Worcestershire Health and Care NHS
NHS Trust

Quality Governance Strategy 2015 - 2017

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Document Author	Della Lewis, Head of Quality Governance
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Responsible Group	Quality and Safety Committee
Responsible Director	Sandra Brennan, Director of Quality (Executive Nurse)
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Training and Development

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

Contents

1 Introduction

Worcestershire Health and Care NHS Trust implements a range of strategies to ensure systems and structures support staff in their quest to maximise care quality and safety.

This document outlines the plan for the continued development of Quality Governance at in the Trust.

Improving the quality of outcomes and experience is central to everything we do; our vision and strategic aims reflect this priority.

The Trust vision is:

'**To strive to be a leading organisation that works effectively in partnership with our stakeholders to deliver high quality integrated health and care services'.**

Quality governance is at the heart of such vision, ensuring that systems and processes are in place to assist staff to deliver quality care.

Furthermore, our agreed strategic goals define what we want our organisation to achieve;

- We will always provide an excellent patient experience
- Our services will always be safe and effective
- We will work in partnership to improve the integration of health and care
- Our organisation will be efficient, inclusive and sustainable.

In terms of our organisational values, we will be:

- **Courageous** – displaying integrity, loyalty and the courage to always do what is right
- **Ambitious** - striving to innovate and to improve through effective teamwork
- **Responsive** - focusing on the needs and expectations of people using our services
- **Empowering** - empowering people to take control of their own health and wellbeing
- **Supportive** - enabling our staff to achieve their full potential and take pride in the services that they deliver.

2 Aim

This strategy outlines the structure of quality governance assurance processes in the Trust and identifies six key priorities for taking forward to implementation during 2015 to 2017. These priorities are highlighted in the document and are contained in the initial Strategy Implementation Plan (Appendix 1).

The aim is to ensure people have a clear understanding of how the Trust's systems support the delivery of safe, high quality care. Successful implementation of this Quality Governance Strategy means that we consistently:

- identify and share good practice, quality improvement and innovation;

- share learning from improvement actions from when things have not gone well;
- direct resources and support to areas that are not reaching expected standards and targets;
- have clarity and openness in measuring and sharing our performance;
- invite challenge from stakeholders, in particular patients, carers, staff and commissioners;
- celebrate and share our successes.

A key component of Quality Governance is sound risk management practice. The Trust's Risk Management Strategy supports the achievement of the Quality Governance Strategy objectives.

3. Definitions

3.1 Strategy

A strategy is a set of choices designed to work together to deliver the long-term goals of an organisation in the face of uncertainty (Monitor 2014).

3.2 Quality Governance

Monitor defines Quality Governance as being 'the combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best practice; and
- identifying and managing risks to quality of care.'

The Care Quality Commission (CQC) uses 5 key questions to judge quality and asks if services are:

- safe
- effective
- caring
- well-led
- responsive.

4. Scope

This Quality Governance Strategy applies to all services provided by Worcestershire Health and Care NHS Trust, all people who access the services of the Trust and all staff working in and for the Trust, both clinical and non-clinical.

All services and individual members of staff are required to fully engage with the principles and framework contained in this strategy.

5. Responsibilities

5.1 Trust Board

The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and has a statutory duty of quality to ensure high standards of quality governance. The Chief Executive has overall accountability for Quality Governance, delegating the executive responsibility to the Director of Quality (Executive Nurse) and the Medical Director who in turn are responsible for reporting to the Trust Board on the quality governance agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively.

Non-executive Directors in the Trust have an active role in providing assurances to the Trust Board on the management of risk and quality governance across the organisation.

5.2 Quality and Safety Committee

The Quality and Safety (Q&S) Committee reports to Trust board.

Chaired by a Non-executive Director, with a membership consisting of two other Non-executive Directors, the Chief Executive, Medical Director, Director of Quality (Executive Nurse), Director of Operations, Head of Quality Governance, the committee provides a strategic control in accordance with clearly defined terms of reference. This board committee reviews and scrutinises the robustness of the quality governance agenda across the Trust.

Q&S advises the Board on key issues which affect the safety and quality of services within the Trust by: -

- Rigorous review of the Quality Dashboard, high-level risk registers, Board Assurance Framework and monthly governance reports
- Ensuring there are clear and robust accountability arrangements at all levels of the Trust for quality governance.
- Ensuring that intelligent information is available to support decision-making
- Ensuring that organisational learning takes place and that organisational memory is retained.

5.3 Clinical Governance Sub-committee

The Clinical Governance Sub-committee reports to the Q&S Committee.

Chaired by the Director of Quality (Executive Nurse), this monthly sub-committee provides a detailed scrutiny regarding quality governance including compliance with regulatory requirements and aims to be highly proactive in its search for assurance and risks. Membership consists of SDU leads, clinical directors and senior managers who have responsibility for specific functions, for example the Head of Medicines Management.

The sub-committee reviews the quality reports for each of the SDUs together with Trust-wide information in relation to quality and patient safety. A number of sub-groups report to the

Clinical Governance Sub-committee to support the assessment of assurance and risk. This arrangement is set out in a 'meetings map' (Appendix 2).

A report from the Clinical Governance sub-committee is provided to each Quality and Safety Committee, highlighting key issues and risks together with actions being taken.

Quality Governance Strategy 2015-17
Priority 1
The Clinical Governance Sub-committee was established in February 2015. The reports from the Clinical Governance Sub-committee to the Quality and Safety Committee will consistently provide clear evidence of challenges raised in committee discussions with associated clarity on actions being taken.

Teams identified as requiring focussed support will be included in the reports to Q&S.

Where significant risks have been identified and control measures are considered to be potentially inadequate, the sub-committee will take immediate and appropriate action and ensure the matter is raised at the Quality and Safety Committee. Escalation in relation to performance issues is undertaken in the processes set out within the Trust's Performance Management Framework.

5.4 Quality Governance in Service Delivery Units

The Service Delivery Units (SDUs) quality governance arrangements report into the Clinical Governance Sub-Committee.

Quality governance in the SDUs has a central role in ensuring there is collaboration and shared learning across the Trust. Monitoring the quality of care begins with individuals and teams who need to have a shared understanding of how the quality of care in their service is measured, and how this impacts on outcomes for patients and staff. SDU Leads have individual responsibility for ensuring that quality governance is managed within each of their service areas with a view to implementing control measures, and establishing monitoring arrangements to ensure compliance.

Quality Governance Strategy 2015-17
Priority 2
Each SDU to implement or review the existing SDU's quality governance process of its own, which reflects the processes within this strategy and places the operational delivery of quality governance into the context of the services within the SDU. The policies will be reviewed, approved and tracked for implementation by the Clinical Governance Sub-committee.

Quality leads, team leaders and managers are required ensure regular quality governance meetings take place in their services. These can be either stand-alone meetings or form part of existing team meetings with protected time for quality issues. Quality governance meetings take place in a spirit of openness, constructive challenge and willingness to reflect and learn. They must be able to show an impact on improving the quality of services.

<u>Standards for Quality Governance Meetings</u>

All quality governance meetings in operational services in the Trust:

- Take place at pre-set regular intervals – at least monthly
- Have minutes or notes recorded with evidence of actions being tracked and implemented
- Generate reports to SDU senior management level if necessary
- Receive reports from SDU senior management level
- Have standing agenda items of, as a minimum:
    - Feedback from the Clinical Governance Sub-committee and/or Quality and Safety Committee
    - Information and analysis of performance against relevant quality metrics
    - Incident reports and action plan implementation
    - Patient experience feedback and action plan implementation
    - Clinical audit and NICE compliance
    - Review of the risk register.

Key sources of information for quality governance meetings are:

- Team Brief
- Ulysses/Incident Reports
- Risk Registers
- Staff surveys or other staff views
- Staff feedback from professional development e.g. conferences attended
- Clinical audit reports
- Compliments and complaints
- Patient Experience information

5.5 All Staff

The achievement of good governance ultimately depends on the behaviour of people as well as the reliability of systems or processes. All staff at every level in the organisation must take responsibility for promoting the processes set out in this policy. Staff should raise any concerns they have, either for staff or patient safety, through the governance processes set out in this strategy, or through the Trust's 'Raising Concerns' Policy.

5.6 The Quality Directorate

The Quality Directorate, led by the Director of Quality (Executive Nurse), has a crucial role in:

- Providing direction and impetus for action, interpreting and acting on national guidance in relation to quality issues
- Providing the organisation with the tools, skills and methodologies to make the best use of the information and data in relation to quality – including workforce metrics, staff training and support, safeguarding, infection control and health and safety data
- Ensuring there is a consistency of approach and joint working between SDUs and corporate departments in relation to quality governance.

The Quality and Safety Team is responsible for coordinating the implementation of the wide range of quality governance processes in the trust including:

- Providing advice and guidance on CQC compliance, Monitor's Quality Governance Assurance Framework and the Trust Development Authority's Accountability Framework
- Providing advice and guidance to the Trust on patient safety issues, including incidents, near misses and the learning from investigation outcomes;
- Leading on ensuring the processes for investigations relating to serious incidents are as efficient and as 'user friendly' as possible

- Promoting and sharing evidence of real improvements made to patient care as a result of learning from incidents
- Overseeing the implementation of associated patient safety work-streams.
- Acting as a central resource for activities required to deliver the Trust's NICE and Clinical Audit Strategies and plans
- Providing support and information regarding patient experience feedback and associated organisational learning
- The Patient Relations Team is responsible for the effective management of complaints, compliments and PALS enquiries

6 Quality Measures and Performance Indicators

Quality measures and performance indicators should ensure that intelligence is available to the Trust, teams, and individuals about how well we are doing and where the potential risks to quality lie. Patients and staff, Trust Board, the Care Quality Commission, Monitor, the Trust Development Authority and commissioning contracts all require assurance that quality is being measured and actions are being taken to address areas of risk.

The right information needs to be gathered, interpreted correctly, and fed back to staff at the front line so that we can sustain and improve quality. This area of work is regularly revised in the Trust as new and improved systems are procured, and metrics are reviewed for efficacy and relevance. We also continue to seek further opportunities for our services in order that true comparisons can be used. National bodies and commissioners also introduce new measures, which the Trust then includes in the monthly reporting cycle.

Monthly performance reports containing all key quality indicators are supplied to the SDU quality leads and managers, the Clinical Governance Sub-committee, Quality and Safety Committee and Board. The Trust's Quality Dashboard brings together a number of measures including national indicators such as the Safety Thermometer, and more local indicators, for example the reporting of incidents within 48 hours.

During 2014/15 a Service Line Report for quality indicators was developed, bringing quality metrics into one place for each team in the Trust. Although problem-sensing within the Trust cannot rely on one method for gathering intelligence, the Service Line Report has provided a way of prompting enquiry and has been endorsed for organisational use by Trust board. The Service Line Report is seen as one way of using the data we have to potentially unearth risks (rather than providing false reassurance).

Quality Governance Strategy 2015-17
Priority 3
This strategy will prioritise embedding the use of the Quality Service Line Report into actionable knowledge and effective organisational responses.

6.1 Data Quality

Considerable time, effort and resources are put into data collection and monitoring systems in the Trust. These include systems for recording various aspects of care, compliance with good practice and clinical outcomes. The challenge of transforming large quantities of data into intelligence about actual harms and potential risks is not underestimated, and considerable investment has gone into improving these systems.

A new Patient Administration System will come into effect during 2015/16 which will provide us with new opportunities to use the data we collect to improve care processes.

Quality Governance Strategy 2015-17
Priority 4
The Quality Directorate will be fully involved in the implementation of the new Patient Administration System and will introduce data quality 'kite marks' into the quality governance reports.

Data quality has been identified as a risk within the Trust, with some data errors and inconsistencies coming to light within the performance reports. A Data Quality Improvement Group (DQIG) is overseeing an action plan for improving data quality, providing transparency regarding the efficacy of the measures we use. DQIG is moving from 3 monthly to 2 monthly meetings from March 2015 with work plan review at each Audit Committee meeting. An agreed kite mark in style of coloured ribbons to be used, staring with quality dashboard from March 2015.

7. Patient Experience

We need to use a wide range of opportunities in the search for genuine learning. At the heart of quality is the interaction between staff and people who use our services, as well as families and carers. We know that the perspective of people who use our services and who work in our services is a key source of intelligence about the quality and safety of our services.

Patient views on quality are actively sought through:

- Friends and Family Test (FFT) surveys of people who use Trust services
- Specific outcome measures such as CAMHS Outcomes Research Consortium (CORC)
- The Trust's and NHS Choice's websites and email contact
- Patient and carer forums
- Complaints, PALS and compliments
- Public events such as the Trust's AGM.

We have introduced the Friends and Family Test (FFT) for patients across services, and by undertaking bespoke patient experience exercises in many services. For the term of this strategy we will be working on ensuring patient experience measures receive much more prominence within our measures of quality, and that the outcomes of such initiatives are more clearly defined in terms of real changes for patients.

Quality Governance Strategy 2015-17
Priority 5
The Patient Experience Strategy will be ratified by May 2015. The strategy will ensure tangible improvements are made as a result of what patients are telling us. This will be monitored by the Clinical Governance Sub-committee.

8. Staff Experience

Research has shown a relationship between positive staff engagement and improved organisational safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally.

As well as maintaining the current events in the Trust that involve Trust staff, it is vitally important that we strengthen the staff voice, as well as the patient voice.

The minimum requirement of the Staff FFT is to give all staff an opportunity to respond at least once a year. The results of staff FFT surveys are shared with staff through Team Brief, and are reported to the Quality and Safety Committee. Additionally the national staff survey results are analysed and reported, together with the feedback from the Patient Safety Walkabouts.

For the term of this strategy we will be working on ensuring the staff voice receives more prominence within our measures of quality.

Quality Governance Strategy 2015-17
Priority 6
There will be targeted staff surveys in services where the Service Line Report is showing there are a higher number of red indicators. The Workforce Quality Improvement Group will oversee this and report to the Clinical Governance Sub-committee.

9 Clinical Audit, Effectiveness and Compliance with NICE Standards and Guidelines

Clinical audit is a well-established tool for assessing the quality and effectiveness of care and services. Clinical effectiveness is about ensuring practice is based on evidence so that we do 'the right things, the right way to achieve the right outcomes' for people who use our services. The Trust requires all clinical services to participate in clinical audit.

A process, as set out in the Trust's Clinical Audit Strategy, is in place to agree a 3 year rolling clinical audit programme with the SDU leads. The audit topics link directly with key risks identified through, for example, incident reporting to ensure priority is given to audits in areas of the greatest number and/or severity of incidents. The audit programme is also encompasses national and service priorities and includes audits of NICE guidance implementation.

Newly published NICE guidelines are assessed for their relevance to clinical teams. Action plans are implemented for any areas of non-compliance. Compliance with the Clinical Audit Programme and NICE compliance is monitored by the Clinical Audit and Effectiveness Groups which reports to the Clinical Governance Sub-committee.

10. Working in Partnership

Worcestershire Health and Care NHS Trust is committed to actively working in partnership for the benefit of patients and carers and welcomes the learning opportunities to be gained from external scrutiny. When inspection reports are received from external agencies such as the CQC or the commissioners, the service will develop an action plan to address issues that have been identified during the inspection. The report and action plan will be presented to the Clinical Governance Sub-committee for approval and monitoring.

A summary of inspections and visits, and the themes arising from them, will be presented to the Quality and Safety Committee on a quarterly basis.

Joint Clinical Quality Review meetings take place on a monthly basis with commissioners to ensure there is compliance with quality elements of the contract.

Where partnership working arrangements are in place with other providers, the Trust will establish agreed joint quality governance arrangements. Some partnerships may result in fully integrated services involving joint management, pooled budgets and totally integrated service provision. Joint governance arrangements will be relative to type of partnership between the agencies involved, but will always place the safety of the people using the service at the centre of the governance arrangements.

11. Quality Account

The Trust is legally required to publish an annual Quality Account. Worcestershire Health and Care NHS Trust sees this as an opportunity to produce a user-friendly review of the Trust's performance in terms of quality, describing what has gone well and where we need to make improvements. We aim to ensure that it is an honest representation of our performance. The Quality Account contains the mandatory sections as set out by the Department of Health Toolkit, A copy of the Quality Account is available on the Trust website.

12. Monitoring Implementation of this Strategy

Compliance with this strategy is monitored by ensuring systems and processes are in place to provide reports, audit trails, scrutiny and assurance of good governance practices to the Trust Board and its sub-committees and internal and external auditors and regulators. Where gaps in assurance are identified action plans are implemented and monitored. Any remaining residual risks are added to and monitored through the Trust's risk registers.

Each of the supporting work streams outlined in the Quality Governance Strategy have identified objectives which are monitored through the relevant committees, performance indicators, dashboards and reporting structures.

The implementation plan for the key points of this Strategy will be monitored by the Clinical Governance Sub-committee.

Appendix 1 - Quality Strategy Implementation Plan Version One March 2015

Key Priority	Action	Lead	Timescale
1. The reports from the Clinical Governance Sub-committee to the Quality and Safety Committee will consistently provide clear evidence of challenges raised in committee discussions with associated clarity on actions being taken. Teams identified as requiring focussed support will be included in the reports to Q&S.	Template to be agreed by Clinical Governance Sub-committee for reporting SDU Governance issues to Clinical Governance Sub-committee.	Head of Quality Governance	March 2015
	Template to be agreed by Quality and Safety Committee for reporting from Clinical Governance Sub-committee to Quality and Safety Committee.	Head of Quality Governance	March 2015
	Identified managers with the Quality and Safety Team to be aligned with specific SDUs.	Head of Quality Governance	April 2015
2. Each SDU to implement or review the existing SDU's quality governance process of its own, which reflects the processes within the Quality Governance Strategy and places the operational delivery of quality governance into the context of the services within the SDU. The policies will be reviewed, approved and tracked for implementation by the Clinical Governance Sub-committee.	Each SDU to present is documented approach to quality governance within the SDU to the Clinical Governance Sub-committee for review and approval.	SDU Leads	April 2015
3. Embed the use of the Quality Service Line Report into actionable knowledge and effective organisational responses.	Flow chart to be drawn up to show process for further action and level of further action. Flow chart to be approved by the Clinical Governance Sub-committee.	Head of Quality Governance	March 2015
	Terms of Reference for 'mock inspections' to be agreed by Clinical Governance Sub-committee	Training and Development Manager	March 2015
	SLR to be compared to Workforce reviews to identify matches.	Head of Workforce Transformation and Head of Quality Governance	March 2015

	Mock inspections to commence	Training and Development Manager and Head of Quality Governance	April 2015
4. The Quality Directorate will be fully involved in the implementation of the new Patient Administration System and will introduce data quality 'kite marks' into the quality governance reports.	Quality 'kite marks' to be included on Quality Dashboard.	Associate Director of Performance and Head of Quality Goverance	March 2015
5. The Patient Experience Strategy will be ratified by May 2015. The strategy will ensure tangible improvements are made as a result of what patients are telling us. This will be monitored by the Clinical Governance Sub-committee.	Patient Experience Group to agree draft Strategy. Consultation and submission to Clinical Governance Sub-committee and Q&S.	Head of Quality Governance	May 2015
6. There will be targeted staff surveys, particularly in services where the Service Line Report is showing there are a higher number of red indicators. The Workforce Quality Improvement Group will oversee this and report to the Clinical Governance Sub-committee.	Staff surveys to be set up on Survey Monkey with specific questions regarding quality. Communication to staff across Trust explaining aim and assuring anonymity.	Head of Human Resources	April 2015

Appendix 2 – Quality and Safety Committee Structure Meetings Map