

Operational Lead: Lisa Webb, Head of Leadership and OD

Aim:

- To ensure all staff live by our values of being bold; that every person counts; to be sharing and open; and being together through being inclusive and responsible.
- That these values are embedded in our culture, our language, how we carry out our roles, and our behaviours to one another and to our patients.

Inspectors found

- Staff did not feel all leaders where visible accessible and approachable and not all staff felt respected supported and valued.
- Not all services had a culture that provided high quality sustainable care. Services were not always focused on the need of the patients receiving care.
- The Trust strategy had not been translated into meaningful and measurable meaningful plans at all levels of the Trust.

We Will:

- Develop our existing leaders with a key focus on developing the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Monitor safe staffing numbers and ensure correct resources demand for skills are met.
- Ensure governance processes are in place to enable progress against delivery of strategies. The CQC highlighted the People Strategy as best practice in layout and the indication of its governance process and measurements. Develop a process whereby all strategies follow this example, this will ensure our strategies dovetail into the CQC Action Plan.
- Measurements of the Trust's culture will be addressed through the Executives and Trust Board meetings. The following areas will be monitored:
    - Staff survey theme progress;
    - Staff Friends and Family Test (FFT);
    - Response rates to the staff survey and the FFT.
- Ongoing and regular review of the culture programmes which have now been running in the Trust since April 2019.
- Monitoring of the engagement of staff attending the NHS England/Improvement culture and leadership programme workshops and listening events.
- Monitoring of the number of staff who anonymously contact the freedom to speak up guardians.
- The introduction of ground rules at start of meetings, this should be a standard agenda item. Stating that only emergency calls can be answered, behaviours and expectations of the group.

The following actions appear within the Well Led section of the CQC Inspection Report and will be addressed by the Trust overarching Quality Improvement Plan

- WL10 The Trust must ensure progress against delivery of the strategies must be consistently monitored/reviewed and evidence sourced
- WL14 Ensure a Trust culture of fairness, openness, transparency, honesty, challenge and candour.
- WL16 The trust must eliminate silo working across the organisation
- WL17 Ensure all staff are aware of the freedom to speak up guardians and how to contact them
- WL22 Ensure senior leaders are engaged at meetings and not distracted by choosing to read and respond to emails on mobile phones
- WL33 Ensure concerns raised by staff are dealt with especially around bullying and harassment

We will use a range of indicators to measure this including

Indicator	Successful when we achieve
Trust Board, Executive, Divisional reports and papers demonstrate consistency and alignment to relevant strategies	**All papers demonstrate consistent alignment to core strategy delivery**
Trust strategies have clear, defined delivery plans	**Delivery plans in place**
Staff survey score – Equality, Diversity and Inclusion (2019 8.9)	**9**
Staff survey score – Health and Wellbeing (2019 5.6)	**5.9**
Staff survey score – Immediate Managers (2019 6.6)	**6.8**
Staff survey score – Morale (2019 5.8)	**6.1**
Staff survey score – Quality of Appraisals (2019 5.7)	**5.6 (achieving)**
Staff survey score – Quality of Care (2019 7.4)	**7.5**
Staff survey score – Safe environment – bullying and harassment (2019 7.8)	**7.9**
Staff survey score – Safe Environment - Violence (2019 9.4)	**9.4 (achieving)**
Staff survey score – Safety Culture (2019 6.4)	**6.7**
Staff survey score – Staff Engagement (2019 6.8)	**7**
Staff survey score – Team Working (2019 6.6)	**6.6 (achieving)**
Staff survey response rate (2019 41%)	**44%**
Staff FFT recommend as place to work (2019/20 Q4 59%)	**63%**
Staff FFT recommend as place for treatment (2019/20 Q4 68%)	**72%**
Staff FFT response rate	
Staff engagement at NHSEI culture and leadership events	**60%**
Freedom to speak up concerns – raised anonymously	
Freedom to speak up concerns – suffered detriment 0%	**0% (achieving)**
Our existing leaders will be supported to develop the following the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills	**September 2020**

How we will communicate our CQC Improvement Plan achievements

Communications and engagement

Building support for the CQC Improvement Plan requires a genuine culture change. Executive, managerial and clinical engagement and ownership are crucial elements to support successful implementation. Communications to engage all stakeholders in the importance of quality, patient safety and the priorities within this plan must be well conceived and consistently repeated across the organisation with all staff actively involved and engaged in the implementation phase. It will also be important to engage external audiences in progress. The programme will require us to maximise the potential of existing communications channels and create new and bespoke communications and engagement platforms.

Internal Core Channels

- Senior manager briefings
- All staff briefings by the chief executive
- Chief Executive's weekly message
- Staff app
- Monday bulletin to all staff
- News@Medway
- Intranet
- Social media staff groups
- Theme of the Month

External channels

- Community engagement events
- News@Medway magazine
- Member events programme
- Governor engagement opportunities in the community
- Presentations to key stakeholders e.g. local authority scrutiny committees
- MP and councillor briefings
- Media briefings
- Social media
- website

Bespoke and new opportunities

- New branding and strapline to promote the improvement plan
- Suite of materials to engage staff
- Collateral to support external stakeholder engagement
- Website presence
- Greater use of social media channels, beyond Twitter
- Dedicated stakeholder bulletin

Progress as of May 2020

- Scoping of communications strategy to support improvement plan underway
- Branding and strapline options being drawn up.