Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 26th November 2014, 1300 – 1700hrs
Trust Conference Room, Warrington Hospital

1300	***W&HHFT/TB/14/168***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/14/169	***Minutes of the previous meeting held on 29th October 2014***	Paper	
	W&HHFT/TB/14/170	***Action Plan***	Paper	Chairman
1305	***W&HHFT/TB/14/171***	***Chairman's Report***	Verbal update	Chairman
	W&HHFT/TB/14/172	***Chief Executives Report [maternity update]***	Verbal update	Chief Executive
		Quality		
1340	***W&HHFT/TB/14/173***	***Dementia – Patient Story***	Presentation	Staff Nurse Clare Roberts
1400	***W&HHFT/TB/14/174***	***Dementia Strategy Update***	Paper	Director of Nursing and Organisational Development
1415	***W&HHFT/TB/14/175***	***Quality Dashboard***	Paper	Director of Nursing and Organisational Development
1430	***W&HHFT/TB/14/176***	***Quality Strategy***	Paper	Director of Nursing and Organisational Development
1455	***W&HHFT/TB/14/177***	***Safety Walk round***	Paper	Director of Nursing and Organisational Development
1500	***10 Minute Break***			
		People		
1510	***W&HHFT/TB/14/178***	***Workforce and Educational Development Key Performance Indicators***	Paper	Director of Nursing and Organisational Development
1520	***W&HHFT/TB/14/179***	***Staffing Levels - Monthly Staffing level exemption Report (October 2014)***	Paper	Director of Nursing and Organisational Development
		Sustainability		
1530	***W&HHFT/TB/14/180***	***Finance Report to 31 October 2014***	Paper	Director of Finance & Commercial Development
1550	***W&HHFT/TB/14/181***	***Corporate Performance Dashboard***	Paper	Associate Divisional Directors for Chief Operating Officer
1600	***W&HHFT/TB/14/182***	***Emergency Preparedness Assurance 2014-15***	Paper	Director of Finance & Commercial Development for the Chief Operating Officer

1610	***W&HHFT/TB/14/183***	***Corporate Risk Register***	Paper	Director of Nursing and Organisational Development
1620	***W&HHFT/TB/14/184***	***Board Assurance Framework***	Paper	Executive
1630	***W&HHFT/TB/14/185***	***Board Committee Reports:*** ***Board Committee Verbal Update*** ***a) Quality Governance Committee held on 11 November 2014 & Action Plan arising from the CQC Report on Maternity*** ***b) Finance and Sustainability Committee held on 19 November 2014*** ***Minutes for Noting:*** ***c) Quality Governance Committee held on 9 September 2014*** ***d) Finance and Sustainability Committee held on 22 October 2014***	Papers	Chair of each Committee
	W&HHFT/TB/14/186	***Any Other Business***		
1700 end		***Dates of next meeting*** *28 January 2014*		

W&HHFT/TB/B/14/169

Warrington and Halton Hospitals NHS Foundation Trust
Board of Directors
Minutes of the Board of Directors
held on Wednesday 29th October 2014
Trust Conference Room, Warrington Hospital

Present:

Allan Massey	Chairman
Mel Pickup	Chief Executive
Karen Dawber	Director of Nursing and Organisational Development
Tim Barlow	Director of Finance and Commercial Development
Jason DaCosta	Director of IT
Carol Withenshaw	Non-Executive Director
Ian Jones	Non-Executive Director
Terry Atherton	Non-Executive Director
Lynne Lobley	Non-Executive Director
Mike Lynch	Non-Executive Director
Rory Adam	Non-Executive Director/Deputy Chair

In Attendance:

Colin Reid	Trust Secretary
Alison Lynch	Deputy Director of Nursing

Apologies:

Paul Hughes	Medical Director
Simon Wright	Chief Operating Officer/ Deputy Chief Executive

W&HHFT/TB/14/150 – Apologies & Declaration of Interest

1 Apologies: as above

2 Declarations of Interest: None reported.

W&HHFT/TB/14/151 – Minutes of Meeting

3 The minutes of the meeting held on 2nd October 2014 were approved.

W&HHFT/TB/14/152 – Action Plan

4 All actions contained in the action plan were either on the agenda, discharged or carried forward to a future meeting.

W&HHFT/TB/14/153 – Chairman's Verbal Update Report

5 The Chairman provided a verbal report on the following matters:

6 a. **NED Appointment Process:** The Chairman reported on the appointment process for the Non-

Executive Director and advised that a preferred candidate had been identified by the Panel, comprising of the Governor Nominations and Remuneration Committee. Due to the preferred candidates external commitments the appointment would be effective from 1 January 2015 and was subject to the Council of Governors approval at the meeting on 27th November 2014.

7 b. **Governor Elections:** the Chairman reported on the election process was now underway for the public and staff governors and would conclude in November. Ballot papers would be issued at the end of this week which the election results available at the Council meeting on 27th November 2014.

8 c. **CQC Inspection:** The Chairman advised that the Trust had received notification from the CQC that it would be conducting its inspection of the Trust at the end of January. He advised that the inspections were carried out by a mixture of inspectors, clinicians, and experts by experience and would assess whether the service overall was: safe, effective, caring, responsive to people's needs and well-led.

9 d. **Monitor event for Chairs:** The Chairman advised that he had attended an event facilitated by Monitor for Chairs of Foundation Trusts. The event focused on Strategic and Business Planning and also looked at the current financial status of FT's.

10 e. **FTN NED Event:** The Chair reported on the FTN event for Non-Executive Directors that focused on strategic Planning which was in line with the Monitor focused event. This would be held in the last quarter of 2014.

11 The Board noted the Chairman's Report.

W&HHFT/TB/14/154 – Chief Executive Verbal Update Report

12 The Chief Executive provided a verbal report on the following matters:

13 a. Secretary of State for Health Visit: The Chief Executive reported on the recent visit to the Trust of the Jeremy Hunt MP, Secretary of State for Health accompanied by David Mowat, MP for Warrington South. She advised the welcoming group comprised of herself, the Chairman and Andy Davies, Warrington CCG. The Chief Executive advised that the Trust had opportunity to showcase the Dementia ward and this allowed the Secretary of State to meet both staff and patients. The Chief Executive advised that he was knowledgeable of the Trust and spoke very highly of staff during the visit. Due to the strict timetable the Secretary of State was following, the Chief Executive advised that she and the Chairman had limited time to talk about the operations of the Trust; however there was discussion on the current CCG proposals for the formation of the GP hubs and in the discussion the Secretary of State had asked if the Trust would be providing services from the Hubs.

14 b. NHS England 5 year forward view: The Chief Executive reported that NHS England had published their 5 year forward view. The view indicated that the £30bn shortfall figure by 2020 was well established and that the NHS would need meet over two-thirds of this through efficiency savings, the balance of £8bn would need to be met by government. The Chief Executive advised that the 'view' was clear about the future of the small/medium sized DGH, which identified the need for working together in collaboration to share services and back-office and management functions or in the provision of integrated care rather than through merger and acquisition.

15 c. CQC Planned Investigation: The Chief Executive referred to the earlier comment from the Chairman regarding the planned investigation by the Care Quality Commission which had provisionally been set for week commencing 26th January 2015. She advised that the investigation would include a large number CQC inspectors accessing all areas of the Trust for three days and would entail speaking to people who use services, as well as carers and advocates; holding focus groups with staff and people who use services; observing care; interviewing key members of the senior management team and staff of all levels; and visiting certain services out of hours.

16 d. CQC Report on Maternity: The Chief Executive reported on the investigation of Maternity Services undertaken by the CQC. She explained that the Report had raised no significant surprises although there was recognition that the action taken by the Trust to address the cluster of intrapartum deaths had been controversial. The Chief Executive explained that with hindsight, the Trust may not have made the same decisions it had done in offering monitoring to mums to be. The Trust was rebuilding confidence with patients.

17 e. Chair Appointment: The Chief Executive reported on the process being undertaken to appoint the Chair of the Trust which was being led by Carol Withenshaw with the Governor Nominations and Remuneration Committee and supported by herself and the Trust Secretary. She explained that the Committee would be shortlisting candidates on 4 November and focus groups and interviews would take place on 13 November. Formal approval of the preferred candidate would take place at a closed meeting of the Council of Governors on 27th November 2014.

18 f. Winter Pressure funding: The Chief Executive advised that the usual course of event would be that the winter pressure funding would flow from the DH to Trusts through Commissioners. She believed that the Commissioners would not be allowed to place caveats on the amount of money flowing through to the Trust and consequently the full amount would be available to invest in the right number of staff to address increased numbers of patients and potentially complex treatments over the winter months.

19 The Chief Executives verbal update report was noted.

W&HHFT/TB/14/155 - Workforce and Educational Development Key Performance Indicators

20 The Director of Nursing and Organisational Development presented the Workforce and Educational Development Key Performance Indicators Report and referred the Board to the summary on page 1 of the report which provided the key points.

21 The Director of Nursing and Organisational Development reported that mandatory training rates had remained largely unchanged from the previous month, however appraisal rates for both non-medical and medical staff had seen a small fall. Sickness absence for September 2014 was the highest in-month rate for more than 12 months at 4.31%. The Director of Nursing and Organisational Development advised that further analysis was required to understand the reasons why this increase had occurred. Consequently the cumulative rate for April – September 2014 increased to 4.09% against a target full year figure of 3.75%

22 The Director of Nursing and Organisational Development reported that the total spend on temporary Staffing fell by £104k in September 2014. The two areas that showed a decrease in spend was Nurse Bank /Agency; £95k and Agency; £66k whilst Medical Locums/Agency increased by £56k.

23 The Director of Nursing and Organisational Development reported on the work of the 'Workforce and Controls Group' which met recently and had progressed a number of workforce schemes, including: a new vacancy control process which had been drafted and approved by ICIC on 24 October 2014; rolling adverts for nursing recruitment was now in place in Unscheduled Care with emphasis on A&E/AMU and Scheduled Care with emphasis on Theatres and these had proved to be very successful with a number of qualified nurses being appointed. The Director of Nursing and Organisational Development advised that the Group was also working on a number of initiatives to streamline the recruitment process with work continuing on putting in place a revised ECF process using Share Point and the adoption of the electronic system for DBS Checks. She advised that it was expected that at least 2 weeks on the average could be saved in the completion of recruitment checks. The Chairman recognised the importance of improving the lead time on recruitment of key staff and welcomed the work being undertaken to shorten the process so that key personnel can be appointed quickly, particularly given the current vacancy and sickness rates.

24 With regard to the Clerical Review, Lynne Lobley asked that progress on the review be reported through the Strategic People Committee so that assurance can be provided by the Committee to the Board on delivery. She felt that this was appropriate given the potential concerns that may arise from it.

Action TB/14/155: The Director of Nursing and Organisational Development to report through the Strategic People Committee the implementation of the Clerical Review.

25 The Board noted the Workforce and Educational Development Key Performance Indicators Report.

W&HHFT/TB/14/156 – Staffing Levels 6 month Report (including Monthly Staffing level exemption Report – August 2014)

26 The Director of Nursing and Organisational Development presented the Staffing Levels 6 month Report which included the Monthly Staffing level exemption Report for August 2014. The Chairman asked that the Report be taken as read and thanked the Deputy Director of Nursing for a very good and compressive paper and asked that once the Report had been accepted by the Board that it was shared with the Governor Quality in Care Committee.

27 Mike Lynch found the Report an excellent piece of work, in particular referred to expectation 9 "Providers of NHS services take an active role in securing staff in line with their workforce requirements" and felt that delivery of this was hugely important to the Trust in retaining experienced staff capable of delivering high quality safe healthcare.

28 Ian Jones referring to a cultural barometer, asked what measures were in place to assess staff. In response the Director of Nursing and Organisational Development advised that the staff undertake a number of surveys including: an annual staff survey which was run independently from the Trust; the Staff family and friends test which is run quarterly and additional ad hoc surveys to understand the views and concerns of the staff.

29 Lynne Lobley felt that the Report although excellent in the provision of information was missing a salient part that related to skill mix of nurses, and thought that the Report could be strengthened with this information included.

30 The Chief Executive referred to the term used in the report 'sign up to safety' that was in the context of whistleblowing and thought that should read 'speak up safely'. She however felt that the Report

showed real depth to the approach and was able triangulate aspects of staffing requirements. The Director of Finance and Commercial Development recognised the work undertaken in producing the Report and wondered whether there was something that could be produced that focused on clinicians. The Director of Nursing and Organisational Development advised that this was not a requirement to do and to undertake an exercise of this nature would be difficult as information to support it was not widely available.

31 Terry Atherton referred to the statement that the whistleblowing policy would be re-launched and asked how that would be undertaken. The Director of Nursing and Organisational Development advised that the policy was being reviewed alongside the 'speak out safely' campaign and went on to explain how both would be addressed with staff and embedded within the Trust. The Director of Nursing and Organisational Development advised that staff would be able to raise concerns without reprisals, however as with all systems of reporting some staff may feel that they could not report and would only do so anonymously. With this in mind a staff would be able to report concerns through an anonymous email address. A feedback loop would be maintained to provide feedback to staff to show that concerns raised had been taken seriously. This would be done through team briefs and if appropriate through one to ones. Terry Atherton noted the processes to be adopted and asked that the process capture all staff. In response to this comment, the Chief Executive advised that all staff would be able to raise concerns, whoever they may be, without reprisal. However junior doctors may not feel as comfortable as other members of staff with having to raise concerns and therefore there was a need to support those individuals. The Chief Executive, recognising that some staff would want to remain anonymous, felt that the culture needed to change and so that all staff would be able to raise concern without fear of doing so.

32 The Board:

a. noted the content of the Report and expectations for reporting staffing capability and capacity to the Board;

b. noted the analysis from the month by month analysis, areas of concern via the Safety Thermometer and mitigating actions in progress; and

c. agreed the progress against the Hard Truths expectations and NICE guidance and the publication of Staffing Data and Exception Report September 2014 set out in appendix 1.

W&HHFT/TB/14/157 Finance Report

33 The Director of Finance and Commercial Development presented the Finance Report as at 30 September 2014 and provided an overview of the financial position of the Trust. He advised that the Report had been reviewed by the FSC prior to being presented to the Board. The Director of Finance and Commercial Development ran through the key themes arising from the Report.

34 Ian Jones asked whether the Director of Finance and Commercial Development could expand further how the Trust managed its cash position. The Director of Finance and Commercial Development advised that the finance team was concentrating on all debt collections, in particular where debtors had become slow in paying. He advised that this was occurring with some regulatory, particularly by NHS organisations who are all in similar financial position and needed to manage their own cash flows. The Director of Finance and Commercial Development advised that if the financial position worsened and liquidity became a problem then the Trust could slow down its capital expenditure. He did feel that a decision of this nature would not be taken likely as a slowdown in capital expenditure could impact on delivery of CIP. The Director of Finance and Commercial Development advised that if liquidity problems did arise, another option would be to seek an advance on the contract from the Commissioners.

35 Rory Adam referred to the over performance against the contract and the potential penalties arising from the Contract and asked whether there was a risk to the financial integrity of the Trust. The Director of Finance and Commercial Development reported that recent discussions had taken place with Warrington CCG, as the primary commissioner, at their request to look at a settlement figure to cover both over-performance and penalties. He advised that the current proposed settlement from the CCG was currently being considered but was potentially unlikely to be accepted and more work was required to evaluate a settlement. He explained that the CCG continued to refer to its statutory obligations to break even and this was driving their ambitions to come to a settlement, however they were not taking into account the impact of that ambition on wider local health economy.

36 Carol Withenshaw referring back to the discussion on cash asked whether expenditure on capital had already slowed down due to the under-spend to date. In response the Director of Finance and Commercial Development advised that this was not the case and the advised that there were times during the year when capital would be drawn down, particularly to support CIP. He reminded the Board that capital expenditure was managed through the Capital Planning Group, which reported through the FSC.

37 The Chairman thanked the Director of Finance and Commercial Development for his reported noting the massive challenges the Trust faced over the next 6 months in order to deliver the best possible financial outcome.

38 The Board recognised the financial risks reported in the paper and noted Finance Report to 30th September 2014.

W&HHFT/TB/14/158 – Corporate Performance Dashboard and Exception Report

39 The Director of Finance and Commercial Development presented the Corporate Performance Dashboard and Exception Report for September 2014 and explained that the full report had been presented to the FSC prior to the exception report coming to the Board.

40 The Director of Finance and Commercial Development advised that the main focus had been on delivery of the A&E 4hr target, however the Board should note that the Trust continued to achieve the required performance against the other national targets.

41 The Board reviewed the actions being undertaken to support delivery of the A&E 4hr target, however these actions alone would not deliver the 4hr target and that there was recognition that a whole system solution was required to deliver the target.

42 The Board noted the status of the Trust Corporate Performance dashboard.

W&HHFT/TB/14/159 – Corporate Risk Register

43 The Chairman opened this item and advised that both the Corporate Risk Register and the Board Assurance Framework were key documents in the delivery of the Trust's objectives and services. He advised that they were both living documents and that as a Board, it needed to be clear what the risks were and what was being done to mitigate them. The Chairman recognised that the Corporate Risk Register was reviewed through the Governance structure and that being the case the Board should be assured that those risks identified were appropriately managed.

44 The Director of Nursing and Organisational Development presented the corporate risk register and referred the Board to the key highlights on the front page of the Report drawing the attention of the Board to the processes following in the identification of the risks, the controls in place and any mitigating actions undertaken to address the risks.

45 Mike Lynch recognising what had been said by the Chairman advised that the register had been presented to the Quality Governance Committee at the last meeting and there was considerable discussion on each risk, controls and actions. He went on to explain that the Associate Director of Governance and Risk had been setting up one to one sessions with Governance Leads on maintenance of the Risk Register and attending senior management team meetings to drive through requirements for maintaining the register.

46 Carol Withenshaw referred to the estates risk 134/170 and noted that it had been on the register for 6 years and asked when the work would be completed to allow the risk to be discharged. In response the Director of Finance and Commercial Development advised that these were ongoing upgrading schemes that would be completed when capital funds became available. Rory Adam felt that the descriptor of the Risk should be looked at to be sure that it was defined appropriately.

47 Carol Withenshaw referred to the corporate nursing risks and in particular risk 000549 relating to limited time/human resource of Antimicrobial Pharmacist. She asked what was being done to address the risk. In response the Director of Nursing and Organisational Development advised that the risk was not referring to a vacancy, but related to working practices. She advised that this risk was being managed and working practices addressed within Pharmacy.

48 The Board considered further the Corporate Risk register and comments on the risks were provided by Rory Adam and Lynne Lobley on the risk 000482; Information Technology and 000216; replacement of ageing resuscitation equipment.

49 The Chief Executive recognising the concerns raised by the Non-Executive Directors, stated that their needed to be a thorough and rigorous testing of the Corporate Risk Register to assure the Board that the risks identified were appropriate and that they were being appropriately managed. She felt that there needed to be real challenge around accountability for the risk and a better understanding of how the risks were recorded and managed. The Director of IT advised that it was very important that all managers were trained in the identification of risks, reported and managed. He felt that it should not be assumed that managers, because of who they were, understood the processes required in the identification and management of risk. The Director of IT felt that similar training should also be extended to the use of the DATIX system.

50 Mike Lynch reported that in the reporting of risks the Trust had made progress and that he was assured that they were being managed, however recognised that there were problems arising from keeping the register up to date. The Chairman referring to the Infection Control Report to be taken later in the meeting asked why the Ebola preparedness had not made the Corporate Risk Register given recommendations contained in the report and that the impact of a case occurring could be catastrophic. The Board discussed whether it would be appropriate for Ebola to be included on the register. Terry Atherton felt that the Trust would be dealing with something unknown as a UK Hospital and his view was that the risk was significantly high enough to warrant inclusion. The Chief Executive noted the comments of the Board however felt that the risk score would be less than 15, with the likelihood of one and an impact of 5. She did feel that this risk would be included on the Departments risk register.

51 Ian Jones referring back to the document advised that as a new NED he found the document very difficult to follow and would welcome a one to one discussion on it.

52 The Chief Executive asked that the Director of Nursing and Organisational Development undertake the thorough review and testing of the register so that the Board can be assured that the risks identified were appropriate and that they were being appropriately managed within the Risk Management framework. The Board agreed that it would receive the reviewed register at its meeting on 26th November 2014.

Action TB/14/159: The Director of Nursing and Organisational Development to undertake the thorough review and testing of the register and provide an updated Corporate Risk Register to the Board meeting on 26th November 2014.

W&HHFT/TB/14/160 – Board Assurance Framework

53 The Chairman asked that the Board review the Board Assurance Framework and asked each Executive Director to report against each risk.

54 a. Risk 1.2: the Chief Executive asked why the likelihood residual score had been increased to 3 (from 2). She felt that the likelihood of harm had not increased and felt that the score would either have remained at 2 or moved down to 1 as the both the CQC planned inspection and the completed maternity inspections would not or did not necessarily mean that the likelihood of risk of harm had increased. The Board considered the risk and the residual score and agreed that it should remain at 10 (L2xI5).

55 b. Risk 3.1: the Board noted the requirement to amend the date for Board approval from December 2014 to March 2015.

56 c. Risk 3.2: the Director of IT advised that he would provide an update on the risk particularly regarding the statement made in the Action Plan – Gaps in Control Assurance.

57 d. Risk 4.3: the Director of Finance and Commercial Development was asked to look at risk 4.3 and assess whether it would be appropriate to add a further risk surrounding contract relationship with the Commissioners and impacts arising from disputes.

58 The Board confirmed, subject to amendments and comments agreed during the meeting, that the BAF and the Corporate Risk Register:

i. covered the Trust's main activities and adequately identified the principal objectives the organisation was seeking to achieve;
ii. adequately identified the risks to the achievement of those objectives; and
iii. confirmed that adequate assurance systems were in place to ensure the systems of control were effective and efficient in controlling the risks identified.

The Chairman asked that, for completeness, the amended Board Assurance Framework be brought back to the Board meeting on 26th November 2014 for review.

Action TB/14/160: The Trust Secretary updated Board Assurance Framework and present it to the Board meeting on 26th November 2014.

W&HHFT/TB/14/161 – Quality Dashboard

59 The Director of Nursing and Organisational Development presented the Quality Dashboard and advised that exception reports were included for non-compliant indicators including Care Indicators; Friends and Family; Pressure Ulcer CQUIN; Catheter Acquired UTI; AQ Stroke and Heart Failure; PROMS and C.Difficile & MRSA. She explained that VTE and Dementia (compliant) had been extracted on the 22nd October 2014 and were provisional until final submission to UNIFY.

60 Rory Adam referred to the exception reporting of pressure ulcers and noted that the Trust was above trajectory of 3.99 agreed with the Commissioners. He asked what was being done to address this. The Director of Nursing and Organisational Development advised that work was underway to identify patients admitted from care homes and directly from home and from this information themes will be identified and shared with care homes, GPs and the Commissioners so that action plans can be drawn up to reduce incidences in the future.

61 Lynne Lobley referred to the Advancing Quality target for heart failure and asked what was being done to address the missed opportunities resulting in non-compliance. The Director of Nursing and Organisational Development advised that patients were required to be seen by the heart failure nurses in order to pass all of the measures, patients that were missed (not seen by the heart failure nurses) were often those who attend at weekend, out of hours or during the evenings or are only at the hospital for a very short period of time. This was being addressed as the provision of a heart failure nurse was not 7 days a week and the target would therefore be discussed at a meeting with regional Advancing Quality leads to focus on this issue. Lynne Lobley understood the difficulties but felt that patients needed the right information even during times when specialists were not available and asked that consideration be given to this being reviewed at the appropriate level within the Governance framework.

62 The Board:

a. Noted that the Pressure Ulcer and falls data had been refreshed for inclusion in the Pressure Ulcer and Falls Reports. The detail of the new Out of Hours transfers indicator has been reviewed; inaccuracies in categorisation on the DATIX system have been identified, the incidents have been re-categorised and the figures have been amended accordingly;
b. noted progress and compliance against the revised key performance indicators; and
c. approved the actions planned to mitigate areas of exception.

W&HHFT/TB/14/162 – Infection Control Quarterly Report

63 The Director of Nursing and Organisational Development presented the Q2 Infection Control Quarterly Report which highlights the Trust's progress year to date against infection prevention and control key performance indicators.

64 The Director of Nursing and Organisational Development advised that during Q2 the Trust had reported 22 cases of Clostridium difficile, 9 of which were hospital apportioned; 7 cases of which occurring in August. Further investigation of the cases identified 5 different ribotypes and that there was no geographical links identified from cases with the same ribotypes. The Director of Nursing and Organisational Development advised that year to date the Trust had reported 34 cases of Clostridium difficile, 16 of which were hospital apportioned against the financial year threshold of 26 cases which was 3 cases above planned trajectory at the end of Q2. The Director of Nursing and Organisational Development advised that additional training was being provided in AMU on collecting blood culture as there was evidence that had blood cultures been taken, a number of

cases may have been identified as community acquired. The Director of Nursing and Organisational Development went on to explain that the Trust was appealing a 2 cases with the Commissioners panel set up to review cases where evidence existed on the source of the infection.

65 With regard to Ebola, the Director of Nursing and Organisational Development advised the Board on the preparedness of the Trust and advised that she would update the Board if there were any issues arising from the threat.

66 Lynne Lobley referred to the hand hygiene audit and asked what was being done to make sure hand hygiene was practised across the Trust. In response the Chief Executive advised that signage was being addressed to point towards the use of the alcohol gel and hand washing hygiene for nursing staff and clinicians was being reinforced. Mike Lynch recognised the excellent work of the infection control team, but felt that the Executive needed to do more to reinforce infection control with clinicians and this should be managed through the Medical Director.

67 The Board noted the infection control report.

W&HHFT/TB/14/162 – Sign up to Safety

68 The Deputy Director of Nursing provided a presentation on the 'Sign up to Safety' initiative and explained that the initiative was designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. She advised that there was a need to listen to patients, carers and staff, learning from what they say when things go wrong and take action to improve patients' safety and this had been highlighted to the Board in a number of patient stories it had received over the year.

69 The Deputy Director of Nursing advised that NHS England's three year aim was to reduce avoidable harm by 50% and save 6000 lives and explained the 5 pledges that all healthcare providers should adhere to: putting safety first; continually learn; honesty; collaboration and support. The Deputy Director of Nursing advised that organisations who are signed up to the initiative other than NHS England was; the CQC; Monitor and the NHS TDA; NHS Improving Quality; and the NHS Litigation Authority.

70 The Deputy Director of Nursing advised that the benefits of the initiative was that outcomes for patients would be improved by providing safe, effective care in the best possible way for patients and would include a focus for collaboration with other service providers to make improvements.

71 Mike Lynch referred to both the Speak out Safely and the Sign up to Safety initiatives and felt that both should be driven with focus on the safety and quality of care to patients and wondered whether it would be appropriate to capture the views of staff so that management could react to concerns raised. The Chief Executive supported this and advised that the initiatives would need to be supported, with a communication campaign that was visual to staff and provided for 24/7 responses. She advised that following Board approval of the initiative, it would be rolled out through team briefs.

72 The Board considered the proposed initiative and fully supported the Trust sign up to it.

W&HHFT/TB/14/162 – Complaints Quarterly Report

73 The Chairman asked that the Q2 Complaints Quarterly Report be taken as read and asked for

comments and areas of clarifications from the Board.

74 Ian Jones felt that the Report read very well and provided a clear balanced overview. He referred to the weekly statement he receives from Michelle Lord, the Patient Experience Matron that set out complaints received over a week. He found this document enlightening however it did not report on whether the complaint had been dealt with and asked whether this could be provided. Lynne Lobley supported the comment and felt that perhaps another way would be to red rate complaints that had significant issues attached to them. The Director of Nursing and Organisational Development advised that the weekly report was to provide the Board with a snap shot at a point in time similar to an early system rather than trying to provide updates on progress of individual complaints.

75 Carol Withenshaw referred to the graphs that showed complaints by Divisions and was concerned that in two of the three Divisions the main complaint was attitude. The Chairman advised that he had also noted this felt that the Trust needed to look closely at how its staff communicated with patients, family and careers.

76 The Chairman thanked the Director of Nursing and Organisational Development, Deputy Director of Nursing and the Patient Experience Matron in producing such an excellent and informative Report and asked the Board to note its content. He asked the Director of Nursing and Organisational Development to consider further whether additional information could be attached to the weekly report without adding additional burden to the process. The Board noted the content of the Q2 Complaints Quarterly Report.

W&HHFT/TB/14/163 - Monitor Governance Statement Q2 2014/15

77 The Director of Finance and Commercial Development presented the Monitor Q2 Governance Statement for consideration and approval of the Board. With regard to the financial statement the Board recognised that there was no change in the position it agreed at the end of Q1.

78 With regard to the Governance Statement, the Chairman asked for comments on whether the Board could approve the statement that: 'the board was satisfied that plans are in place that are sufficient to ensure ongoing compliance with all existing targets'. The Director of Nursing and Organisational Development advised that although the Trust was above the trajectory for C.Diff she had no reason to believe that the Trust would not come deliver or better the planned trajectory for the full year.

79 There was concern regarding delivery of the A&E 4hr target however the Board recognised that the Trust would now be receiving the winter pressure funding from DH without the Commissioner being able to withhold any of the funding and therefore the Board considered that plans would be in place to deliver the A&E 4hr target, with a caveat that there may be other external factors, that was not be in the gift of the Trust, that may impact on delivery. This included the pending decision on the inclusion of the walk in centre figures discussed earlier and in previous meetings.

80 The Board having discussed in detail during the meeting and under this agenda item agreed the Q2 declarations as follows:

81 **Finance Statement:** The Board approved that that whilst it had plans to deliver a continuity of services risk rating of 3 by the end 14/15, at this stage it could **not** confirm that it 'anticipates maintaining a risk rating of at least 3 over the next 12 months'.

82 **Governance Statement:** The Board approved that it could confirm the statement that 'The board is

satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards' (set out in attachment 2).

83 **Otherwise Statement:** The Board confirmed the otherwise statement 'that there were no matters arising in the quarter requiring an exception report to Monitor (Compliance Framework page 17 diagram 8 and page 63) which had not already been reported' (set out in Attachment 3).

W&HHFT/TB/14/164 – Board Committee Report

Board Committee Verbal Updates:

84 The Board received verbal reports on the activities of:

a) ***Finance and Sustainability Committee held on 22nd October 2014.*** Rory Adam provided a short update on the work of the Committee commenting that the FSC had gone in great detail with regards to the financial position of the Trust and the challenges faced by A&E. He further reported that the Committee had received additional information on the reconciliation letters from the Head of Information who attended the meeting who had provided assurances that improvements would now be made in obtaining patient data at admission. Rory Adam further advised that the Committee had been able to challenge the position surrounding the contract with the CCG and the penalties arising from it. The Committee had also received an update on the Commercial Developments the Trust was undertaking, the business planning process and an update on the Lorenzo project which was now reporting through the Committee.

85 The Board noted the verbal updates provided by the Chair of each of the Board Committees.

Minutes for noting

86 Having received verbal update from the Chairs of each of the Committees at earlier Board meetings the Board noted the following minutes:

a) ***Finance and Sustainability Committee held on 17th September 2014***

87 The Board noted the activity of the Board Committee.

W&HHFT/TB/14/165 – Any Other Business

88 None

Next Meeting: 26th November 2014

W&HHFT/TB/14/170

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 26th November 2014

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
29th October 2014	TB/14/155	Action: The Director of Nursing and Organisational Development to report through the Strategic People Committee the implementation of the Clerical Review.	The Director of Nursing and Organisational Development	To be added to the work plan of the Strategic People Committee	Action Discharged
29th October 2014	TB/14/159	Action: The Director of Nursing and Organisational Development to undertake the thorough review and testing of the register and provide an updated Corporate Risk Register to the Board meeting on 26th November 2014.	The Director of Nursing and Organisational Development	See agenda item TB/14/183	Action Discharged
29th October 2014	TB/14/160	Action: The Trust Secretary updated Board Assurance Framework and present it to the Board meeting on 26th November 2014.	Trust Secretary	See agenda item TB/14/184	Action Discharged

W&HHFT/TB/14/171

BOARD OF DIRECTORS

Paper Title	**Chairman's Report**
Date of Meeting	26th November 2014

W&HHFT/TB/14/172

BOARD OF DIRECTORS

Paper Title	**Chief Executive's Report**
Date of Meeting	26th November 2014

W&HHFT/TB/14/173

BOARD OF DIRECTORS

Presentation	Dementia – A Patients Story
	Staff Nurse Clare Roberts
Date of Meeting	26th November 2014

W&HHFT/TB/14/174

BOARD OF DIRECTORS

Paper Title:	Dementia Strategy Work-streams updates
Date of Meeting	26th November 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Associate Director of Nursing, Quality & Patient Experience
Purpose	This paper is for the Board to receive updates on the ten work-streams related to the Dementia Strategy, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs.

Relates to which Trust objectives	✓ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper.

Page/Paragraph Reference

- Updates on progress with the Dementia Strategy
- Updates on progress with National and Local Dementia CQUINs
- Information on other areas of interest to the Board relating to Dementia care

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

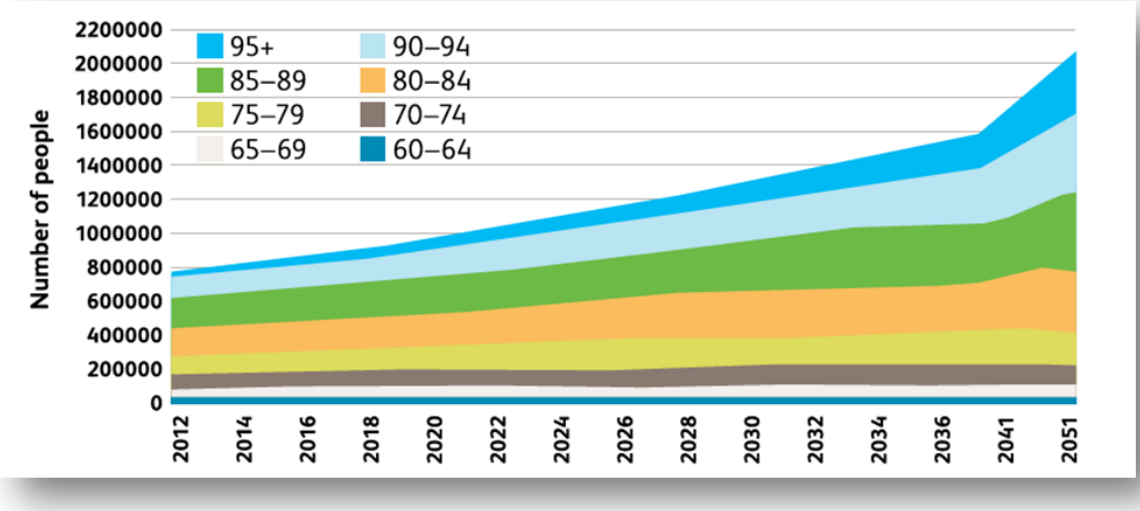
Board is asked to note the paper, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs

Introduction

The Trust approved the Dementia Strategy in October 2013, and have received regular updates in relation to the work of the dementia teams within the organisation. A lot has happened to benefit our patients with dementia, and as an organisation we could not be prouder of our developments. We know that there is the required drive within our hospitals to provide the best possible care for patients with dementia. This paper provides an update to the Trust Board on current achievements and progress made by Trust Dementia Steering Group (Forget Me Not) against the ten key areas of the strategy. It also updates on progress made in relation to the local and national dementia CQUINs in implementing work against the agreed timelines.

Background

According to the projections below, there will be over 850,000 (855,700) people with dementia in the UK by 2015; over 1 million (1,007,485) by 2021; and 2 million (2,092,945) by 2051.



The Government identified Dementia as a National priority and within the Department of Health's "National Dementia Strategy" (2009). Following on from this National Strategy a new commissioning framework for Dementia was launched in July 2011. Since this time the Trust has worked on various work-streams toward ensuring that those patients with Dementia receive the best possible care.

The "Prime Ministers Challenge on Dementia", launched in March 2012, its focus being to "drive improvements in health and social care, to create Dementia friendly communities and to undertake better research". Increasing diagnosis rates has been highlighted as a National objective.

Trust Dementia Strategy

At Warrington and Halton Hospitals our staff are dedicated to providing the best possible care for patients with Dementia, our Strategy sets out the framework by which we will achieve this with ten key areas identified which are underpinned by

action plans monitored by the Dementia Steering Group.

Update on the Ten Key Areas of the Dementia Strategy

Dementia Champions
Champions are in place at board level and the dementia ward champion role is in place in clinical areas, with specific roles and responsibilities for improving the care of dementia patients within Warrington and Halton Hospitals

Our dementia champions include trained non-clinical and clinical staff in place at ward and department levels who have received additional training. We have an identified senior medical and senior nursing lead for dementia within the Trust. A dementia champion is in place in almost every clinical area. The ward/department based champions come together regularly to gain up to date knowledge and skills in relation to patients with dementia in our hospital. They then cascade and disseminate that information in their own clinical area.

Dementia Information
There will be accessible information about the dementia champions which is available to carers, patients and staff. There will be Dementia Awareness packs on the wards, and information relating to dementia will be available on our intranet and Trust website.

Every ward has a dementia information board, which is updated by the Dementia Champion. Information is provided on local dementia services, and what the patient and their family with dementia can expect from our services. The dementia web community holds information for staff, and this area and that of the Trust website is to be an area of focus in 2015/16. We are developing these information boards in other areas of the Trust, for example outpatients.

Dementia Awareness packs are being developed by the cognitive assessment team (CAT) which focus on:

- Improving the quality of care delivery and information patient and relatives to expectations
- Pre-operative assessment / screening of patients who either have dementia or who may develop post-operative delirium. This is being developed by the pre-operative team.

Additionally our clinical librarian has developed a regular electronic dementia awareness bulletin that can be accessed by all grades of staff with links to latest dementia research and knowledge.

A ‘dementia community’ has been put together within the local hospital intranet which contains the appropriate clinical assessment tools and management plans to support staff in the delivery of care. Links are also given to interactive education websites and voluntary agencies.

Dementia Training

A dementia training framework will be developed to provide awareness and training for all staff within the Trust. Awareness sessions will be included in the mandatory training for all clinical staff. Training will be available as taught, interactive, resource files and e-learning. Training will include the use of non-medication methods of addressing behavioural problems.

The Trust has previously used an external training company to provide dementia training. The training gave an awareness of dementia and was ran over a full day, however numbers that could attend were restricted due to a practical element of the training and these sessions proved costly.

Staff also have access to e-learning through the NHS e-learning portal. There have been staff trained through the e-learning packages.

The Trust also give staff access to a level 2 national qualification in the principles of dementia care. This award is achieved through completion of workbooks approved by the Northern Council for Further Education (NCFE).

The table below demonstrate the number of staff who have completed NCFE level 2 booklets relating to care precision for patients with dementia.

Number	**Work Area**
4	Car Parking and Security
22	Nursing
2	Allied Health/Scientists
4	Administration

The table below demonstrate the number of staff who are working toward NCFE level 2 learning

Number	**Work Area**
7	Allied Health
5	Nursing
3	Administration/Other

The Trust is required to make quarterly returns to Health Education Northwest on the numbers of staff and staff groups who have undertaken Tier 1 training in dementia.

The agreed definition of Tier 1 dementia training is training to familiarise staff with recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support.

The learning outcomes of this training must be :-

- Staff will have greater awareness and confidence to support patients affected by dementia
- Better diagnosis, treatment and care of those with dementia;
- This will enable NHS staff to identify the early symptoms of dementia;

- This training will ensure NHS staff are aware of the needs of patients affected by dementia and their families and carers to enable them to provide safe, dignified and compassionate care;
- GPs will be able to identify and work with patients affected by dementia;
- The training will signpost staff to the most appropriate care;
- The training will raise awareness of the increased likelihood of mental health problems presenting in those with Long Term Conditions.

Quarter 1 Returns for Warrington and Halton Hospitals

Medical	Registered Nurses	ST and T	Clinical Support	Information Support	TOTAL
35	210	80	153	4	482

Quarter 2 Returns for Warrington and Halton Hospitals

Medical	Registered Nurses	ST and T	Clinical Support	Information Support	TOTAL
35	227	92	180	11	545

The increase in training numbers between the 2 quarters is reduced as no taught training session took place during this time.

We have approached St Helens and Knowsley College have been approached to deliver Tier 1 training in-house. It has been requested that they deliver twenty half day sessions and funding of £6,000 has been set aside to cover this. There has unfortunately been a delay in this training commencing due to staffing changes at the College. These sessions are due to commence early December and will be available for all staff in the organisation to attend. This will meet the minimum training requirements for Health Education Northwest.

A training needs analysis is to be submitted to the Clinical Education Department that highlights the level, duration and content of training required by specific staff groups. This will enable the future sourcing and funding of required training and will ensure that staff have the correct knowledge and competency to provide a high standard of care to our service users.

Additionally, our Specialist Nurse for Older People has developed links with Countess of Chester Dementia Training lead to explore the possibility of joint future training requirements.

Personalised Care Planning

Following individual patient assessment, the care plan will reflects the needs of the patient relating to:

- *Privacy and dignity*
- *Nutrition and hydration*
- *Pain assessment and control*
- *Communication*
- *Continence*
- *Carer and family involvement*

Our new nursing care booklet includes individual patient assessment relating to the above, however we recognised that a more bespoke care planning method is required. Therefore our Specialist Nurse for Older People has produced a suite of care plans for patients with Dementia, delirium or cognitive impairment which have been launched in November 2014.

Patient Experience

Patients and carers feedback will be sought to ascertain levels of satisfaction with care. We will audit the experience of patients, their family or carers to test whether they feel supported by our staff. We will develop plans to address areas for improvement.

We have developed a survey to seek the opinion of carers of the care provided to patients with dementia. We have also developed some unique ways ascertaining levels of patient satisfaction that is separate to the Trust's current approach.

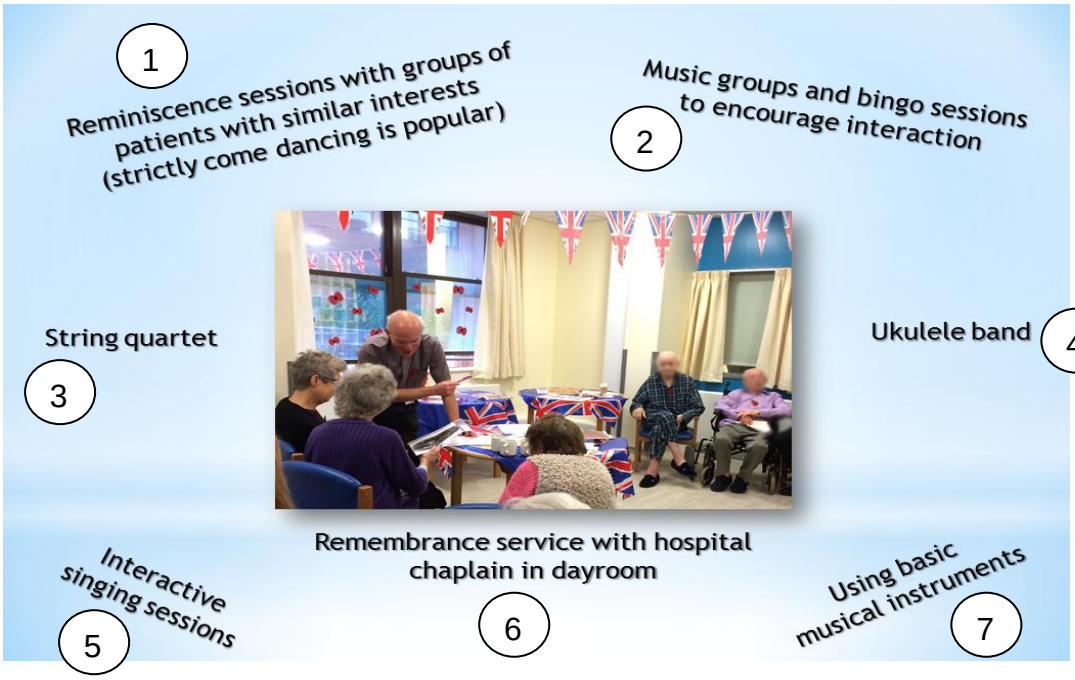
The following are the results of an audit of our new approach, the Forget Me Not Wheel, to getting the views of patients and their carers together based on their experience on the Forget Me Not unit.

RECEPTION	GARDEN	TOILETS/ENSUITE	LOUNGE/DINING AREA	PATIENT BAY/SIDE ROOM	QUIET ROOM
welcoming	N/A	Very clean well equipped	friendly	excellent	N/A
lively	beautiful	ok	Very nice	excellent	N/A
Gave good information	Beneficial in good weather	Always very clean and tidy	Clean and tidy	Always clean and tidy	Welcoming and restful
adequate	Tranquil and very impressive	fantastic	Peaceful and calming. Well thought out	Very necessary and ideal for patients who need peace and quiet	Small but suitable for purpose
Bright, cheerful, spacious, friendly, inviting	Peaceful, pleasant, calm, welcoming, accessible	Large, clean, airy, bright, good facilities	Comfortable, colourful, friendly, relaxing, cheerful	Open, roomy, spacious, bright, friendly	Peaceful, calm, pleasant, quiet, tranquil
Very good	Lovely to have fresh air	good	good	Very good and happy	good
Well signposted	N/A	N/A	Well equipped	Spacious side rooms but more space needed around bedside	small
Bright and convenient	Neat and tidy	N/A	Smart and suitable	Clean tidy and bright	Very compact
Big, nice, bright, busy, cheerful and clean	N/A	Well signposted, clean and nice, big enough, light	N/A	Happy feeling, bright and cheerful, nice curtains, view of children's playground	N/A Patient on oxygen so bedside and toilet only
Quite good, like the colours and meeting others, like being able to chat to others	N/A	Clean not dirty, reasonable amount of room	N/A	Staff always available, Colour codes helpful, like visiting times	N/A

Enhancing the Healing Environment

Every single one of our Board members is aware of the excellent progress that has been made in the last six months to B12, which has become our Forget Me Not Unit. Other wards have also adopted a range of the characteristics that make a ward 'dementia friendly'. For example, the wall and door colours are contrasting where appropriate, and bathroom furniture is also designed to be dementia friendly.

Additionally, we have regular sessions in place on the Forget Me Not Unit and other wards where ‘enhanced healing’ through interaction takes place.



Leos Quartet playing in June just after we opened the unit

The Rock-a-Hula's

Patients and their families (and our staff) joining in

In addition to nominating one ward in the Hospital to be our Dementia Ward, all other wards and departments will be reviewed using an approved tool to identify how 'dementia friendly' they are. This now forms part of the Department and Ward Evaluation Scheme (DAWES).

Early identification of Patients with Dementia

All patients over the age of 75 who are admitted to Warrington and Halton Hospitals who present with confusion/ memory loss, will be screened by our nursing staff as part of a holistic assessment. All patients who require it, will receive an assessment by the specialist nurse team, who will refer the patient to appropriate other services. We will forge partnerships working with community teams to improve the assessment of patients with dementia.

We have achieved consistently our target of screening over 90% of patients eligible by our nursing staff. We have senior members of community teams as part of our Steering Group, and have invited a senior member of staff from 5 Boroughs Partnership Trust to join our group to ensure that we are continue to identify opportunities to improve.

Reduction of movement of Patients with Dementia

Patients will not be moved between wards if at all possible. Moves at mealtimes and medication times will also be avoided. Discussion regarding movement of patients with dementia will focus on the effect on the wellbeing of the patient. Carers and families should also be involved in any decision to move a patient with dementia. Our discharge planning will be holistic and carers and families will be involved in decisions affecting patients with dementia from the time of admission to the hospital.

We will develop a plan to monitor the movement of patients with Dementia, and put in place actions to restrict moves that are not in the patient's best interest. We audited a sample group of patients with a diagnosis of dementia or confusional states who are readmitted to hospital within 30 days.

We reviewed 10 sets of case notes in real depth to identify themes and trends related to the re-admission. The lessons learned were around advocacy and leadership in providing care. We found that the:

Discharge checklist was well used
Discharge care planning needs improvement
Discharge card use to improve
Discharge summaries to improve
Dementia referrals at admission with key worker to be identified – advocacy
Discharge Planning to be led more closely by MDT
Discharge Summaries to accurately reflect MDT actions taken and to provide a clear plan to the GP / NH
Dementia nursing team to be established to provide unique advocacy

The findings were shared with the readmission group and work is ongoing to address the recommendations of the audit.

Identification System

An agreed system will be in place across the Hospital so that staff are aware of the person's dementia (visual identifier behind the bed or in the notes). This will result in easy identification of patients with dementia on the ward so that appropriate responses can be provided to their needs.

We have launched the use of the Forget Me Flower symbol behind the patient's bed. The symbol reminds staff that the patient either has a diagnosis of dementia or has cognitive impairment and that they should ensure that their approaches to the patient are appropriate. This is accompanied by information to staff, carers and families about what this means for the patient.

Forget Me Not Campaign

All staff will be aware of the campaign to raise awareness of patients with Dementia, and those with other reasons that affect their cognition. A bank of Dementia Friends will be developed, where staff will pledge to support patients with Dementia or cognitive impairment. A programme of events, The Forget Me Not Events, will provide focussed activities within ward areas aimed at providing stimulation, diversion and help to reduce the agitation and loneliness that so often accompanies Dementia. Wards will have a suite of activities, including games, memory boxes, and other products aimed at keeping hands busy and stimulating the mind. We will promote the use of our Forget Me Not silicone wristbands for patients, carers, staff and families to raise awareness of dementia and cognitive impairment.

Information has been provided earlier in this report in relation to this aspect of the dementia strategy.

Trust Dementia Steering Group (Forget Me Not) and National and Local Dementia CQUIN Updates

The Trust Dementia Steering Group (Forget Me Not) has responsibility for delivery of the Trust's Dementia Strategy and the objectives of the Dementia 2013/2015 Strategy work plan, against agreed timelines. The Dementia Steering Group (Forget-Me-Not Group) meets monthly (at least 9 times per year) to provide a strategic direction to developing Dementia services within the Trust. The group has representatives from across professions including Estates, together with representatives from carers, and Alzheimer's UK local representatives..

A National Dementia Commissioning for Quality and Innovation (CQUIN) payment framework for was Dementia launched in April 2012. Its aim is to incentivise the identification of patients with Dementia and other causes of cognitive impairment alongside their other medical conditions, to promote appropriate investigations and to prompt appropriate referral at discharge. The CQUIN objectives form part of Trust Strategic Objectives. The Trust agreed a local CQUIN with Warrington Clinical Commissioning Group.

Overview of achievements and progress in both National and Local CQUIN requirements from 1st April to 30th September 2014:

National Dementia CQUIN

Find, Assess and Refer

We are required to (and know that it is the right thing to do – find patients who might have dementia, to assess them in accordance with our assessment criteria and refer those patients onto pathways and services, such as memory clinics. We assess the proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services in the community. We need to achieve over 90% in each section. The value of this part of the CQUIN to the Trust is £312,162. We are achieving this to date as demonstrated in the tables below.

Find

Month	Target >90%
April	94.55%
May	95.69%
June	95.43%
July	94.26%
August	96.26%
September	92.11%

Investigate

Month	Target >90%
April	100%
May	100%
June	100%
July	100%
August	100%
September	96.67%

Refer

Month	Target >90%
April	100%
May	100%
June	100%
July	100%
August	100%
September	100%

Clinical leadership.
We are required to ensure we have a named lead clinician for dementia and that this role is clearly documented in the individual's job plan. The value of this part of the CQUIN to the Trust is £52,162

Local CQUIN – Improve the Care of patients with dementia
We have worked toward setting an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of shorter lengths of stay. This effective foundation is further supported by our successful King's Fund bid under the 'Improving Environment of Care for People with dementia' . As part of our local CQUIN we have agreed to improve the care and experience of patients with dementia further throughout the next 2 years.

Since the opening of the FMNU we have monitored the following:

- Length of stay
- Number of completed Dementia Assessments – including This is Me and initial assessment documentation
- Falls
- Pressure Ulcers
- Number of reported incidents of violent and aggressive behaviour on the FMNU.
- Level of the need for !:1 nursing on the FMNU
- Re-admissions with 7 days of patients on the FMNU
- Re-admisisons within 30 days of patients with clinically coded dementia
- Number of patients from the FMNU in permanent admissions to care homes
- Carer feedback.
- Staff sickness in FMNU
- Number of complaints

With the exception of reporting on readmissions, which will form part of the second year of the CQUIN, we are achieving compliance with all areas of the CQUIN.

Dementia CQUIN update						
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (RN)	0.22	0.14	0.14	0.36	0.06	1
Sickness (CSW)	0.5	1	1.5	2.03	1.36	0.96
Specialling 1:1 (RN)	4.31	1.87	0	0	0	0
Specialling 1:1 (CSW)	3.88	0.22	5.02	4.45	9.5	2.65
Slips/Trips/ Falls	6	12	5	4	7	12
Incidents of violence/aggression	2	5	16	5	9	4
Readmission within 7 days - FMN Unit	0	0	0	0	0	0
Readmission within 30 days - patients with suspected dementia						
Average LOS on FMN Unit	N/A					27.9
Pressure ulcers developed whilst a patient on FMN Unit	1 (grade 2)	0	0	0	0	0
Relative complaints from FMN Unit	0	2	1	0	0	0
Permanent admissions to care homes from FMN Unit	N/A					7
Completed "This is Me" documents on FMN Unit	N/A					21
Completed "This is Me" documents across rest of the Trust	Not available	This forms Q4 of the CQUIN and we have developed a mechanism through meditech to achieve this				
Patients where FMN Unit admission criteria not met	N/A	3	0	0	0	0

Update on other areas of work

Dementia Conference July 2014

We were incredibly proud to host our first ever dementia conference. Over 100 trust staff were joined by expert national speakers, patients and carers to learn and share best practice – and hear the impact that high quality, compassionate staff interaction has on patients and families.

Dementia media and promotion

Since opening the ward we have built a strong media and promotional campaign to maximise publicity of the unit and share the best practice across the service.
Articles and promotion have appeared in:

- Warrington Guardian – pre launch, opening and several detailed follow up articles

- Runcorn World
- Runcorn Weekly News
- Liverpool Post
- Warrington Worldwide
- BBC Radio Merseyside
- BBC North West Tonight
- Nursing Times
- Nursing Standard
- Alzheimer's Magazine
- Health Estates Journal
- Journal of Dementia Care
- Alzheimer's Research UK

Contact has also been made with national broadcast media planning desks (BBC TV and Radio and ITN/Sky. Whilst the ward is not something they'd typically feature as a stand alone national item we've encouraged them to add us as a contact for a broadcast venue for future media pieces on dementia.

We were very proud to showcase our Forget Me Not Unit when Jeremy Hunt, the Secretary of State for Health visited us in September 2014. Mr Hunt said that our dementia unit was one of the best examples of dementia care provision he had seen.

Stakeholder events
The trust has also used its events programme to publicise the ward:

- Widnes Vintage Fair (Sept 2014) – the team took a 'rempod' reminiscence display down to the event for two days to encourage people to leave their memories and get dementia aware.
- Halton Party in the Park (Aug 2014) – as above but aimed at a younger audience
- FTN Conference 2014 – the trust bid and was awarded a showcase slot at this national FT event and shared learning from our work to over 700 delegates with 60 positive contacts from trusts across the country.

Anti-psychotic drugs audit

An antipsychotic/sedative audit was carried out in May 2014 to determine prescribing practice of clinicians within the Trust who manage the cognitively impaired patient - specifically the use of antipsychotic and sedative medication. The results were favourable with a significant reduction in the use of these drugs. Since our last audit in 2013, we have reduced the use of antipsychotic medication from 19% to 3%, and sedatives for 27% to 4.6%. The audit has been presented at medical audit and recommendations/best practice discussed with clinicians with an action plan being developed. This action plan will be monitored and reviewed via the Dementia Steering Group (Forget Me Not).

Areas for continued focus

- Training figures to be improved
- Identification of patients who have dementia who are re-admitted to hospital (when they did not stay in the FMNU)
- Monitoring of the use of This is Me Booklet in all ward areas

Recommendations

This paper is for the Board to receive updates on the ten work-streams related to the Dementia Strategy, the work of the Dementia Steering Group (Forget Me Not) and National and Local CQUINs

W&HHFT/TB/14/175

BOARD OF DIRECTORS

Paper Title:	Quality Dashboard (2014/2015) November 2014
Date of Meeting	
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
Purpose	To monitor performance against the KPIs within the Trust's Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- Exception reports are included for non-compliant indicators including Care Indicators; Friends and Family; Pressure Ulcer CQUIN; AQ Stroke and Heart Failure and C.Difficile
- Please note that VTE and Dementia (compliant) were extracted on the 19th November 2014 and are therefore provisional until final submission to UNIFY.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to:

- Note that the data for a number of indicators can change month on month. This applies to incidents (including pressure ulcers and falls), as incident type and severity can alter once reviewed, complaints and concerns as complaints can become concerns (and vice versa), with the agreement of complainants, and to mortality data which is rebased.
- Note progress and compliance against the revised key performance indicators
- Approve actions planned to mitigate areas of exception

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Intelligent Monitoring																			
Banding	March 14 (5)						3						5						
Number of elevated risks	1						2						1						
Number of risks	4						5						3						
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98												98
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	108	108	107														107
Total deaths in hospital	Not set		98	89	76	263	74	81	96	251	94								608
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0	0								0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	6	10	4	20	4	8	10	22	4								46
Incidents of moderate, major or catastrophic harm under investigation	N/A		4	0	2	6	0	3	4	7	8								21
Falls																			
All falls (approved)	Not set		91	78	87	256	89	78	79	246	76								578
Moderate, major and catastrophic	<=13 per year	IP	1	2	2	5	2	3	0	5	0								10

harm falls (approved)																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	2	2	0								2
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0	0								1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0	0								2
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	1	2	0								2
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	1	1	2								3
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	12	3	3	18	9								40
Grade 2 Hospital Acquired – stretch target (20% reduction)	<=90 per year	IP	3	8	2	13	12	3	3	18	9								40
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0	0								0
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100	100								100
% of patients with a pressure ulcer (Community or	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.99	3.73		3.37	5.63* amended	4.95		4.34								

hospital acquired) (ST)																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1	0								2
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9	3								19
MSSA	Not set		1	0	1	2	1	0	1	2	1								5
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7	3								18
Never Events	0 per year	QC	0	0	0	0	0	0	0	0	0								0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	13	6	22	5								53
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	PILOT		PILOT								
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31		94.56								
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100		100								
Number of patients who developed a HA VTE	Baseline TBC	QC	7	8	4	19	12	0	0	12									31
Number of patients who developed a HA VTE (under review)			0	0	1	1	1	5	4	10									11
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98		97.4								

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month	IP	4	2	2		2	4	5		0								
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99		0								
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45		92.70								
Dementia Assessment % (Part 2)	>=90%	C	100	100	100*		100	100	91.89		100								
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100		100								
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7	99								
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6	96								
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9	83								
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4	98.8											98.8
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4	96.7											96.7
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1	84.3											84.3
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1	76.1											76.1
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3	60											60

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
COPD (data not yet released)	>=50%	IP, C																	
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC															0.41		0.40
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC															0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar 2014)	IP,QC															0.065		0.065
Patient Experience																			
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results	C				70.9				72	STAFF SURVEY								
Staff F&F place to work (as above)	Q3 Staff survey results					66.8				67									
Always events (Q1&2 implementation, Q3 data collection)	TBC	IP									84%								
Mixed sex occurrences	0	QC	6	3	0		0	0	0	0	0								9
Friends and family test																			
Friends and Family Test. **Star rating**	TBC		4.54	4.5	4.58		4.53	4.6	4.58		4.6								
Friends and Family Test Inpatients **Net promoter changed to % recommending Trust – November 2014.**	>=94% (National average including independent)	OH	76	74	81		76	77	94%										
Friends and Family Test A&E **Net**	>=86% (National average)	OH	42	35	41		40	45	82%										

promoter changed to % recommending Trust – November 2014.																			
	Threshold	**IC**	**A**	**M**	**J**	**Q1**	**J**	**A**	**S**	**Q2**	**O**	**N**	**D**	**Q3**	**J**	**F**	**M**	**Q4**	**YTD**
Friends and family response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26	13.57								18.24
Friends and family response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55	32.85								30.03
Complaints and concerns																			
Number of concerns received	Not set	IP	2	9	6	17	16	10	6	32	5								49
Number of complaints received **Please see note below.**	2013/2014 received 422 (No threshold set)	IP	31	40	38	109	52	30	31	113	52								274
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.50	98.23	97.92								97.58

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

2. Exception reporting

Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The results (random sample) indicate sustained compliance with the falls risk assessment, Waterlow is compliant in October at 96% and MUST is much improved at 83%. The Patient Quality & Safety Champion has increased surveillance and feedback around risk assessments in order to improve compliance going forward.

Friends and Family

The A&E response rate for F&F has fallen below the required 15% for two months. We will refocus efforts to ensure that the Trust achieves >=15% on a monthly basis in order to achieve 15% overall for Q3 and 20% by Q4.

Clostridium Difficile

Clostridium difficile

3 hospital apportioned cases of Clostridium difficile were reported in October. The total number of hospital apportioned cases is 19 YTD against the threshold of 26 cases. The business case for increase in hours for the Antibiotic Pharmacist role has been approved and is awaiting appointment. A number of proactive initiatives are being planned for European antibiotic awareness day in November. The 2 cases that were submitted to Commissioners for appeal failed and we are awaiting feedback.

Advancing Quality – Heart failure and Stroke

Heart Failure

The nursing and medical teams continue to work toward patients with HF receiving the treatment they require and in the vast majority of patients this is the case. We are working on looking at the fails which are in the main due to patients who were admitted and discharged with a diagnosis of Heart Failure within 24 hours. We are looking to develop a document similar to that used in the pneumonia workstream in support of this. Importantly, it must be noted that concerns were raised at our last AQ meeting that there may be issues with accuracy of recording HF patients who may not eventually have heart failure (it would really be unusual only to be admitted for 24 hours with this condition), and it has been agreed that there will be a separate meeting to discuss Heart Failure and other conditions with Sam Doddridge and / or Liz Kanwar from AQuA as they had offered their assistance to the Trust in both Heart Failure and Stroke.

Stroke

Processes to monitor non-compliance have been improved and if any measures are missed they raise this with the individual nurse. The issue with inappropriate use of ring fenced stroke beds for non-stroke patients still remains but they stress that staff are trying hard to keep these beds available for stroke patients but that with the general bed situation this is not always possible. AQ Adjudicators have also stated that the timing for the 4 hour stroke measure is to be taken from the notes when the patient reaches the ward and not MEDITECH which results in breaches for the 4 hour Stroke measure. These KPIs are monitored by the AQ Group and the CQUIN Group. This was narrowly missed, with a cumulative score of 60% for April 2014 – August 2014, against a target of 60.4%

4. KPI Updates

Pressure ulcer (Community or hospital acquired) (ST)

This indicator is in place to monitor progress with the national CQUIN - The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey / Total number of patients surveyed on the day.
The Trust median baseline for October to March 2014 was established at 3.99. We have agreed improvement value of <=3.99 with commissioners. The Trust is required to show improvement in the period November 2014 to March 2015. The Trust is currently over the target of 3.99. The main issue is old PU (known as community). Analysis of "old to new" shows that the rate has increased due to the number of old PU's Work being undertaken to identify the patients who are admitted from care homes and directly from home and we will then identify themes e.g. location of PU and long term conditions to share with care homes and GP's. Report will be sent to the CCG.

CQC: Intelligent Monitoring

The Elevated risk is:
Whistleblowing (18-7-13 – 29-9-14)

The risks are:
Composite indicator: In-hospital mortality - Cardiological conditions and procedures (01-May-13 to 30-Apr-14)
Composite indicator: In-hospital mortality - Haematological conditions (01-May-13 to 30-Apr-14)
NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

See the related Board paper for further details

W&HHFT/TB/14/176

BOARD OF DIRECTORS

Paper Title:	Quality Strategy (2014/2017) November 2014
Date of Meeting	
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing Programmes Manager) Alison Lynch (Deputy Director of Nursing) Hannah Gray (Clinical Effectiveness Manager)
Purpose	The Quality Strategy articulates the Trusts quality objectives for 2014/2015. The framework for quality provides a blended model which combines the Monitor Quality Governance Framework and the key domains of patient safety, clinical effectiveness and patient experience as set out within the Darzi Report. (To replace the Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy.)

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Clinical Commissioning Group(s)	October 2014
	Governance Committee	11th November 2014
	Quality in Care Committee	11th November 2014
	Senior Managers	October 2014

Relates to which Trust objectives

	appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- This Strategy establishes and defines the "Darzi" committee structure which will be a new approach to managing quality within the Trust. It also supports the view that a new Clinical Audit Committee reporting to the Clinical Effectiveness Committee should be developed.
  The Strategy also defines the priorities for quality improvement and sets realistic, measurable goals.
  The Strategy identifies the risks to quality and the steps needed to mitigate these risks; and sets out the vision for quality in a way that engages staff, patients and the local community.

This strategy sets out key priorities and the principles that the Trust will continue to develop and apply to current and future planned services.
In Q4 MIAA will be undertaking a review of systems and processes in place to manage the Quality Agenda. This Quality Strategy incorporates best practice as determined by Monitor and the CQC.

- The Clinical Commissioning Groups; Quality in Care; Medical Director; Non-Executive Director; Director of Nursing; Clinical Effectiveness Lead – Medical; Board Secretary and the Associate Director of Governance have been consulted and their feedback has informed the 2nd version of this Strategy.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to:

- Approve and ratify the Quality Strategy including the blended model which combines the Monitor Quality Governance Framework and the key domains of patient safety, clinical effectiveness and patient experience as set out within the Darzi Report.
- Agree the formation of a Clinical Audit Committee to report to the Clinical Effectiveness Committee.
- Agree implementation of the Darzi Committee structure including replacing the Clinical Governance, Audit and Quality Sub Committee and Quality Governance Committee with a committee of the Board to be known as the Quality Committee.
- Agree revised committee structure reporting to the Quality Committee including the proposal that Emergency Planning Sub Committee reports to Finance and Sustainability; Information Governance and Corporate Records Sub-Committee reports via IMT to Finance and Sustainability.
- The strategy proposes the formation of a Health and Safety Committee to manage non clinical risk including fire; estates and security management. The Health and Safety Committee could report to either the Quality Committee or the Strategic People Committee – the Board is asked to agree appropriate forum for this function.
- Agree the proposal that the risk registers will be reviewed by the feeder committees to the Quality Committee. (This will require minor changes to the Risk Management Strategy)
- Agree that the committees reporting to the Quality Committee are given delegated authority to review and ratify policies within their remit.
- Agree the draft Terms of Reference with the proviso that the individual committees will undertake a full review at their inaugural meeting to agree standing items; work streams and membership.
- Agree that the new committee structure will undertake a staged implementation as follows:-
    1. Governance Committee – inaugural meeting in December / January to agree Terms and Reference and reporting process for feeder groups. (Handover from Clinical Governance, Audit and Sub Committee and Quality Governance Committee)
    2. Emergency Planning and Information Governance to move within the remit of Finance and Sustainability
    3. Feeder committees to meet from February 2015
    4. MIAA Review of Quality January / February 2015.

QUALITY STRATEGY 2014 - 2017

Contents

FOREWORD

Our mission is High Quality, Safe Healthcare and our staff work together to provide high quality, safe health care services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. We serve a local population of 322,111 people (127,400 in Halton and 194,711 in Warrington. The majority of our emergency care and complex surgical care is based at Warrington Hospital whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Cheshire and Merseyside Treatment Centre is home to our orthopaedic surgery services.

This is a complex organisation with an annual budget of around £210 million and the Trust employs over 4,200 staff to provide access to care for over 500,000 patients a year. Although each hospital site specialises in particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton so people can access their initial appointments close to home wherever possible. We also provide some outpatient services in a number of locations in the local community.

As a Trust Board we take our responsibilities for the safety of our patients as our primary objective. Warrington and Halton Hospitals NHS Foundation Trust is a learning organisation that consistently transforms practice by learning from both our mistakes and those of others in order to provide the best possible health care. This strategy consolidates this approach by defining the combination of structures and processes at and below Trust Board level to lead on Trust-wide quality performance to ensure that required standards are achieved. This will be supported and achieved via MONITOR's Quality Governance approach by:-

- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

This strategy establishes and defines the "Darzi" committee structure which will be a new approach to managing quality within the Trust. The strategy also defines the priorities for quality improvement and sets realistic, measurable goals. It identifies the risks to quality and the steps needed to mitigate these risks; and sets out the vision for quality in a way that engages staff, patients and the local community.

This strategy sets out key priorities and the principles that the Trust will continue to develop and apply to current and future planned services. It is acknowledged that there are a number of strategy and policy documents which underpin this Quality Strategy. Enabling strategies include:-

- Medical Appraisal and Revalidation Policy
- Complaints and Concerns Policy
- Risk Management Strategy
- Clinical Audit Strategy
- Incident Reporting Policy
- Clinical Audit Policy
- Management of National Guidance including National Confidential Enquiries (NCEPOD), National Institute of Clinical Excellence (NICE) High Level Enquiries and CAS Alerts Policy.

		E-Signatures to be obtained following ratification
Mel Pickup	Chief Executive	

Simon Wright	Chief Operating Officer and Deputy Chief Executive	
Karen Dawber	Director of Nursing and Organisational Development	
Paul Hughes	Medical Director	
Tim Barlow	Director of Finance and Corporate Development	
Jason De Costa	Director of Information Technology	
Alan Massey	Chairman	

INTRODUCTION

The Trust's mission is to be the provider of 'high quality, safe healthcare'. To enable us to achieve this, we have developed four strategic objectives they are:

- To ensure all patients are safe in our care
- To give our patients the best possible experience
- To be the employer of choice for the health care we deliver
- To provide sustainable local health care services

This Quality Strategy (which replaces the "Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy") underpins these four objectives, aiming to deliver high quality safe healthcare in a timely and responsive manner, provided in high quality, safe therapeutic environments and maintaining compassionate and respectful care. The strategy also draws together the following initiatives to deliver a clear plan of how the Trust will work to achieve this. Our values are blended into our Quality People and Sustainability Framework (QPS) as follows:-

QPS Framework

QUALITY		PEOPLE		SUSTAINABILITY	
SAFETY	-We will reduce harm -We will have no avoidable deaths -We will manage and reduce risk	WORKFORCE	-We will develop the competency of all our staff and provide them in the right numbers -We will be 'European Working Time Directive' compliant -We will support our staff to be 'fit and well' to work -We will continually review the Terms and Conditions of our staff	GOOD GOVERNANCE	-We will be complaint across all areas of regulation -We will provide robust assurance to our board of directors -We will be an effective board of directors -We will develop and encourage our Governors and members
EFFECTIVENESS	-We will improve clinical outcomes -We will use evidence based practice -We will support research and development, audit and innovation -We will deliver right care in the right place and at the right time	ENGAGEMENT	-We will communicate with all our staff -We expect all our staff to take accountability -We aim to be the employer of choice -We encourage staff loyalty and recognise their discretionary effort	FINANCIAL VIABILITY	-We will agree robust contracts for services -We will develop service line management -We will review how we use our estate -We will look to collaborative working with other healthcare providers -We will invest in IT to support innovative working
EXPERIENCE	-We will have an ethos of good customer care and personalisation -We will support 'No Decision About Me, Without Me' -We will get 'the basics' right (warm, safe, clean, fed, cared for)	LEADERSHIP	-We will develop and reward talent -We will support the development of good leaders and role models -We will invest in education, training and development	PROFILE AND PERCEPTIONS	-We will be a good corporate citizen -We will effectively market our services and look to grow and develop commercially for strategic advantage -We will pursue the collection of charitable funds to support our development and enhance patient care.

The quality of patient care and the safe, effective manner in which it is provided is the core business of the NHS, and our organisation strives to provide the best possible care in order to remain a sustainable health provider of choice.

In recent years there has been a major national policy shift in the importance attached to this. Building on the work of Lord Darzi's 'High Quality Care for All', the White paper published in 2010 'Equity and

Excellence; Liberating the NHS' outlines the government's intention to establish improvement in quality and health care outcomes as the primary purpose of all NHS funded care.

The delivery of high quality services, together with the ability to demonstrate a programme of continuous service improvement, is seen as one of the most important indicators of a successful health care organisation. The Department of Health (DoH) NHS Outcomes Framework 2014/2015 provides indicators grouped within five domains, which set out the high-level national outcomes that the NHS should be aiming to improve.

The Commissioning for Quality and Innovation (CQuIN) payment framework forms part of the income received by the Trust; and Monitor's Quality Governance Framework re-emphasises the focus on quality. This framework was designed following failings at Mid Staffordshire Foundation Trust as a tool to encourage and support current good practice for quality governance. (Appendix 3) Monitor defined quality governance as being the combination of structures and processes at and below board level to lead on trust-wide quality performance to ensure that required standards are achieved. This will be achieved by:-

- 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.

More recently, the Francis Report (2013) has focussed everyone's attention nationally on the failings of the NHS. This final report of the Public Inquiry into the failings in care at another trust provided a detailed and systematic analysis of the factors contributing to those failures. It identified that warning signs existed and could have revealed the issues earlier. Francis has provided the foundations for all health care providers to look at their existing policies and strategies in a different light, to ensure that similar failings are never repeated.

The Trust is also registered (without concerns) with the Care Quality Commission (CQC) and has developed effective systems to assure continued compliance with the essential standards of quality and safety contained within the Health and Social Care Act 2008. These systems focus both upon measuring outcomes around the patient experience and regular observations of key aspects of care for example nutrition and medicines management.

The Trust will ensure that we develop and integrate these tools and processes into the quality agenda to ensure a sophisticated whole systems approach. This will include and not be exclusive to an internal annual review of our systems and processes using both the Quality Governance Framework and the CQC Outcome framework. We will also instruct our internal auditors to undertake a whole systems audit of quality in order to provide assurance that systems are in place to address national and local clinical and quality requirements to ascertain if they are fit for purpose.

VISION & STRATEGIC OBJECTIVES

Our organisational vision is to be the "most clinically and financially successful healthcare provider in the mid-Mersey region by 2019". (Operational Business Plan - 2014/2017)

During 2013/14 we continued to strengthen and perform well on quality by investing in staff in key areas, by strengthening our clinical teams – more doctors, more nurses and more allied health professionals. Leadership programmes are in place including more devolved management through the divisions.

Importantly, in terms of quality the Trust invested in new services including maternity, dementia and the use of IM&T to support enhanced clinical delivery. We developed new strategies for nursing, dementia and quality. We have performed well in relation to a number of inspections including a thematic Review of Dementia by the Care Quality Commission however a recent inspection of maternity services revealed areas for improvement which the Trust is acting upon. The Trust has implemented the Friends and Family initiative across inpatient; accident and emergency; maternity services and more recently across day case and outpatient services, investment in an infrastructure to support this initiative has resulted in a substantial increase in service user participation.

The development of QPS provides the Trust with a framework to ensure the future quality and sustainability of our services and the development of our workforce. The purpose of this strategy is to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the Trust**.** We will do it by:

- Obtaining assurance that the Trust is well managed and compliant with regulatory requirements including compliance with the Care Quality Commission standards and with Monitors Quality Governance Framework
- Making quality and quality improvement a core responsibility for and owned by all staff and ensuring that they are supported to fulfil this role.
- Continuous improvement of patients' experience, safety and outcomes,
- Reducing the risk from clinical errors and adverse events, as well as being committed to learning from mistakes and importantly sharing the learning across the Trust.
- Ensuring that patients receive the right treatment, at the right time, in the right place, have their individual needs taken into account and be treated/cared for in a safe environment taking into account best practice
- Implementing quality standards and pathways - responding to the needs of patients and users as individuals and using best practice and evidence based care to deliver a personal service. For example, supporting people who are at the end of their life to die where they wish and ensuring when patients with dementia are cared for in our hospitals we provide an environment that reflects their specific care and well-being needs.
- Supporting staff in their training and development, through appraisal, revalidation, and personal development plans, to ensure they are equipped to deliver high quality health care
- Meeting all the requirements of both national and local CQuINs
- Ensure participation in national and local clinical audit which is now a statutory and contractual requirement for healthcare providers.
- Ensuring a patient centred and patient led approach to care that includes treating patients courteously, involving them in decisions about their care and embracing the principle of shared decision making. (Liberating the NHS: No decision about me without me – DoH 2010)

However, ultimately, it is the Board of Directors who, are responsible for overseeing the quality of care being delivered across all services and assuring itself that quality and good health outcomes are being achieved throughout the organisation. Effective governance requires that the Trust Board pays equal

attention to quality of care as they do to the management of finances and that our processes support the provision of intelligent information to facilitate this.

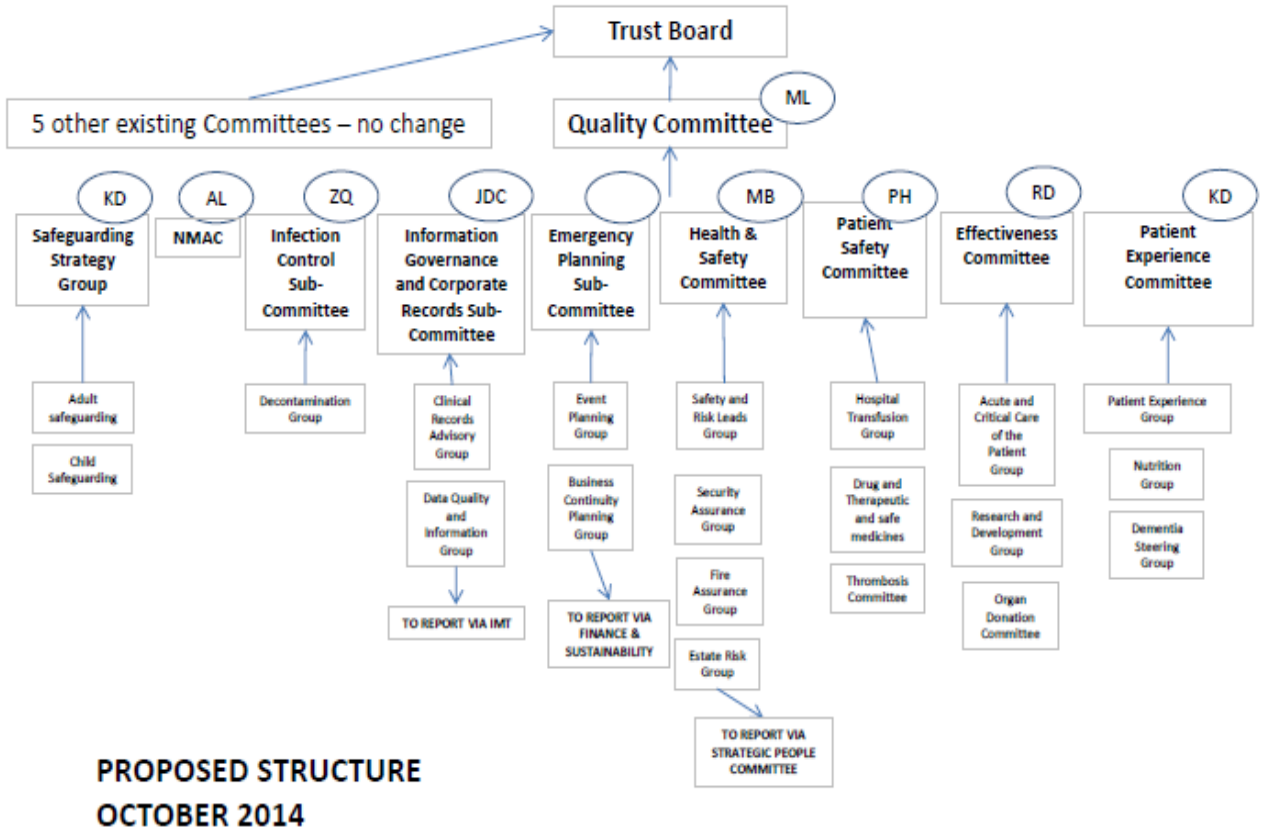
QUALITY – WHAT IS IT?

Quality is the golden thread that must run through all of our services, business plans and objectives. As we aim to be the most clinically and financially successful healthcare provider in the mid-Mersey region by 2019 we must clearly articulate what this means for the Trust and ensure that this is communicated to and developed in partnership with our staff, patients and key stakeholders.

We recognise that what happened in another organisation was not only a system failure (in part relating to roles of different external organisations and agencies), but that it was a failure of the organisation itself to listen and learn from incidents, near misses, complaints, and concerns raised by both patients and staff. This strategy supports our goal of continually learning; improving the quality and safety of care provision as well as improving the patients' experience of that care.

Quality has three main elements: patient safety, clinical effectiveness and patient experience (Darzi Report, High Quality Care for All: June 2008). High quality organisations are safe, effective, person centred, timely, efficient and equitable. The Trust has restructured the committees in line with this approach to ensure that we provide an equal balance and assurance on all aspects of quality within the organisation and that we can measure and improve quality at all levels and throughout all areas of the Trust.

Quality Committee Structure (proposed) Appendix 12



Quality is only achieved if all three of these domains are present and delivering on just one or two in isolation is not enough. The three committees (and other feeder committees) will manage the "quality" function of our QPS Framework through to the Quality Committee. This Committee is accountable to the Trust Board for the development and implementation of the Trust's Quality Strategy and for promoting and assuring quality so that patients have effective and safe care with a positive experience of services delivered by the Trust.

QUALITY FRAMEWORK

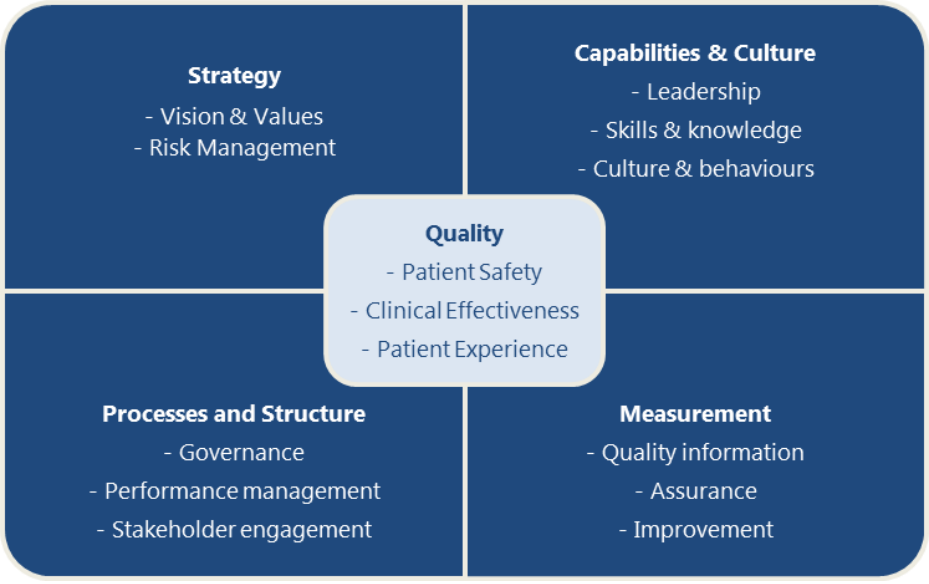
Our approach to quality is aligned to Monitor's Quality Governance Framework QGF (Appendix 3) which sets out the key elements of quality from strategy through to culture, capabilities, processes and ensuring we have the right information to measure quality.

NB: The QGF informs the Well Led Statement of Intent; (Monitor, CQC and Trust Development Authority) which trusts are required to self-assess against every three years.

Our framework for quality (Figure 1) provides a blended model which combines the Monitor Quality Governance Framework and the key domains of patient safety, clinical effectiveness and patient experience as set out within the Darzi Report.

All three committees will ensure that they comply with the measures within the Monitor Framework and are thus fit for purpose in managing their specific function and the Quality Committee which will have the overarching responsibility to review and measure the work of these committees in order to provide assurance of compliance to the Trust Board and escalate risks and exceptions to compliance if required. This process will support the Trust in responding to the CQC requirements of the organisation being "Safe; Effective; Caring; Responsive and Well Led".

Figure 1: Quality Framework



QUALITY - EXTERNAL CONTROLS AND INFLUENCES

As well as responding to the internal management of quality the Trust also has an obligation to comply with and report via external agencies in relation to both the management of and transparency in communicating this to the wider community.

Care Quality Commission

Both Monitor and the Care Quality Commission (CQC) have placed quality at the heart of their regulatory regimes via Monitor's Compliance and Quality Governance frameworks, and the CQC's essential standards of quality and safety. The CQC has within the last twelve months published its intelligence reports and risk bandings on all NHS trusts for the first time in their Intelligent Monitoring Reports that we fully support as a way of highlighting risk in the health service.

The intelligent monitoring reports are based on 150 indicators that measure patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results. It gathers information from accredited sources to give an informed view and raise any questions necessary on the quality and safety of each hospital's service. It helps the CQC to know where to focus their new, stringent inspection resources. The CQC band each trust into one of six categories based on the risk from these indicators that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk.

CQC new Inspection Regime (Keogh Framework)

If trusts are placed into a high risk band it can trigger an inspection. The CQC will now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They will spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections will be a mixture of unannounced and announced and they will include inspections in the evenings and weekends when it is recognised that patients can experience poor care.

This Trust will continue to invest resources in ensuring that staff, understand these processes and it has since February 2014 provided drop in sessions in order to raise awareness about the new CQC Inspection Regime.

Quality Report (Account)

This Trust provides and publishes an annual Quality Report about the quality of our services. This Quality Report is an important way for all trusts to report on quality and show improvements in the services they deliver to local communities and stakeholders. The Quality Report also includes a statement from the Trust Board (or equivalent) summarising the quality of the NHS services that we provide; our organisation's priorities for quality improvement for the coming financial year; a series of mandated statements from the Trust Board for which the format and information required is set out in regulations; and a review of the quality of services in our organisation. The quality of the services is expressed via improvement priorities and quality indicators through the three domains of quality namely patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided. The Trust Board, in partnership with staff, stakeholders and governors, has reviewed data relating to quality of care and agreed our improvement priorities for 2014/2015. The Trust has strong internal mechanisms to implement and monitor improvement priorities to improve patient outcomes, going forward the Quality Committee will be accountable to the Trust Board for monitoring compliance and escalating non-compliance to Trust Board as required. The Quality Strategy articulates the Trusts quality priorities for 2014/2015 which are communicated internally by Improvement Priority Quarterly Reports and externally by the Quality Report. Improvement priorities and quality indicators are also

included in the Quality Dashboard, all of which improves the assurance that the Board receives at year end when the Quality Report is signed off.

Commissioning for Quality and Innovation Framework (CQUIN)

The CQUIN framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead.

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals. The amount of income in 2013-2014, conditional upon achieving quality improvement and innovation goals, was £4,617m. The Trust has strong internal mechanisms to comply with national, local and specialist commissioning CQUINs, going forward the Quality Committee will be accountable to the Trust Board for monitoring compliance with the CQUINs and escalating non-compliance to Trust Board as required.

Clinical Commissioning Groups (CCG)

CCGs commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services.

Clinical focus and adding value

Commissioners have a key role (in partnership with service providers) in designing services to meet local priorities. They are, in reality, the 'customer' as opposed to the 'consumer'. GPs, in particular, will have significant face-to-face contact with the patient and will also have knowledge of local hospitals and senior doctors. CCGs will therefore play an important role in identifying and driving continuous quality improvement. In addition to information from regulators, CCGs will have their own intelligence based on contract monitoring and patient and public engagement. This Trust will ensure that we have considered the views of commissioners in setting and monitoring quality goals.

The commissioning responsibilities of each CCG include:

- Planning services based on the needs of the local population
- Securing services that meet the needs of the local population
- Monitoring the quality of care provided including implementation and compliance with Commissioning for Quality and Innovation (CQUINs).

The Trust is required by regulation to share our Quality Report/Account with relevant clinical commissioning groups for comment as determined by the NHS (Quality Accounts) Amendment Regulations 2012.

Healthwatch

Healthwatch England gathers information, reports on and raises issues nationally on all health and social care – providers and commissioning

Local Healthwatch works with local people to gather views and experiences to inform local and national services.
It aims to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Its creation reflects the 'no decision about me without me' drive.
Healthwatch also has a seat on the Health and Wellbeing Board. It has a responsibility to ensure that the views and experiences of patients, carers and other service users are represented and taken into account when local needs assessments and strategies are prepared.

It also seeks to promote and support the involvement of patients and the public in the commissioning and provision of local health and care services and where possible that their views influence how services are to be run.

Through representing the views of communities and their concerns about their local health and social care services, Healthwatch will help build a picture of where services are doing well and where they can be improved

The Trust is required by regulation to share our Quality Report/Account with Local Healthwatch organisations for comment as determined by the NHS (Quality Accounts) Amendment Regulations 2012.

Overview and Scrutiny Committees

Local Councils are run by elected members known as councillors. A small number form the cabinet, or executive, taking strategic decisions and setting priorities for the council.
The rest of the councillors are involved in the scrutiny function as such each council has a health overview and scrutiny committee dedicated to scrutinising local NHS policy, planning, and impact against local needs and inequalities.
This committee is made up of councillors (and in two-tier areas often includes district/borough members as well as county councillors)

The Trust is required by regulation to share our Quality Report/Account with Overview and Scrutiny Committees for comment as determined by the NHS (Quality Accounts) Amendment Regulations 2012.

Patient Safety Collaborative

NHS-England has developed a 5-year national programme with the aim to improve patient safety outcomes across England through the development of regional Patient Safety Collaboratives within AHSNs. The purpose (as envisioned by the 2013 Berwick report) is for the NHS to develop a culture of continuous learning and sharing data in an open and transparent manner and make a significant reduction in patient harms. These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. These learning systems will identify safety issues at a local level and then design, implement and evaluate the solutions, as they are adopted by organisations locally. A large part of the collaboration programme will see the sharing of these solutions across the country, so that successful new initiatives can be shared to bring best practice to similar health providers nationwide.
Organisations that "sign up to safety" can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Sign up to Safety

The Trust has also joined the "Sign up to Safety" campaign which is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.
Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS.

The Trust has submitted its sign up document setting out the actions that we will undertake in response to the five Sign up to Safety pledges and published this on our website for staff, patients and the public to see. The next stage will be to turn these actions into a safety improvement plan (including a driver diagram) which will show how the Trust intends to save lives and reduce harm for patients over the next 3 years. Going forward the Darzi committees will be accountable to the Quality Committee for monitoring compliance with this plan.

Open and Honest Care

The Trust has signed up to the "Open and Honest Care: driving improvement programme" and along with a number of North West trusts regularly publishes information on quality and safety measures and incidences of harm in our hospitals. As a member of the programme, we continue to work with patients and staff to provide open and honest care, and through implementing quality improvements, further reduce the harm that patients can sometimes experience when they are in hospital.
We have made a commitment to publish a set of patient outcomes and patient experience and staff experience measures so that patients and the public can see how we are performing in these areas.
Each month we collaborate with other care providers to share what we have learned and to use this information to identify where changes can be made to improve care. Importantly sharing this information supports the Trusts ethos of being transparent about the quality of our services

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Finally, we believe that patients must always come first if we are to deliver the best and safest care possible. We believe that patient care is everyone's responsibility. We feel that this Strategy forms part of a solution to this issue by describing how all the key quality initiatives they will be monitored to improve patient outcomes, safety and experience.

We will revisit this Strategy on an annual basis and at a three year review period. The test of success will be the delivery of high quality healthcare to all our patients.

AIMS AND OBJECTIVES OF THE STRATEGY

To describe to our staff and patients how the organisation will improve patient quality and provide a framework to do this.

SCOPE

The strategy will:

- Clearly sets out our patient safety, effectiveness and patient experience priorities to improve the quality of all our clinical services, updated annually as part of the annual planning cycle
- Set out how we will measure and report our progress against identified improvement indicators.
- Set out the structures, systems and processes necessary to deliver and monitor all aspects of the strategy and to demonstrate a positive effect on clinical care
- Provide a framework to support and motivate our staff to deliver the highest possible quality care providing staff with an environment where the pursuit of continuous quality improvement is both encouraged and required.
- Complement our existing governance arrangements toward ensuring that quality is our underpinning principle, via the Quality Committee, and operational committees including the DARZI committee(s) reporting to this Committee
- Outline the duties and responsibilities of staff in delivering this strategy
- Support the delivery of national priorities and commissioner requirements for the provision of quality healthcare

The Darzi2 domains are well recognised in the NHS and accepted as the definition of the main components of quality in England; they are also set out in law in the Health & Social Care Act 2012. This Trust has adopted these domains as its definition of quality. These are:-

The Trust has restructured the committees in line with the above Darzi model to support our objective of building a quality focussed structure that supports the continuous collation and review of information

and data to further improve the internal management and assurance processes around these critical functions underpinning high quality care and gain assurance that quality is being managed effectively. Going forward these three Committees will report to the Quality Committee namely:-

Patient Safety Committee, (Appendix 5) Ensuring patient safety is a fundamental element of high quality healthcare. At this Trust, providing safe, quality healthcare to our patients is not only a top priority, but a value that we uphold every day. This Committee will be responsible for leading on risk management and reducing avoidable harm such as falls, drug errors or rates of healthcare associated infection

Clinical Effectiveness Committee, (Appendix 4) the evidence reveals a wide variation in the clinical effectiveness of care delivered across the country this Committee will be responsible for the effectiveness of treatment of the care provided to our patients – measured by both clinical outcomes and patient related outcomes. Importantly it is felt that whilst Clinical Effectiveness will provide a high level review of clinical audit prior to papers going to the Quality Committee that Clinical Audit will require a dedicated committee that reports to Clinical Effectiveness to manage the detail of clinical audit e.g. approving registration and support; forward planning and generally ensuring that local audits support the quality agenda effectively. It is therefore proposed that a Clinical Audit Committee will be developed to support this

Patient Experience Commiittee, (Appendix 6) patient experience data is seen as a key indicator in identifying problems in care. This Committee will look at all aspects of the quality of caring. This means how personal care is including compassion, dignity and respect with which patients are treated. This will be achieved by a review of information and data on the patient experience including complaints, concerns, patient feedback and patient stories – how positive an experience people have on their journey through the NHS can be even more important to the individual than how clinically effective care has been.

Membership

All three Committees will include membership as follows:-
Patient Safety Chair – Medical Director
Clinical Effectiveness Chair – Medical Clinical Effectiveness Lead
Patient Experience Chair – Director of Nursing and OD

- Members selected based on expertise and specialist knowledge
- Non-Executive Director
- Divisional representation
- Patient / carer representation
- CCG Quality Lead

Quality Committees – non Darzi

Infection Control Committee (ICC) (Appendix 7)
Safeguarding Strategy Group (SSG) (Appendix 8)
Medical Advisory Group (MAG) (Appendix 10)
Health and Safety Committee (HSC) – still required
Nursing and Midwifery Advisory Committee (NMAC) (Appendix 9)

Professional Advisory Group (PAG) (Appendix 11)
(NB: Revised Terms of Reference in Appendix)

Key Performance Indicators

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

Each of the supporting Committees outlined above will monitor their identified objectives and targets via performance indicators and dashboards. The Quality Dashboard (Appendix 1) which has been aligned to the performance measures from the CQUINs; quality contract; quality report and MONITOR requirements will be reviewed by the Quality Committee prior to review at the Trust Board.

Assurance Process

All feeder committees to the Quality Committee will take responsibility for the assurance function within their remit for example a serious untoward incidents (SUI) relating to pressure ulcers will be reviewed by the Patient Safety Committee and a SUI related to patient transfer will be reviewed by the Patient Experience Committee. They will agree and ensure that KPIs relating to their function are developed and monitored continuously so any early warnings regarding possible deterioration of services is identified and acted upon.

The individual committees of the Quality Committee will ensure that risks are escalated appropriately and included in the risk registers if required. The Quality Committee will oversee, monitor and maintain the Board Assurance Framework and Risk Register(s) and seek assurance that the risk ratings are correct and that appropriate actions are taking place to mitigate and/or eradicate risk.

The Quality Committee will review and analyse all quality data and information about services to ensure recognition of early warning signs e.g. Quality Dashboards, Quality profiles and other data/intelligence about services including patient and staff experience. Escalate to Trust Board as required.

DUTIES AND RESPONSIBILITIES

Overall accountability for quality begins and ends with the Trust Board. Key responsibilities include:-

- Engaging with stakeholders to set quality priorities and standards and communicating these across the whole organisation. The Board, through engagement with others both within and outside the organisation, sets the priorities and expectations for the organisation. It clarifies the strategic direction, quality priorities and values for the organisation and defines how performance against these key areas will be measured and monitored. Importantly it will ensure that these priorities and expectations are clearly communicated and cascaded to all levels of the organisation to provide a strong sense of purpose, clarify boundaries and enhance accountability.
- Ensuring that high quality care is being delivered and risks to quality are being effectively managed. The Board will utilise processes and systems of assurance and escalation to gain insight and intelligence internally and externally on the quality of its services (in particular

where services are underperforming or even harming patients). These processes and systems will also hold management and clinicians to account for their performance.

All staff have a role to play in maintaining patient safety, providing effective care and in ensuring that the patients experience of that care is the best that it can be.

This section provides clarity around the responsibilities and roles within the organisation.

Board of Directors (BoD)

It is the responsibility of both Non-Executive and Executive Directors to ensure systems and processes are in place to monitor and implement this procedural document. The arrangements for quality should complement, and be fully integrated with all other aspects of the Trust Board's responsibilities, for corporate governance.
The data and information that the Trust board receives should include a specific reference to the quality issues that the Trust Board is considering as well as standing items such as policy updates, audit results, quality outcomes (including complaints, incidents and claims), local, organisation and national updates on quality performance and performance benchmarks.

Chief Executive (CEO)

- Accountable to the Trust Board for the quality of care provided across the Trust and organisational compliance with the CQC essential standards of quality and safety
- Ensures systems and processes for quality are in place and that assurance for these processes is provided to the Trust Board
- Ensure that there are suitable arrangements in place for staff, patients, carers and families to raise concerns about quality and care standards and ensure these are responded to.

Director of Nursing and Organisational Development (DNOD)

The Director of Nursing, and Organisational Development and the Medical Director have delegated responsibility from the Chief Executive to lead this Strategy.

- Overall accountability to the Chief Executive for ensuring the Trust has a robust quality governance infrastructure in place including an appropriate committee and accountability structure, clearly defined roles and responsibilities, policies, procedures, systems and information to support and promote continuous improvement in clinical services.
- The professional lead for Nursing, Midwifery and Allied Health Professionals and for ensuring the safe delivery of quality nursing, midwifery and allied professionals care.
- Responsible for recommending the Trust's approach to quality to the Trust Board and is accountable for delivery of the Quality Strategy to the Chief Executive
- Joint responsibility with Medical Director for ensuring adequate governance systems are in place across clinical services and medical, nursing and allied health professions.
- Ensures the Trust maintains a GREEN Monitor Governance Risk Rating
- Ensures the Trust is registered with the Care Quality Commission and has a suitable infrastructure in place to achieve and maintain compliance with required quality and safety standards
- Ensures the Trust takes account of and achieves compliance with the Monitor Quality Governance Framework
- Provides assurance to the Trust Board of the effectiveness of all of the above, where improvements may be needed and for ensuring these are enacted

Medical Director (MD)

- The Medical Director is the Lead for Mortality and Morbidity as required by Monitor and the Care Quality Commission.
- The Medical Director is the professional lead for Consultants and Trust Grade Doctors responsible for ensuring the safe delivery of quality medical care.
- Ensures medical care is monitored as part of Mortality and Morbidity reviews in all Specialties.
- Provides assurance to the Trust Board on the performance of the clinical services in relation to quality, identifies where improvements may be needed and for ensuring these are enacted
- Joint responsibility with Director of Nursing for ensuring adequate clinical governance systems are in place across clinical services and medical, nursing and allied health professions.

Deputy Director of Nursing, Quality and Patient Experience (DDNQPE)

The Deputy Director of Nursing, Quality and Patient Experience works with and deputises for the Director of Nursing in ensuring the safe delivery of all patient care. He/she is accountable to the Director of Nursing and has organisational responsibility for quality of care and patient experience and supporting the Trust Board in carrying out their responsibilities for this strategy. The postholder has specific responsibility for

- Quality Report
- Improvement Priorities
- CQUIN
- Quality Indicators
- Open and Honest
- Sign up to Safety

Associate Director of Governance (ADG)

The Associate Director of Governance has operational and managerial responsibility for Governance, Risk, Health and Safety, Patient Safety, Coroners, Litigation and Audit.
The ADG is responsible for providing support/advice to Executive Directors and Associate Directors in appropriate governance arrangements in relation to this strategy. The post holder is responsible the CQC Registration and Statement of Purpose for the Trust.

Divisional Medical Directors

The Divisional Medical Directors work with the Medical Director in ensuring the safe delivery of medical care. The post holders are responsible for the on-going development of the medical elements of the strategy and its implementation. The post holders are accountable to the Medical Director and have organisational responsibility for quality of care, patient and staff safety and clinical effectiveness, supporting the executive director in carrying out their responsibilities for this strategy.

Medical Clinical Effectiveness Lead (MCEL)

The Clinical Effectiveness Lead reports to the Medical Director and works with the multidisciplinary team to review quality and safety indicators within an agreed overarching framework.

Consultants

In addition to their main role and for the purposes of revalidation, consultants must demonstrate regular participation in activities that review and evaluate the quality of their work. Quality

improvement activities should be robust, systematic and relevant to their work and include an element of evaluation and action which where possible, demonstrates an outcome or change.

Divisional Operational Directors, Divisional Medical Directors, Divisional Governance Managers, Associate Directors of Nursing/Heads of Department, Clinical Leads and Audit and Governance Leads

- All staff receive the necessary information and where relevant training to enable them to work within the Trust and effectively support the delivery of high quality care as determined by the Quality Governance Strategy.
- Ensure a Divisional Quality Framework is in place to monitor identified quality initiatives relating to the implementation of local objectives
- Lead quality improvement and patient safety requirements to progress the strategy and monitor this through divisional integrated governance meetings feeding up to the relevant committee and onto the Clinical Governance, Audit and Quality Subcommittee.
- The Divisional Integrated Governance Group Leads will identify medical and nursing leads for their divisions to take key elements of the strategy forward within their division as required.
- Staff are identified and released to attend mandatory training and other appropriate training to support the delivery of high quality care.

Clinical Effectiveness Manager (CEM)

The Clinical Effectiveness Manager works with the Medical Director in coordinating clinical effectiveness activity ensuring that the Trust has access to timely and meaningful information and data by:-

- Proactively identifying, where the Trust may be an outlier (using HED and other internal data)
- Leads the clinical data analysis and interpretation to drive the quality and safety of healthcare delivery within the Trust
- Develops implements and reviews structures for mortality and safety review (and provides centralised analysis and identification of themes) within the organisation to ensure that the Trust is continually reviewing and improving the quality of care it provides.
- Supports the process for Consultant revalidation
- Sign up to Safety (in conjunction with the Corporate Nursing Programmes Manager)
- Quality Dashboard (in conjunction with the Corporate Nursing Programmes Manager)

The post holder in conjunction with the Corporate Nursing Programmes Manager will analyse the data to inform the strategy going forward and identify areas of concern and escalate information in a timely manner.

Corporate Nursing Programme Manager (CNPM)

The Corporate Nursing Programmes Manager works with the Deputy Director of Nursing, Quality and Patient Experience in the implementation, monitoring and provision of reports for performance in relation to quality initiatives in relation to:-

- Producing the Quality Report
- CQUINs – national; local and specialist
- Improvement Priorities
- Quality Indicators
- Open and Honest
- Sign up to Safety (in conjunction with the Clinical Effectiveness Manager)

- Quality Dashboard (in conjunction with the Clinical Effectiveness Manager)

The post holder in conjunction with the Clinical Effectiveness Manager will analyse the data to inform the strategy going forward and identify areas of concern and escalate information in a timely manner.

Patient Experience Matron (PEM)

The Patient Experience Matron is responsible for the development of patient feedback mechanisms in order to gain valuable information of how people experience our services as follows:-

- Collation of results and themes from all surveys/feedback, and PALS
- Friends and Family
- Complaints, concerns and compliments
- Patient Advice and Liaison Service (PALS)
- NHS Choices – feedback Patient Opinion

These processes support the PEM in compiling a detailed analysis of the patients experience care at Warrington and Halton Hospitals. The PEM is also key link for developing relationships with external organisations and stakeholders in relation to patient experience e.g. LINks and Healthwatch.

Council of Governors

The Council of Governors has a Quality sub-committee "Quality in Care" of ten Governors which exists to assist the Trust in the development and implementation of the Trust's quality programme. It monitors the quality of the services delivered by the hospital to identify priorities for improvement and provides input into the annual Quality Account which the Trust is statutorily required to publish. Governors are playing a lead role in seeking ways to make the document more accessible and readable. The Quality in Care Committee carries out its functions, to assure the Council of Governors that there is a comprehensive and thorough approach to monitor the quality and safe care provided to patients and staff of the Trust.

QUALITY PRIORITIES 2014 - 2015

PATIENT SAFETY

The international evidence base built over the last thirty years shows that all health care workers make errors and that levels of harm are comparable in all settings. It is now widely accepted that about 10% of all patients admitted to hospital will be unintentionally harmed in some way. To put that into context: there are more deaths annually as a result of health care than from road accidents, breast cancer and AIDS combined. Recent financial estimates suggest that adverse events cost the UK £2 billion in 2000 in extra hospital days alone and £400 million in paid negligence claims. Other costs, such as suffering of patients, their families and the health care workers involved, are incalculable. http://www.evidenceintopractice.scot.nhs.uk/patient-safety/

The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority, this is further evidenced by the Trusts commitment to establishing safety priorities for the Sign up to Safety campaign.

A “patient safety incident” is any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to patients. It is recommended as the preferred term when considering adverse events, near misses and significant events to minimise confusion and help the formal reporting of relevant incidents.

Patient safety incident examples:

- A patient has a severe allergic reaction to a medication.
- A patient’s breathing is suppressed after a syringe driver’s flow rate is set inappropriately high.
- An incision is made on the wrong limb of a patient scheduled for a joint replacement.

The Patient Safety Committee will agree a formal update programme of work across the Trust and provide regular updates to the Quality Committee with escalation to the Trust Board where appropriate. It will also:-

- develop a culture where patient safety is integral to the day-to-day provision of clinical care
- establish greater integration and whole system working between professional groups and Commissioners in an integrated work programme forming both contractual and local standards
- set out the structures and processes necessary to deliver and monitor patient safety throughout the organisation and to demonstrate a positive effect on clinical care and patient experience
- implement proactive mechanisms (Global Trigger Tool) to monitor for adverse events routinely throughout the Trust

Terms of reference have been drafted for the Patient Safety Committee (Appendix 5). During 2014/2015 the Safety Committee will be responsible for a number of work streams including:-

Standing Items

- Risk registers
- Divisional Reports
- Patient Safety KPIs
- Quarterly Corporate Groups and Specialist reports:-
  - Transfusion
  - Acute Care of the Patient
  - NEWS & PEWS
  - Resuscitation DNARCPR
  - Palliative Care
  - Medical Devices
  - Medical Gasses
  - CAS Alerts
  - Consent
  - Needle stick
  - VTE
  - CQC Outcomes and Intelligence monitoring
  - Clinical Incidents - Level One and Two Action Plans monitoring
  - High Level Enquiries
  - Mental Health
  - Claims analysis
  - Drugs and Therapeutics
  - Policies and Procedures

Work streams linked to the Quality Report; Quality Contract and CQUINs 2014/2015: -

- Incidents that result in severe or catastrophic harm (QC)
- Venous thromboprophylaxis (QC)
- No NPSA 'never events' (QC)
- Medicines Management – development of indicators and on-going monitoring (QI) MEDICINES MANAGEMENT

CLINICAL EFFECTIVENESS

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 our patients.

This Strategy aims to deliver a clinically effective and safe organisation for patients by:

- Developing a culture where clinical effectiveness is integral to the day-to-day provision of clinical care
- Ensuring that clinical audit – and the high quality, robust and trustworthy data that underpins and is generated by it – is a significant element in this Trusts' governance of quality.
- Being accountable for ensuring that clinical audits are aligned both to national audits and the Trust's key quality priorities. The use of clinical audit will also be adapted to reflect priorities and risks within .the Trust.

- Ensure the Healthcare Evaluation Data (HED) system is in place to review, prioritise and monitor quality and patient safety indicators
- Morbidity and Mortality Review reports from Quality Care Review Group and Divisions following their review of patient deaths
- Establish greater integration and whole system working between professional groups and Commissioners in an integrated work programme
- Setting out the structures and processes necessary to deliver and monitor clinical effectiveness throughout the organisation and to demonstrate a positive effect on clinical care and patient experience
- Ensuring the review of current practice and amending clinical pathways as appropriate
- Implementing national guidance ensuring that best practice is disseminated and under performance is addressed
- Ensuring that the Board of Directors is assured of robust arrangements for the management of clinical effectiveness activity through review of existing reporting arrangements
- Knowledge management – ensuring staff have access to and know how to use the evidence they require

Standing Items

- Divisional Reports
- Quarterly Corporate Groups and Specialist reports:-
  - Best practice critical care bundles
  - Research and Development
  - Morbidity and Mortality Review reports from Quality Care Review Group and Divisions following their review of patient deaths.

- TARN
- National Guidance including NICE and NCEPOD review, progress and compliance.
- Clinical audit – ensuring that our programme is effective, informed by our priorities, and delivers improvement where required.
- Cancer Services
- Organ Donation
- Clinical Incidents Level 1 and 2 Investigations findings
- New procedures – ensuring we have a system that promotes the safe introduction of new procedures and devices
- Policies and Procedures
- Clinical Effectiveness KPI's

Work streams linked to the Quality Report; Quality Contract and CQUINs 2014/2015: -

- Patient reported outcome measures – ensuring that the Trust participates in the national PROMs programme and uses locally developed PROMs where appropriate. (QI)
- The deteriorating patient (C)
- Morbidity and Mortality Review. Reports the Care Quality Review Group following their review of patient deaths. Hospital Standardised Mortality Ratio (HSMR) lower than 100 and Summary Hospital-level Mortality Indicator) (SHMI) lower than 100. Crude mortality rate. (IP)
- Regional Advancing Quality targets (C; IP)

PATIENT EXPERIENCE

By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm. The following objectives have been developed to achieve this;

- Build on existing work to further develop robust systems and processes for gaining both quantitative and qualitative feedback from users
- Develop more robust analysis of complaints and PALS contacts to inform service improvement
- Ensure that the way in which we manage complaints provides a responsive, patient focussed service.
- Develop systems and processes that appropriately link willing patients, governors and other stakeholders with teams trying to make service improvements
- Develop training and an accompanying toolkit to assist team / department leaders to maximise and sustain the capacity and capability of individual team members to impact positively on patient experience
- The Trust Board will play an active leadership role in advocating improvements in the patient experience
- Develop a minimum data set and dashboard for teams and departments to drive reliability and consistency of patient experience
- Every service within the Trust will use patient experience to gain insight and identify opportunities for improvement
- Every service within the Trust will, having identified opportunities for improvement, implement at least one patient experience improvement project annually
- The Director of Nursing will lead Trust wide initiatives to make improvements following the identification of themes from patient feedback.

- The Trust will further develop systems and processes to provide feedback to users and other stakeholders, both at service / department and corporate level.

Standing Items

- Divisional Reports
- Quarterly Corporate Groups and Specialist reports:-
  - Readmissions
  - Discharge
  - UTIs associated with indwelling catheters (within the hospital setting) (QI)
  - Avoidable hospital acquired grade 2, 3 & 4 pressure ulcers (C, IP, QC)
  - Patient falls (IP, QI, QC)
  - Complaints (IP; QC)
  - The Friends and Family Test
  - Mixed sex occurrences (MSO) breaches
  - Response to complaints
  - Always Events
  - Transfer
  - Clinical Incidents Level 1 and 2
  - PALS
  - Clinical Care Indicators

Work streams linked to the Quality Report; Quality Contract and CQUINs 2014/2015: -

- In-Patient Survey - improvement in low performing indicators (IP)
- Always Events
- Improving nutritional assessment (QI)
- Dementia
- Patient Experience Indicators
- Falls management

GOVERNANCE ARRANGEMENTS

The structures and processes supporting the implementation of the strategy are identified as follows:

The following committees ensure progress against the identified aims (Terms of Reference can be found at appendix):

- Quality Committee
- Clinical Effectiveness Committee
- Patient Safety Committee
- Patient Experience Committee

Additional committees who will support the quality agenda and will report directly to the Quality Committee include:-

- Safeguarding Strategy Group
- MAG
- NMAC
- Infection Control Sub Committee
- Health and Safety Committee

The committees will report to the Quality Committee via a written report on a bi-monthly basis.

- The development of detailed action plans underpin the Strategy, these will be subject to regular monitoring and progress reporting by exception through to the Quality Committee.
- The Quality Committee will escalate risks and concerns by exception to Trust Board.
- The production of an annual Quality Report/Account to be reviewed by the Quality In Care and Quality Committee and other important partners to demonstrate progress and achievements. This will be signed off by the Audit Committee and Trust Board prior to submission to Parliament
- Provide assurance to the Trust Board that quality assurance and clinical governance mechanisms are integral to monitoring services to ensure better outcomes for patients.
- The Quality Committee will oversee the requirements of the Trusts compliance with the Annual Governance Statement; Quality Governance Framework and CQC Registration.
- The production and review of a monthly Quality Dashboard Report which reports on the KPIs detailed in Appendix 1 and is reported at the Board of Directors' meetings.
- Production, implementation and monitoring of Darzi and ward balanced scorecards to ensure that all contractual quality measures are monitored and exceptions reported by the Quality Committee to the Trust Board.
- The integration of effective reporting structures from the divisions, through to the Quality Committee onto the Trust Board.
- By clearly defining at every level within the organisation, individual objectives, responsibilities and accountabilities for improving quality and including them within their personal development plans
- By empowering staff to report risk and incidents and to register their concerns about unsafe practice, through an open and fair culture which is supported by effective Human Resources and Risk Management policies and procedures.
- By providing relevant training at all levels within the organisation as an integral element of the Trust's training and development plans.
- By providing the necessary training and development throughout the organisation as part of the Delivering High Quality Care to empower and enable staff to play their part in realising the strategy.
- Outcomes will be monitored by the identified committee onto the Quality Committee
- The strategy is a three year plan which will be reviewed annually to ensure its work plan and direction remain valid and appropriate.

QUALITY COMMITTEE

The Quality Committee, chaired by a Non-Executive Director, will scrutinise the management of quality providing assurance to Trust Board that robust governance arrangements to manage quality are in place throughout the organisation. Please refer to Appendix 2 for the Terms of Reference.

The Committee will also gain the assurances for the compliance necessary to sign off the Annual Governance Statement; any unacceptable or high levels of risk/assurance will be reported through to the Trust Board. In order to fulfil these responsibilities the Quality Committee under its Terms of Authority will be a formal Committee of the Trust Board established to provide a strategic approach to supporting the quality agenda, corporate objectives and the Care Quality Commission Essential Standards for Quality and Safety.

QUALITY – PROCESS TO MANAGE ASSOCIATED RISKS

Warrington and Halton Hospitals NHS Foundation Trust faces a wide range of risks associated with maintaining an acute hospital incorporating two hospital sites which lie 11 miles apart. These are documented in the Trust's Board Assurance Framework (BAF), which, records the potential risks to the achievement of the Trust's strategic objectives, which are; -

- Failure to deliver a high quality, safe patient experience
- Failure to ensure that all our staff are committed, equipped and supported to deliver high quality care
- Failure to generate surpluses to ensure our services are sustainable in the long term
- Failure to create a culture of excellence and mutual respect
- Failure to develop partnerships that support our business strategy and enhance our reputation

The Trusts will ensure that the BAF directly links to the strategic and quality objectives, with assurance as the achievement of the quality objectives being supported by the Quality Committee in addition to the Audit Committee.

The Risk registers are developed from risks identified by:

- Risk assessments - organisational, clinical, business, financial and environmental factors
- Incident and 'near miss' reporting and investigation including root cause analysis (RCA) e.g. pressure ulcer assessments
- CQUIN
- Improvement Priorities
- Mortality Reports
- Claims, complaints and Patient advice and Liaison (PALS) reports
- HM coroner inquests
- Central Alert System (CAS)
- External assessments e.g. Care Quality Commission, risk management assessments, Health & Safety Executive, Environmental Health (EHO), Audit Commission, Mersey Internal Audit Agency
- Internal assessments including review of National Guidance including NICE Guidance and NCEPOD recommendations, High Level Enquiries, Inspection and Accreditation, Audit Outcomes and Audit Committee reports.
- Patient and Public Involvement Forums
- Patient and Staff surveys
- Outcomes from hearings/investigations
- Changes in legislation/strategy

These risks, dependant on their scores are then incorporated into a Trust Risk Register.

Trust Part 1 Risk Register – All risks of 15-25 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk monthly and ensure any actions are implemented.

Trust Part 2 Risk Register – All risks of 12 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented.

Part 3 Risk Register – All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers. All will be reviewed annually and discussed/reviewed at local meetings.

The individual committees of the Quality Committee will ensure that risks are escalated appropriately and included in the risk registers if required. The Quality Committee will oversee, monitor and maintain the Board Assurance Framework and Risk Register(s) and seek assurance that the risk ratings are correct and that appropriate actions are taking place to mitigate and/or eradicate risk. The Board Assurance Framework and Risk Registers will then be reviewed at Trust Board at agreed frequency.

STAFF ENGAGEMENT - COMMUNICATION AND CONSULTATION

The Trust will employ a variety of methods to share and enable involvement in the review and development of its strategic quality goals and objectives. . This will include engaging both internal and external stakeholders including Commissioners by ensuring

- transparent and accessible quality outcomes;
- patient and staff feedback and views sought and reviewed;
- a range of approaches taken;
- quality performance communicated and discussed with stakeholders, e.g. commissioners; and
- governor involvement.

The Trust has well established internal communications systems namely the Hub, weekly updates, monthly team briefs and quarterly newsletters which we will utilise to ensure that staff are aware of the strategy and implement the systems included within their areas of responsibility.

Staff engagement levels have grown according to the NHS national staff survey and we have clear systems for informing staff of news in the trust which audit well. The challenge moving forward is to engage more effectively with our staff – our staff are ambassadors for change if communicated with and engaged with effectively. Joint work between the Trust's Human Resources and Communication Team is taking place with the objective of developing a comprehensive engagement strategy / work plan.

TRAINING AND SUPPORT

The Trust recognises that the successful implementation of this Strategy is dependent upon the provision of appropriate and sufficient training to all levels of the organisation. This is reflected into the Trust Training and Development Policy that includes the Trust Training Needs Analysis.

MONITORING OF THE STRATEGY

CQC Minimum requirements	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
1,2,3,4,5,7,8, 9,16,17,18,19			Annually			Quality Committee

SOURCES/ REFERENCES

NHS Operating Framework 2014/15
NHS England 2014/2015 NHS Standard Contract
Quality governance: How does a board know that its organisation is working effectively to improve patient care? - Guidance for boards of NHS provider organisations. Monitor; April 2013.
Monitor Quality Governance Framework July 2010
Care Quality Commission Essential Standards for Quality and Safety 2010
Care Quality Commission Intelligence Monitoring 2013
The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 – March 2009 (Chaired by Robert Francis QC) 2010
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Chaired by Robert Francis QC) 2013
High Quality Care for All' 2010
Equity and Excellence; Liberating the NHS' 2011

GLOSSARY OF TERMS

AQUA: Advancing Quality Alliance.
CQUIN: Commissioning for Quality and Innovation
CVC: Central Venous Catheter
CQC: Care Quality Commission
GPs: General Practitioners.
HSMR: The Hospital Standardised Mortality Ratio compares the expected number of 80% of in-hospital deaths with the actual number, standardising the results to take account of regional differences in age, sex, deprivation and co-morbidity. It also adjusts for palliative care coding.
HR; Human Resources
OD: Organisational Development
MEWS: Modified Early Warning Score
MSO: Mixed Sex Occurrence
NHSLA: National Health Service Litigation Authority
SHMI: The Summary Hospital-level Mortality Indicator includes all in-hospital deaths plus those occurring up to 30 days post discharge, standardises for age, sex and co-morbidity but makes no adjustment for either deprivation or palliative care.
SUI: Serious Untoward Incident
UTIs: Urinary Tract Infections.
VTE: Venous Thromboembolism

ASSOCIATED DOCUMENTS

- Nursing and Midwifery Strategy
- Risk Management Strategy
- Framework for Medical Clinical Governance
- End of Life Care Strategy

- Comments, Compliments, Concerns and Complaints Policy
- Policy for the Reporting and Management of Incidents and Investigations
- WHHFT Annual Plan 2014-17

APPENDICES

Appendix 1 Quality Dashboard
Appendix 2 Quality Committee
Appendix 3 Quality Governance Framework
Appendix 4 Clinical Effectiveness Committee Terms of Reference
Appendix 5 Safety Committee Terms of Reference
Appendix 6 Patient Experience Committee Terms of Reference
Appendix 7 Infection Control Committee – Terms of Reference
Appendix 8 Safeguarding Strategy Group – Terms of Reference
Appendix 9 Nursing and Midwifery Advisory Group – Terms of Reference
Appendix 10 Medical Advisory Group – Terms of Reference
Appendix 11 Professional Advisory Group
Appendix 12 Trust Quality Structure
Appendix 13 Health and Safety – Terms of Reference

APPENDIX 1 QUALITY DASHBOARD (KEY PERFORMANCE INDICATORS)

Introduction

The Quality Governance Strategy includes within its framework the essential indicators which require consistent review and monitoring to ensure a safe, high quality organisation. It was felt that this should not take place in isolation to indicators contained within other schemes of governance which the Trust is required to report progress. The KPIs in the Quality Dashboard have been reviewed in line with the revised requirements for 2014/2015 from the:-

- CQUINs – National (Specialised Commissioners and Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required).
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators
- Sign up to Safety – national patient safety topics
- Open and Honest

This is part of a wider review of Quality KPIs to align reporting with the restructuring of committees to improve the management of quality initiatives under safety; effectiveness and experience.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Intelligent Monitoring																			
Banding	March 14 (5)						3						5						
Number of elevated risks	1						2						1						
Number of risks	4						5						3						

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Safety																			
Mortality																			
HSMR (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	98	98	98		98												98
SHMI (12 month rolling)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC	108	108	107														107
Total deaths in hospital	Not set		98	89	76	263	74	81	96	251	94								608
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0	0	0	0	0	0								0
Incidents resulting in Moderate, Major or Catastrophic harm																			
Incidents resulting in moderate, major or catastrophic harm	TBC	QC	6	10	4	20	4	8	10	22	4								46
Incidents of moderate, major or catastrophic harm under investigation	N/A		4	0	2	6	0	3	4	7	8								21
Falls																			
All falls (approved)	Not set		91	78	87	256	89	78	79	246	76								578
Moderate, major and catastrophic harm falls (approved)	<=13 per year	IP	1	2	2	5	2	3	0	5	0								10
Moderate, major and catastrophic harm falls (awaiting approval)	N/A		0	0	0	0	0	0	2	2	0								2

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Major and catastrophic harm falls (approved)	<=2 per year	QC	0	0	1	1	0	0	0	0	0								1
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2	0	0	0	0	0								2
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0	1	0	1	2	0								2
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0	0	0	1	1	2								3
Grade 2 Hospital Acquired	<=101 per year	IP	3	8	2	13	12	3	3	18	9								40
Grade 2 Hospital Acquired – stretch target (20% reduction)	<=90 per year	IP	3	8	2	13	12	3	3	18	9								40
Grade 2 Hospital Acquired (under review)	N/A		0	0	0	0	0	0	0	0	0								0
% RCA / mini investigation completed	100%	IP	100	100	100	100	100	100	100	100	100								100
% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (November 2014 – March 2015) (median YTD)	C	4.92	3.99	3.73		3.37	5.63* amended	4.95		4.34								
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1	0	0	1	1	0								2
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7	1	7	1	9	3								19

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
MSSA	Not set		1	0	1	2	1	0	1	2	1								5
Out of hours transfers	TBC	BK	1	2	5	8	1	5	1	7	3								18
Never Events	0 per year	QC	0	0	0	0	0	0	0	0	0								0
Number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'.	Annual: <75 = G 75 – 85 = A >85 = Red	QC	8	11	7	26	3	13	6	22	5								53
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT		PILOT	PILOT	PILOT		PILOT								
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.61		95.33	95.30	95.31		94.56								
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100	99.6	100		100								
Number of patients who developed a HA VTE	Baseline TBC	QC	7	8	4	19	12	0	0	12									31
Number of patients who developed a HA VTE (under review)			0	0	1	1	1	5	4	10									11
% free from harm (ST)		OH	97.3	99.2	97.8		98	96.4	98		97.4								
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month	IP	4	2	2		2	4	5		0								

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39		0.40	0.89	0.99		0								
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*		94.26	96.59	92.45		92.70								
Dementia Assessment % (Part 2)	>=90%	C	100	100	100*		100	100	91.89		100								
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*		100	100	100		100								
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6	98.8	98.9	98	98.7	99								
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93	95.6	93.3	83	90.6	96								
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9	81.6	71.1	75	75.9	83								
Effectiveness																			
Advancing Quality % compliance (cumulative scores)																			
Acute MI	>=95%	IP, C	100	98.4	98.9		98.4	98.8											98.8
Hip and Knee	>=95%	IP, C	95.2	96.5	95		96.4	96.7											96.7
Heart failure	>=90.2%	IP, C	100	90.9	87.9		83.1	84.3											84.3
Pneumonia	>=73.9%	IP, C	68.6	72.8	74.4		75.1	76.1											76.1
Stroke	>=60.4%	IP, C	69.7	61.4	57		58.3	60											60
COPD (data not yet released)	>=50%	IP, C																	
Patient Reported Outcome Measures (PROMS)																			
Hip replacement (Average health gain)	0.44 (latest England average Mar 2014)	IP,QC															0.41		0.40

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Knee replacement (Average health gain)	0.32 (latest England average Mar 2014)	IP,QC															0.34		0.34
Groin surgery (Average health gain)	0.085 (latest England average Mar 2014)	IP,QC															0.065		0.065
Patient Experience																			
Staff friends and family question (needing care) (Extremely likely and likely responses from F&F quarterly staff survey)	TBC Q3 Staff survey results	C				70.9				72	STAFF SURVEY								
Staff F&F place to work (as above)	Q3 Staff survey results					66.8				67									
Always events (Q1&2 implementation, Q3 data collection)	TBC	IP									84%								
Mixed sex occurrences	0	QC	6	3	0		0	0	0	0	0								9
Friends and family test																			
Friends and Family Test. **Star rating**	TBC		4.54	4.5	4.58		4.53	4.6	4.58		4.6								
Friends and Family Test Inpatients **Net promoter changed to % recommending Trust – November 2014.**	>=94% (National average including independent)	OH	76	74	81		76	77	94%										
Friends and Family Test A&E **Net promoter changed to % recommending Trust – November 2014.**	>=86% (National average)	OH	42	35	41		40	45	82%										
Friends and family response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75	19.55	17.58	14.51	17.26	13.57								18.24

Friends and family response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55	32.20	30.02	26.39	29.55	32.85								30.03
Complaints and concerns																			
Number of concerns received	Not set	IP	2	9	6	17	16	10	6	32	5								49
Number of complaints received **Please see note below.**	2013/2014 received 422 (No threshold set)	IP	31	40	38	109	52	30	31	113	52								274
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51	96.88	100	97.50	98.23	97.92								97.58

APPENDIX 2: QUALITY COMMITTEE TERMS OF REFERENCE

Title: QUALITY COMMITTEE Terms of Reference	Warrington and Halton Hospitals NHS NHS Foundation Trust
Author's Name:	
Scope: Annual Governance Statement Monitor Governance Framework CQC Outcome 16 BAF 1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework BAF 3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review.	**Classification:**
Replaces: QUALITY GOVERNANCE COMMITTEE & CLINICAL GOVERNANCE, AUDIT AND QUALITY SUB COMMITTEE	
To be read in conjunction with the following documents: Quality Strategy	

Unique Identifier:	**Review Date: October 2015**	
Issue Status:	**Issue No:**	**Issue Date:**
Approved by: Trust Board	**Ratification Date:**	
Document for Public Display:		

1. **Purpose**

   The Quality Committee (the Committee) is established as a committee of the Trust Board in accordance with Warrington and Halton Hospitals NHS Foundation Trust constitution, standing

orders and scheme of delegation. These terms of reference set out the membership, remit and responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the Trust's constitution and standing orders.

The Quality Committee is responsible for the development and implementation of the Trust's Quality Strategy, which sets out its plan for quality improvement and quality assurance of all services.

The Quality Committee will promote and assure quality so that patients have effective and safe care with a positive experience of services delivered by the Trust.

The Quality Committee is accountable to the Trust Board for ensuring that the integrated governance framework is implemented throughout the organisation, so providing assurance to the Trust Board that organisational risks are being managed appropriately and that quality and safety is adhered to in line with the CQC Essential Standards of Quality and Safety and the

2. Accountability & Terms of Reference

The Committee is a formally constituted Committee of the Trust Board.
The Chairman of the Committee will be an independent Non-Executive Director
The Committee will report directly to the Trust Board following each meeting providing assurance that robust governance arrangements to manage quality are in place throughout the organisation.

Terms of Reference

Ensure that the Quality Strategy is developed and implemented so as to support the Trusts Annual and Strategic Plans. In doing so, the Committee will seek assurance that Trust services incorporates and upholds the tenets of quality (patient safety, experience and clinical effectiveness), and that the quality priorities within the NHS Contract and recommendations for the National Quality Board are met.

Implement and monitor the process for the sign off of the quality report / accounts before they are presented to the Trust Board for formal approval.

The Committee will receive reports from the Infection Control Sub-Committee; Clinical Effectiveness Committee; Patient Safety Committee; Safeguarding Strategy Group; Patient Experience Committee; Health and Safety Committee; NMAC and MAG on matters and risks relating to Quality.

Undertake an annual review of the Quality Strategy to ensure that it reflects all required priorities.

Undertake an annual review of the Risk Management Strategy to ensure it reflects all required priorities.

To receive Pharmacy Reports and updates.

Provide assurance to the Trust Board that quality assurance and clinical governance mechanisms are integral to monitoring services to ensure better outcomes for patients. Escalate risks and concerns by exception to Trust Board.

Oversee the requirements of the Trusts compliance with the Annual Governance Statement; Quality Governance Framework and CQC Registration.

Receive reports and action plans of internal including serious untoward incidents / external reviews that have identified areas of risk to quality of care.

To ensure that local Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services.

Receive quarterly CQUIN Reports to provide assurance of compliance and escalate exceptions to Trust Board.

Receive quarterly Improvement Priority Reports to provide assurance of compliance and escalate exceptions to Trust Board.

Oversee, monitor and maintain the Trust Assurance Framework and Trust Risk Register, seek assurance that appropriate actions are taking place to mitigate and/or eradicate risk

To review and analyse all quality data and information about services to ensure recognition of early warning signs e.g. Quality Dashboards, Quality profiles and other data/intelligence about services including patient and staff experience. Escalate to Trust Board as required.

The Quality Committee will be responsible for establishing the internal audit plan (MIAA) for all functions within its remit e.g. Clinical Audit.

To commission assessment of services where clinical practice falls below best practice.

3 Specific requirements

4 Membership

Core Member	Nominated Deputy	Representing
Non Executive Director (Chair)	Non Executive Director	Non Executive Director
Non Executive Director	Non Executive Director	Non Executive Director
Chief Executive	Deputy Chief Executive	Lead Executive Director
Director of Nursing & Organisational Development	Deputy Director of Nursing Deputy Director of Human Resources	Nursing Strategy. Patient Experience Committee
Director of Finance	Deputy Director of Finance	Finance
Chief Operating Officer	Deputy Chief Operations Officer	Operations
Medical Director	Medical Clinical Governance Operations Lead	Clinical Service. MAG Patient Safety Committee
Medical Clinical Effectiveness Lead	Deputy Director of Nursing and Quality	Clinical Effectiveness Committee
Director of IT		
Divisional Medical Representative	DIGG Lead Unscheduled Care	Medical Leadership

Associate Director of Governance & Risk	Head of Safety and Risk	Governance & Risk
Deputy Director of Nursing and Quality	TBA	NMAC
Associate Director of Operations, WCSS	Associate Director of Nursing	Divisional Operations
Associate Director of Operations, Unscheduled Care	Associate Director of Nursing	Divisional Operations
Associate Director of Operations, Scheduled Care	Associate Director of Nursing	Divisional Operations
Chief Pharmacist	Deputy Chief Pharmacist	Trust Pharmacy Service
Head of Allied Health Professionals	Senior AHP	Trust APH Representative
Nursing and Quality Lead	GP Governing Body Member	Warrington CCG
GP Governing Body Member	Nursing and Quality Lead	Warrington CCG
Patient / Carer Representative		
In Attendance	**Nominated Deputy**	**Representing**
Board Secretary	Executive Secretary	Minute Taker/Secretary to the Committee
Co-opted members as appropriate	-	-

Frequency of meetings

5 Monthly

6. Quorum

A quorum shall be when one Non-Executive Director, two Executive Directors; the Director of Nursing or deputy; and one Senior Clinician are in attendance

All Core members and in their absence, their nominated Deputy shall have one vote. In the event of a tie, the Chairman of the Committee shall have the casting vote.

7. Review

Annually

8. Managing Effectiveness

Work Plan

- Quality Dashboard monthly
- Improvement Priorities Quarterly Report
- CQUIN Quarterly Report
- Quality Governance Framework Assessment
- Corporate Risk Register 15+
- CQC Registration
- MONITOR Authorisation
- CQC Intelligent Monitoring
- Quality Account / Report monthly from February until sign off
- Assurance Framework and Risk Registers
- Annual Governance Statement

- Risk Management Quarterly and Annual Report
- Clinical Audit Quarterly and Annual Report and Forward Plan
- NICE Quarterly and Annual Report
- NCE Quarterly and Annual Report
- Patient Experience & Complaints Quarterly and Annual Report
- CQC Outcomes – compliance
- Incident Investigations Annual Report
- Infection Control Quarterly and Annual Reports
- Serious Incident
- High Level Enquiries
- Reports by exception from feeder committees – bi monthly

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act, 2000.

APPENDIX 3: MONITOR - QUALITY GOVERNANCE FRAMEWORK (WELL LED FRAMEWORK)

Strategy	Capabilities and culture	Processes and structure	Measurement
1A Does quality drive the trust's strategy? 1B Is the board sufficiently aware of potential risks to quality?	2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 2B Does the board promote a quality-focused culture throughout the trust?	3A Are there clear roles and accountabilities in relation to quality governance? 3B Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? 3C Does the board actively engage patients, staff and other key stakeholders on quality?	4A Is appropriate quality information being analysed and challenged? 4B Is the board assured of the robustness of the quality information? 4C Is quality information used effectively?

Strategy	**Example good practice**
1A: Does quality drive the trust's strategy?	Quality is embedded in the trust's overall strategy • The trust's strategy comprises a small number of ambitious trust-wide quality goals covering safety, clinical outcomes and patient experience which drive year on year improvement • Quality goals reflect local as well as national priorities, reflecting what is relevant to patient and staff • Quality goals are selected to have the highest possible impact across the overall trust • Wherever possible, quality goals are specific, measurable and time-bound • Overall trust-wide quality goals link directly to goals in divisions/services (which will be tailored to the specific service) • There is a clear action plan for achieving the quality goals, with designated lead and timeframes Applicants are able to demonstrate that the quality goals are effectively communicated and well-understood across the trust and the community it serves The board regularly tracks performance relative to quality goals
1B: Is the board sufficiently aware of potential risks to quality?	The board regularly assesses and understands current and future risks to quality and is taking steps to address them The board regularly reviews quality risks in an up-to-date risk register The board risk register is supported and fed by quality issues captured in directorate/service risk registers The risk register covers potential future external risks to quality (e.g. new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks There is clear evidence of action to mitigate risks to quality Proposed initiatives are rated according to their potential impact on quality (e.g. clinical staff cuts would likely receive a high risk assessment) Initiatives with significant potential to impact quality are supported by a detailed assessment that could include: • 'Bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (e.g. Lean) • Internal and external benchmarking of relevant operational efficiency metrics (of which nurse/bed ratio, average length of stay, bed occupancy, bed density and doctors/bed are examples which can be markers of quality) • Historical evidence illustrating prior experience in making operational changes without negatively impacting quality (e.g. impact of previous changes to nurse/bed ratio on patient complaints) The board is assured that initiatives have been assessed for quality All initiatives are accepted and understood by clinicians There is clear subsequent ownership (e.g. relevant clinical director) There is an appropriate mechanism in place for capturing front-line staff concerns, including a defined whistleblower policy Initiatives' impact on quality is monitored on an ongoing basis (post-implementation) Key measures of quality and early warning indicators identified for each initiative Quality measures monitored before and after implementation Mitigating action taken where necessary

Capabilities and Culture	Example good practice:
2A: Does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?	The board is assured that quality governance is subject to rigorous challenge, including full NED engagement and review (either through participation in Audit Committee or relevant quality-focused committees and sub-committees) The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board Board members are able to: • Describe the trust's top three quality-related priorities • Identify well- and poor-performing services in relation to quality, and actions the trust is taking to address them, • Explain how it uses external benchmarks to assess quality in the organisation (e.g. adherence to NICE guidelines, recognised Royal College or Faculty measures). • Understand the purpose of each metric they review, be able to interpret them and draw conclusions from them • Be clear about basic processes and structures of quality governance • Feel they have the information and confidence to challenge data • Be clear about when it is necessary to seek external assurances on quality e.g. how and when it will access independent advice on clinical matters. Applicants are able to give specific examples of when the board has had a significant impact on improving quality performance (e.g. must provide evidence of the board's role in leading on quality) The board conducts regular self-assessments to test its skills and capabilities; and has a succession plan to ensure they are maintained Board members have attended training sessions covering the core elements of quality governance and continuous improvement
2B: Does the board promote a quality-focused culture throughout the Trust?	The board takes an active leadership role on quality The board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other trusts and external organisations) The board regularly commits resources (time and money) to delivering quality initiatives The board is actively engaged in the delivery of quality improvement initiatives (e.g. some initiatives led personally by board members) The board encourages staff empowerment on quality Staff are encouraged to participate in quality / continuous improvement training and development Staff feel comfortable reporting harm and errors (these are seen as the basis for learning, rather than punishment) Staff are entrusted with delivering the quality improvement initiatives they have identified (and held to account for delivery) Internal communications (e.g monthly newsletter, intranet, notice boards) regularly feature articles on quality

Structures and Processes	Example good practice
3A: Are there clear roles and accountabilities in relation to quality governance?	Each and every board member understand their ultimate accountability for quality There is a clear organisation structure that cascades responsibility for delivering quality performance from 'board to ward to board' (and there are specified owners in-post and actively fulfilling their responsibilities) Quality is a core part of main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions Quality performance is discussed in more detail each month by a quality-focused board sub-committee with a stable, regularly attending membership
3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Boards are clear about the processes for escalating quality performance issues to the board • Processes are documented • There are agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints. Robust action plans are put in place to address quality performance issues (e.g., including issues arising from serious untoward incidents and complaints). With actions having: • Designated owners and time frames • Regular follow-ups at subsequent board meetings Lessons from quality performance issues are well-documented and shared across the trust on a regular, timely basis, leading to rapid implementation at scale of good-practice There is a well-functioning, impactful clinical and internal audit process in relation to quality governance, with clear evidence of action to resolve audit concerns • Continuous rolling programme that measures and improves quality • Action plans completed from audit • Re-audits undertaken to assess improvement A 'whistleblower'/error reporting process is defined and communicated to staff; and staff are prepared if necessary to blow the whistle There is a performance management system with clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels

3C: Does the board actively engage patients, staff and other key stakeholders on quality?	Quality outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance The Board actively engages patients on quality, e.g.: • Patient feedback is actively solicited, made easy to give and based on validated tools • Patient views are proactively sought during the design of new pathways and processes • All patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the Board • The board regularly reviews and interrogates complaints and serious untoward incident data • The board uses a range of approaches to 'bring patients into the board room' (e.g. face-to-face discussions, video diaries, ward rounds, patient shadowing) The board actively engages staff on quality, e.g.: • Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (e.g. monthly 'temperature gauge' plus annual staff survey) • All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board The board actively engages all other key stakeholders on quality, e.g.: • Quality performance is clearly communicated to commissioners to enable them to make educated decisions • Feedback from PALS and LINks is considered • For care pathways involving GP and community care, discussions are held with all providers to identify potential issues and ensure overall quality along the pathway • The board is clear about Governors' involvement in quality governance

Measurement	Example good practice
4A: Is appropriate quality information being analysed and challenged?	The board reviews a monthly 'dashboard' of the most important metrics. Good practice dashboards include: • Key relevant national priority indicators and regulatory requirements • Selection of other metrics covering safety, clinical effectiveness and patient experience (at least 3 each) • Selected 'advance warning' indicators • Adverse event reports/ serious untoward incident reports/ patterns of complaints • Measures of instances of harm (e.g. Global Trigger Tool) • Monitor's risk ratings (with risks to future scores highlighted) • Where possible/appropriate, percentage compliance to agreed best-practice pathways • Qualitative descriptions and commentary to back up quantitative information The board is able to justify the selected metrics as being: • Linked to trust's overall strategy and priorities • Covering all of the trust's major focus areas • The best available ones to use • Useful to review The board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines Quality information is analysed and challenged at the individual consultant level The board dashboard is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the board commits time and resources to developing new metrics
4B: Is the board assured of the robustness of the quality information?	There are clearly documented, robust controls to assure ongoing information accuracy, validity and comprehensiveness • Each directorate/service has a well-documented, well-functioning process for clinical governance that assures the board of the quality of its data • Clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (e.g. incidents) • Electronic systems are used where possible, generating reliable reports with minimal ongoing effort • Information can be traced to source and is signed-off by owners There is clear evidence of action to resolve audit concerns • Action plans are completed from audit (and subject to regular follow-up reviews) • Re-audits are undertaken to assess performance improvement There are no major concerns with coding accuracy performance

4C: Is quality information being used effectively?	Information in Quality Reports is displayed clearly and consistently Information is compared with target levels of performance (in conjunction with a R/A/G rating), historic own performance and external benchmarks (where available and helpful) Information being reviewed must be the most recent available, and recent enough to be relevant 'On demand' data is available for the highest priority metrics Information is 'humanised'/personalised where possible (e.g. unexpected deaths shown as an absolute number, not embedded in a mortality rate) Trust is able to demonstrate how reviewing information has resulted in actions which have successfully improved quality performance

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APPENDIX 4: CLINICAL EFFECTIVENESS COMMITTEE - TERMS OF REFERENCE

Title: **CLINICAL EFFECTIVENESS COMMITTEE** **Terms of Reference**	Warrington and Halton Hospitals NHS NHS Foundation Trust
Author's Name:	
Scope: Annual Governance Statement Monitor Governance Framework CQC Outcome 16 BAF 1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework BAF 3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review.	**Classification:**
Replaces:	
To be read in conjunction with the following documents: Quality Committee - Terms of Reference & Quality Strategy	

Unique Identifier:	**Review Date: October 2015**	
Issue Status:	**Issue No:**	**Issue Date:**
Approved by:	**Ratification Date:**	
Document for Public Display:		

1. **Purpose**

The Clinical Effectiveness Committee is established in accordance with Warrington and Halton Hospitals NHS Foundation Trust constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit and responsibilities and reporting

arrangements of the committee and shall have effect as if incorporated into the Trust's constitution and standing orders.

The Clinical Effectiveness Committee is accountable to the Quality Committee for ensuring that the clinical effectiveness (evidence based practice) is implemented throughout the organisation, so providing assurance to the Quality Committee that a framework for safe effective clinical practice is developed and implemented that has a focus on improving patient clinical outcomes.

2. Accountability Terms of Reference

The Chairman of the Clinical Effectiveness Committee will be the Executive Director.

The terms of reference will be reviewed annually by the Clinical Effectiveness Committee and reports of progress made will be written to demonstrate compliance with these terms of reference and will contribute to the Trust's annual Quality Report and Accounts.

- Facilitate and manage clinical effectiveness and clinical audit across Warrington and Halton NHS Trust.
- Provide monitoring of clinical effectiveness through scrutiny of clinical audit programme and its implementation, including review of clinical policy to support safe effective clinical practice.
- Provide advice and report to Quality Committee and allied decision making groups of Patient Safety and Patient Experience on matters relating arising from scrutiny that impact upon the Trusts operational plan and clinical patient outcomes.
- Provide a forum to review, discuss and monitor the implementation of relevant NICE guidance.
- Provide coordinated and appropriate responses to ensure safe, effective clinical practice as part of consultation process for clinical policy under review or development within the Trust.
- Morbidity and Mortality Review reports from Quality Care Review Group and Divisions following their review of patient deaths.
- To receive and approve the annual Clinical Audit Forward Plan, ensuring that it is consistent with the clinical audit needs of the Trust.
- Clinical Audits - review, discuss and monitor both local and national audits. When carried out in accordance with best practice standards, clinical audit:
- Provides assurance of compliance with clinical standards;
- Identifies and minimises risk, waste and inefficiencies;
- Improves the quality of care and patient outcomes
- Produce a Clinical Audit Annual Report for the Quality Committee and Trust Board.
- National Confidential Enquiries
- PROMS
- Acute Care of the Patient
- NEWS & PEWS
- Resuscitation
- Palliative Care
- DNAR
- AQUA Advancing Quality Measures
- TARN
- Palliative Care
- Cancer Services
- Organ Donation
- Clinical Incidents - Level one and two action plans

- Ensure full engagement with the divisions in relation to all aspects of clinical effectiveness.
- To agree and ensure that KPIs relating to clinical effectiveness are developed and monitored continuously so any early warnings regarding possible deterioration in services is identified and acted upon.
- R&D
- To review and approve relevant policies and procedures and provide a list of ratified policies to the Quality Committee

3. Specific requirements

4. Membership

The membership of the Clinical Effectiveness Committee is:-

- Medical Clinical Effectiveness Lead (Chair)
- Clinical Effectiveness Manager
- Director of Nursing
- Medical Director
- Deputy Director of Nursing
- Clinical Audit Manager
- Associate Directors of Nursing/Head of Midwifery
- Associate Divisional Directors
- Divisional Medical Directors
- Patient / Carer representative
- Corporate Nursing Programmes Manager
- Associate Divisional Managers
- Non-Executive Director
- CCG Quality Lead

Trust staff may be co-opted as members where their contribution is deemed to enhance the work of the Group.

70% attendance is required. A nominated deputy is to attend in the absence of the member.

5. Frequency of meetings

Monthly

6. Quorum

The Committee will be considered quorate with at least 4 members from the membership list and a designated Chair.

7. Review

Annual

8. Managing Effectiveness

- Formal minutes to be submitted to the Quality Committee and shared with the other feeder Committees.
- Monitoring attendance
- Bi-monthly reports to the Quality Committee
- Exceptions to be escalated to the Quality Committee on a monthly basis.

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act, 2000.

APPENDIX 5: PATIENT SAFETY COMMITTEE – TERMS OF REFERENCE

<table>
<tr><td>Title:

PATIENT SAFETY COMMITTEE

Terms of Reference</td><td rowspan="2">Warrington and Halton Hospitals NHS
NHS Foundation Trust</td></tr>
<tr><td>Author's Name:</td></tr>
<tr><td>Scope:
Annual Governance Statement
Monitor Governance Framework
CQC Outcome 16
BAF 1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework.
BAF 3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review.</td><td>Classification:</td></tr>
<tr><td colspan="2">Replaces:</td></tr>
<tr><td colspan="2">To be read in conjunction with the following documents: Quality Committee – Terms of Reference and the Quality Strategy</td></tr>
</table>

<table>
<tr><td>Unique Identifier</td><td colspan="2">Review Date: October 2015</td></tr>
<tr><td>Issue Status:</td><td>Issue No:</td><td>Issue Date:</td></tr>
</table>

Approved by:	Ratification Date:
Document for Public Display:	

1. Purpose

The Patient Safety Committee is established in accordance with Warrington and Halton Hospitals NHS Foundation Trust constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit and responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the Trust's constitution and standing orders.

The Patient Safety Committee is accountable to the Quality Committee

The purpose of the Patient Safety Committee is to provide the Quality Committee with assurance that high standards of care are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care and to identify, prioritise and manage risk arising from clinical care.

2. Accountability Terms of Reference

The Chairman of the Patient Safety Committee will be the Executive Director.

The terms of reference will be reviewed annually by the Patient Safety Committee and reports of progress made will be written to demonstrate compliance with these terms of reference and will contribute to the Trust's annual Quality Report and Accounts.

- Ensure full engagement with the divisions in relation to all aspects of patient safety.
- To review and consider relevant published reports or data in relation to. NRLS, CQC and agree corrective action for any concerns identified and monitor a clear escalation and feedback process to the Quality Sub Committee.
- To review Safety Alerts (CAS) and consider implications to services and ensure actions are implemented within timeframes.
- To review all information and data including Serious Incidents, Never Events, and Serious Case Reviews, ensuring that corrective and preventative action is taken and that lessons learned are widely disseminated.
- Risk Register
- CQC Outcomes
- Serious Untoward Incidents (SUI)
- High Level Enquiries
- Reports from divisions
- Claims analysis
- Medical Devices
- Consent
- Mental Health
- Medical Gases
- VTE
- Transfusion
- Mental Health
- Clinical Incidents - Level one and two action plans

- To agree and ensure that KPIs relating to patient safety are developed and monitored continuously so any early warnings regarding possible deterioration of services is identified and acted upon.
- To review and approve relevant policies and procedures and provide a list of ratified policies to the Quality Committee

3. Specific requirements

4. Membership

The membership of the Patient Safety Committee is:-

- Medical Director (Chair)
- Director of Nursing
- Associate Director of Governance
- Deputy Director of Nursing
- Associate Directors of Nursing/Head of Midwifery
- Associate Divisional Directors
- Divisional Medical Directors
- Patient / Carer representative
- Clinical Effectiveness Manager
- Head of Safety and Risk
- Corporate Nursing Programmes Manager
- Associate Divisional Managers
- Patient Experience Matron
- Non-Executive Director
- CCG Quality Lead

Trust staff may be co-opted as members where their contribution is deemed to enhance the work of the Committee.

70% attendance is required. A nominated deputy is to attend in the absence of the member.

5. Frequency of meetings

Monthly

6. Quorum

The Committee will be considered quorate with at least 4 members from the membership list and a designated Chair.

7. Review

Annual

8. Managing Effectiveness

- Formal minutes to be submitted to the Quality Sub Committee and shared with the other feeder Committees.
- Monitoring attendance
- Quarterly reports to the Quality Committee
- Exceptions to be escalated to the Quality Committee on a monthly basis.

APPENDIX 6: PATIENT EXPERIENCE COMMITTEE - TERMS OF REFERENCE

Title: PATIENT EXPERIENCE COMMITTEE **Terms of Reference**	Warrington and Halton Hospitals NHS NHS Foundation Trust
Author's Name:	
Scope: Annual Governance Statement Monitor Governance Framework CQC Outcome 16 BAF 1.1 Risk of failure to achieve agreed national and local targets of all mandatory operational performance and clinical targets as defined in the Monitor Risk Assessment Framework BAF 3.3 Failure to provide staff, public and regulators with assurances post Francis and Keogh review.	**Classification:**
Replaces:	
To be read in conjunction with the following documents: Quality Committee – Terms of Reference and the Quality Strategy	

Unique Identifier:	**Review Date: October 2015**	
Issue Status:	**Issue No:**	**Issue Date:**
Approved by:	**Ratification Date:**	
Document for Public Display:		

1. Purpose

The Patient Experience Committee is established in accordance with Warrington and Halton Hospitals NHS Foundation Trust constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit and responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the Trust's constitution and standing orders.

The Patient Experience Committee is accountable to the Quality Committee

The purpose of the Patient Experience Committee is to provide the Quality Committee with assurance that high standards of care are provided by the Trust and in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care and to identify, prioritise and manage risk arising from clinical care
The terms of reference will be reviewed annually by the Patient Experience Panel and reports of progress made will be written to demonstrate compliance with these terms of reference and will contribute to the Trust's annual Quality Report and Accounts.

The Patient Experience Panel will ensure the Trust delivers on the:

- Quality Strategy: patient experience section
- Clinical Governance Framework#
- Dementia Strategy
- Carers Strategy

The Committee will review progress made against the targets outlined to deliver this aim and steer the direction of this work to maximise the Trust's success.

2. Accountability Terms of Reference

The Chairman of the Patient Experience Panel will be the Executive Director.
The terms of reference will be reviewed annually by the Patient Experience Committee and reports of progress made will be written to demonstrate compliance with these terms of reference and will contribute to the Trust's annual Quality Report and Accounts.

- Ensure full engagement with the divisions in relation to all aspects of patient experience.
- Complaints and concerns
- PALS
- Patient Falls
- Nutrition
- Pressure Ulcers
- Mixed Sex Occurrences
- Always Events
- UTIs and Catheters
- Clinical Care Indicators
- Patient Feedback (including, FFT, surveys etc)
- Discharge and transfer KPI's
- Readmissions
- Transfer of care
- Dementia KPI's
- Clinical Incidents - Level one and two action plans
- Open and Honest data
- To agree and ensure that KPIs relating to patient experience are developed and monitored continuously so any early warnings regarding possible deterioration of services is identified and acted upon.

- To review all information and data including complaints trends, ensuring that corrective and preventative action is taken and that lessons learned are widely disseminated.
- To review and approve relevant policies and procedures and provide a list of ratified policies to the Quality Sub Committee

3. Specific requirements

4. Membership

The membership of the Patient Experience Committee is:-

- Director of Nursing (Chair)
- Medical Director
- Deputy Director of Nursing
- Associate Directors of Nursing/Head of Midwifery
- Associate Divisional Directors
- Divisional Medical Directors
- Patient / Carer representative
- Clinical Effectiveness Manager
- Corporate Nursing Programmes Manager
- Patient Safety Champion
- Associate Divisional Managers
- Patient Experience Matron
- Patient Experience Matron
- Tissue Viability Specialist Nurse
- Non-Executive Director
- CCG Quality Lead

Trust staff may be co-opted as members where their contribution is deemed to enhance the work of the Committee.

70% attendance is required. A nominated deputy is to attend in the absence of the member.

5. Frequency of meetings

Monthly

6. Quorum

The Committee will be considered quorate with at least 4 members from the membership list and a designated Chair.

7. Review

Annual

8. Managing Effectiveness

- Formal minutes to be submitted to the Quality Committee and shared with the other feeder groups.
- Monitoring attendance
- Quarterly reports to the Quality Committee
- Exceptions to be escalated to the Quality Committee on a monthly basis.

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act, 2000.

APPENDIX 7: INFECTION CONTROL COMMITTEE – TERMS OF REFERENCE (TO BE RATIFIED OCTOBER 2014)

Title: Infection Control Sub-Committee Terms of Reference	Warrington and Halton Hospitals NHS NHS Foundation Trust
Authors Name: Associate Director of Infection Prevention and Control	
Scope: Sub-Committee Terms of Reference	**Classification:**
Replaces: Issue 5	
To be read in conjunction with the following documents: N/A	

Unique Identifier:	**Review Date:** October 2014 **This document is no longer authorised for use after this date**	
Issue Status: Current	**Issue No: 6**	**Issue Date: October 2014**
Approved by: Infection Control Sub-Committee	**Ratification Date: October 2014**	

Document for Public Display: Yes

1 Purpose

The Infection Control Sub-Committee is accountable to the Trust Governance Committee for ensuring that an effective and robust infection prevention and control framework is implemented throughout the organisation, so providing assurance to the Board that organisational infection risks are being managed appropriately.

2 Accountability Terms of Reference

The Sub-Committee is a formally constituted Sub-Committee of the Trust Board.

The Chairman of the Sub-Committee will be a Trust Consultant Medical Microbiologist.

The Deputy Chair will be the Director of Nursing/Director of Infection Prevention and Control.

The Sub-Committee will report directly to the Trust Governance Committee providing assurance that effective and robust infection prevention and control arrangements are in place throughout the organisation.

The Infection Control Sub-Committee has delegated powers from the Trust's Governance Committee to approve policies/guidelines and procedural documents relating to the prevention and control of infection.

3 Specific requirements

a) To advise and support the Infection Control Team.
b) To assure the Chief Executive, Trust Board and Governance Committee that effective and robust Infection Control systems are in place.
c) To ensure robust monitoring of all elements of Infection Prevention and Control is undertaken through an annual work plan.
d) To monitor progress against Infection Control Action Plans e.g. bacteraemia reduction, Clostridium difficile reduction and compliance with the Code of Practice for the Health and Social Care Act.
e) To review surveillance data on healthcare associated infections and advising actions if required.
f) To review and advise the Trust Board on ways to improve surveillance.
g) To ensure plans are in place for the Trust's response to major outbreaks of infection within the Trust and in the community and to monitor their implementation. To provide a forum for discussion of outbreak reports, root cause analysis and lessons to be learned.
h) To receive reports from Matrons and ensure action plans are implemented.

i) To receive reports from the Estates and Facilities Departments and ensure action plans are implemented.
j) To receive minutes from the Decontamination Group meetings that provides assurance of robust decontamination processes throughout the Trust.
k) To receive minutes from the Water Safety Group meetings that provides robust assurance of water safety throughout Trust premises.
l) To receive minutes from the Anti-Microbial Steering Group meetings that provides assurance of prudent antimicrobial prescribing and action taken where prescribing non-compliance is identified e.g. feedback of point prevalence prescribing audits.

m) To ensure that training and supervision systems are in place for all staff and contractors working within the Trust and that those systems are regularly monitored.
n) To link into all clinical and non-clinical activities of the Trust i.e. bed management, purchasing and building.
o) To provide a forum for information/discussion/feedback of audit/research/new and evolving infection prevention and control issues.
p) To ratify infection prevention and control related policies, guidelines and procedural documents.
q) To monitor and review the progress of the work plan and produce an annual report.

4 Membership

- Consultant Medical Microbiologist – Chairman
- Director of Infection Prevention and Control – Deputy Chair
- Consultant Microbiologist/Infection Control Doctor
- Infection Control Matron/Associate Director of Infection Prevention and Control
- Infection Control Nurse Specialists
- Antibiotic Pharmacist
- IV Nurse Specialist
- Divisional Infection Control Lead Consultant - Scheduled Care
- Divisional Infection Control Lead Consultant - Unscheduled Care
- Divisional Infection Control Lead Consultant - Women, Children and Clinical Support Services
- Divisional Heads of Nursing/Head of Midwifery (Infection Control Leads)
- Matrons Scheduled Care
- Matrons Unscheduled Care
- Matrons Women, Children and Clinical Support Services
- Workplace Health and Wellbeing Consultant/Nurse Manager
- Consultant Communicable Disease Control/PHE representative (to attend quarterly or co-opted more frequently if required)
- Facilities Manager
- Estates Manager
- Community Healthcare Trust Representative

Other members will be co-opted as prompted by the work of the Infection Control Sub-Committee.

When a member of the Infection Control Sub-Committee is unable to attend they will send their nominated deputy in their place. 70% attendance will be achieved by the core/nominated deputy approach.

5 Frequency of meetings

The Infection Control Sub-Committee will meet monthly.

Quorum

6

The meeting will be quorate when the Chair (Consultant Medical Microbiologist) or the Deputy Chair (Director of Nursing/Director of Infection Prevention and Control [DIPC]), the Infection Control Matron/Associate DIPC or an Infection Control Nurse Specialist and the three clinical Divisions are represented.

If the meeting is not quorate, any policies/guidelines due to be ratified will either be deferred to the next meeting or can be approved by Chairman's action.

7 Review

The Infection Control Sub-Committee will review the Terms of Reference, membership and governance arrangements annually.

8 Managing Effectiveness

The Director of Infection Prevention and Control will review the effectiveness of the Infection Control Sub-Committee annually with the Chair of the Governance Committee.

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act, 2000.

APPENDIX 8: SAFEGUARDING STRATEGY GROUP – TERMS OF REFERENCE

INSERT

- SAFEGUARDING STRATEGY GROUP

APPENDIX 9: NURSING AND MIDWIFERY ADVISORY COMMITTEE – TERMS OF REFERENCE

Title: Nursing and Midwifery Advisory Committee **Terms of Reference**	Warrington and Halton Hospitals NHS NHS Foundation Trust
Author's Name: Alison Lynch	
Scope:	**Classification:**
Replaces: Previous TOR for the Nursing and Midwifery Advisory Committee	
To be read in conjunction with the following documents: The Trust's Nursing and Midwifery Strategy The Trust's Quality Strategy Quality Committee – Terms of Reference	

Unique Identifier:	**Review Date:**	
Issue Status: Awaiting review and approval	**Issue No:**	**Issue Date:**
Approved by:	**Ratification Date:**	
Document for Public Display:		

1. Purpose

The Nursing and Midwifery Advisory Committee has a key role in shaping the Trust's Nursing and Midwifery agenda to improve clinical standards and patient experience

The Nursing and Midwifery Advisory Committee is a formal sub-committee of the Quality Committee and is authorised on the behalf of the Board to assure a strategic approach to the development of nursing and midwifery across the organisation.

The objectives will be in line with the Care Quality Commission Essential Standards for Quality and Safety, and the Nursing and Care Quality Forum's priority themes to:

to promote **accountable nurse leaders** across the NHS.
to encourage the **right culture and the right values**
to **involve, listen to, hear and respond to feedback** from patients
to make sure that nurses have the **time** to give high-quality care to patients

2. Accountability Terms of Reference

The Nursing and Midwifery Advisory Committee will be a formal Committee of the Quality Committee.

The Nursing and Midwifery Advisory Committee Chairperson will be the Director of Nursing.

The terms of reference will be reviewed annually by the Nursing and Midwifery Advisory Council

3. Main areas of work of the committee

- To ensure compliance with the principles of Quality, People, Sustainability (QPS) Strategy, clinical governance, patient safety, quality and audit within the nursing and midwifery services the Trust provides.
- To assure the Board on all elements of professional nursing and midwifery services and ensure appropriate monitoring mechanisms are in place.
- Ensuring the ward accreditation scheme (DAWES) demonstrates ward to board assurance in monitoring patient safety and appropriate action is taken if non-compliant. (C) NMAC
- To highlight and address problematic areas relating to patient safety, patient experience, and quality of care that may have been identified that require escalation to the Governance Committee.
- To continually review the Nursing and Midwifery Strategy, ensuring objectives are witihin agreed timeframes
- To continually review information gained from patient safety incidents, complaints and patient experience reports. The committee will receive quarterly reports from the Patient Safety: Clinical Effectiveness and Patient Experience Committee highlighting specific issues relating to nursing care and patient experience.
- To monitor the progress of action plans that relate to nursing care (including falls, pressure ulcers, themes from complaints) ensuring that Nursing and midwifery issues are improved upon as a whole rather than in isolation, and to inform the training and education agenda.
- To ensure the Trust meets the statutory requirements of the Care Quality Commission in relation to registration and in continuous progress against the essential standards required by the Nursing and Midwifery Council.
- To note new nursing related guidelines, policies and procedures and their updates prior to Ratification at the Clinical Governance Audit and Quality Sub Committee.
- To lead the development of a culture of continuous, demonstrable improvement in the quality of the patient experience and improvement in health care outcomes.
- To ensure that patient and public views are considered at all levels of the Governance Structure.
- To review progress against nursing themes highlighted in High Level Enquiries.

- To receive the Approved minutes/action notes review reports from the Patient Safety; Clinical Effectiveness and Patient Experience Committees reporting to the Quality Committee to ensure compliance with their terms of reference as part of the annual work plan.
- To receive and review external reports from national bodies such as Care Quality Commission, Royal Colleges, Confidential Enquiries, Monitor, National Patient Safety Agency etc.
- To commission reports, projects and task and finish groups

4. Membership

The membership of the Nursing and Midwifery Advisory Council is:-

- Director of Nursing Chair
- Deputy Director of Nursing
- Divisional Heads of Nursing/Midwifery
- Senior Nurse AED
- Matrons
- Assistant Matrons
- Head of Education
- Quality Improvement Matron
- Specialist Nurses (Lead from each Division)
- Medicines Safety Nurse

Other Trust staff may be co-opted as members where their contribution is deemed to enhance the work of the Committee.

70% attendance is required. A nominated deputy is to attend in the absence of the member.

5. Frequency of meetings

The committee will meet monthly.

6. Delegated Powers & Reporting Arrangements

The Group will have delegated responsibilities for the development of initiatives across the Trust related to professional nursing practice.

Reporting Arrangements

The Nursing and Midwifery Advisory Committee meetings will be minuted and the draft minutes reported to the Quality Committee

7. Review

The Nursing and Midwifery Advisory Committee will undertake a review of its Terms of Reference and membership each year, and will write an Annual Report to demonstrate its achievements and compliance with its terms of reference.

APPENDIX 10: MEDICAL ADVISORY GROUP – TERMS OF REFERENCE

Title: Medical Advisory Group (MAG) **Terms of Reference**	Warrington and Halton Hospitals NHS NHS Foundation Trust
Author's Name: Paul Hughes	
Scope:	**Classification:**
Replaces: Clinical Advisory Group	
To be read in conjunction with the following documents: Medical Clinical Governance Policy Quality Strategy Quality Committee – Terms of Reference	

Unique Identifier: **MAG**	**Review Date:** **1.7.15**	
Issue Status: 2nd Draft	**Issue No:** **1**	**Issue Date:** **1.7.14**
Approved by:	**Ratification Date:**	
Document for Public Display: Yes		

1. **Purpose**

The Medical Advisory Group (MAG) has a key role in shaping the Trust's clinical agenda to improve clinical standards and patient experience.

The MAG is a formal sub-committee of the Quality Committee (QC) and is authorised on the behalf of the Board to assure a strategic approach to the development of clinical care across the organisation.

The objectives will be in line with the Care Quality Commission (CQC) Essential Standards for Quality and Safety, and its priority themes will be to:

- To encourage the right culture and the right values within the Trust
- To involve, listen to, hear and respond to feedback from patients
- To make sure that doctors have the time to give high-quality care to patients.

2. Accountability Terms of Reference

The MAG will be a formal group of the QC. The Chairperson will be the Medical Director. The terms of reference will be reviewed annually.

3. Main areas of work of the committee

- To provide Medical Leadership for the Trust.
- To ensure the principles of 'Good Medical Practice' are translated into high standards of medical practice in the Trust.
- To ensure compliance with the principles of Quality, People, Sustainability (QPS) Strategy, with particular reference to clinical governance, patient safety, quality and audit, within the clinical services the Trust provides.
- To assure the Board on medical professional issues and ensure appropriate monitoring mechanisms are in place.
- To highlight and address problematic areas relating to patient safety, patient experience, and quality of care that may have been identified that require escalation to the Governance Committee.
- To continually review the Medical Clinical Governance Strategy, ensuring objectives are achieved within agreed timeframes.
- To monitor the progress of action plans that relate to medical care, ensuring issues are improved upon across the organisation rather than in isolation, and to inform the training and education agenda.
- To note new clinical guidelines, policies and procedures and their updates (relevant to medical practice) prior to ratification at the QC.
- To lead the development of a culture of continuous, demonstrable improvement in the quality of the patient experience and improvement in health care outcomes.
- To ensure that patient and public views are considered at all levels of the Governance Structure.
- To review progress against clinical themes highlighted in High Level Enquiries.
- To receive and review external reports from national bodies such as Care Quality Commission, Royal Colleges, Confidential Enquiries, Monitor, National Patient Safety Agency etc.
- To commission reports, projects and task-and-finish groups

4. Membership and Attendance

The membership of the MAG is:-

- Medical Director
- Divisional Medical Directors
- Clinical Leads
- Divisional Integrated Governance Group Leads
- Medical Appraisal Lead

- Research & Development Lead
- Director of Medical Education/Deputy Directors of Medical Education
- Chair of Medical Staff Committee
- Chair of Local Negotiating Committee

Other Trust staff may be co-opted as members where their contribution is deemed to enhance the work of the Group.

The Medical Management Coordinator will record attendance, which will be reviewed annually. Each member is expected to achieve a minimum of 70% attendance. A nominated deputy may attend in the absence of the member.

5. Frequency of meetings

The committee will meet on a monthly basis.

6. Delegated Powers, Quoracy & Reporting Arrangements

The Group will have delegated responsibilities for the development of initiatives across the Trust related to professional medical practice.

Quoracy

Meetings of the MAG will be considered quorate when a minimum of two out of the four Medical/ Divisional Medical Directors plus a minimum of five other members are present.

Reporting Arrangements

Notes of Actions agreed by the MAG meetings will be kept by the Medical Management Coordinator and the approved minutes reported to the QC.

7. Review

The MAG will undertake a review of its Terms of Reference and membership each year, and will write an Annual Report to the Board, to demonstrate its achievements and compliance with its terms of reference.

APPENDIX 11: PROFESSIONAL ADVISORY GROUP – TERMS OF REFERENCE
(Reports to Strategic Workforce Group)

Title: **Non-Medical Professional Advisory Group** **Terms of Reference**	Warrington and Halton Hospitals NHS NHS Foundation Trust

Author's Name: Carol Millington		
Scope:	**Classification:**	
Replaces: New Group		
To be read in conjunction with the following documents: Quality Strategy Quality Committee Medicines Policy Risk Management Framework Nursing and Midwifery Strategy		
Unique Identifier:	**Review Date:**	
Issue Status: **Awaiting review and approval**	**Issue No:**	**Issue Date:**
Approved by:	**Ratification Date:**	
Document for Public Display:		

1. Purpose

The Professional Advisory Group will:-

1. Work together as a multi-professional forum to help to provide safe, quality services across the organisation
2. Be a professional reference group and advise the Board and senior Management on profession specific issues, relating to quality and safety of patients.
3. Advise the group of aspects of patient safety where these are relevant to or compromise clinical care.
4. To play a role in the integration of all governance, evidence and business planning across the professions.
5. Contribute to the reviews, consultation and developments of the health needs and strategic priorities of the Trust.
6. Provide professional advice, as requested, on major workforce and education changes such as modernising careers and workforce.

2. **Accountability Terms of Reference**

   The Professional Advisory Group Chairperson will be a nominated member of the group

   The terms of reference will be reviewed annually by the group.

3. **Specific requirements**

   Papers for the meeting will be circulated no later than one week in advance of the session. Agenda and minutes will be produced for each meeting.

   No papers should be tabled, by exception

4. **Membership**

Professional Lead
Chair
Deputy Director of Nursing
Director of Nursing and Organisational Development
Associate Director of Nursing and Head of Midwifery
AHP and Health Care Scientists Lead
Education Lead
Pharmacy Lead
Audiology Lead
Research Lead
Radiology Lead
Occupational Therapy Lead
Physiotherapy Lead
Dietetic Lead
SALT lead
Orthoptic Lead
Biomedical Scientist Lead
Cardio Physiologist Lead
Medical Engineering Lead
Orthotic Lead
Operating Department Lead

Other staff may be co-opted as members where their contribution is deemed to enhance the work of the group.

70% attendance is required. A nominated deputy is to attend in the absence of the member.

5. **Frequency of meetings**

   The Professional Advisory Group shall meet monthly and at such other times as may be considered necessary.

6. **Reporting Arrangements**

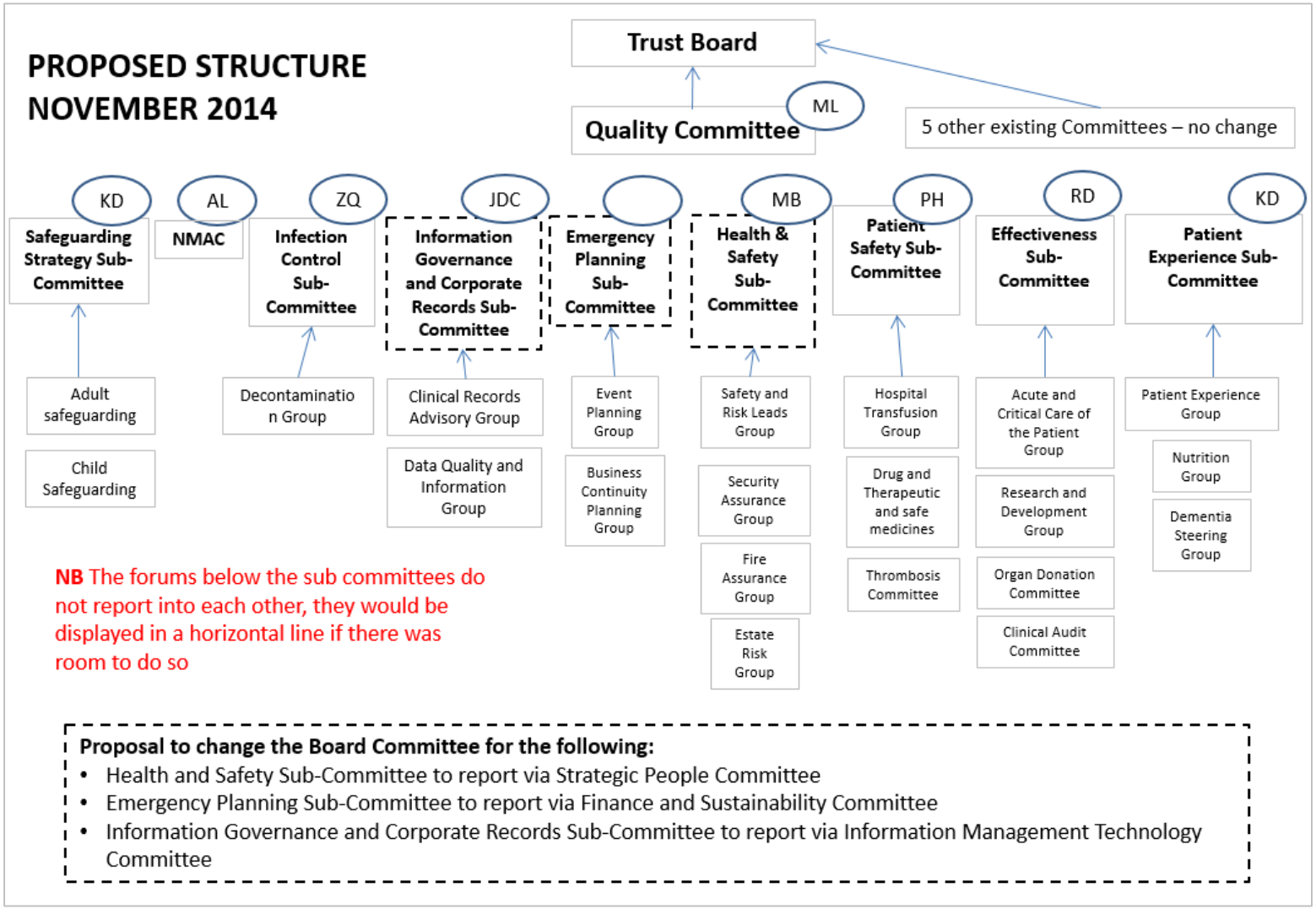
The Group will report to the Strategic Workforce Meeting, submitting any relevant document to the meeting as part of the agreed work plan.

7. Review

The Group will review its terms of reference and membership

The next review date is May 2015

Appendix 12: TRUST QUALITY STRUCTURE



EQUALITY IMPACT ASSESSMENT

To be completed and attached to any policy or procedural document when submitted to the appropriate committee for consideration and approval.

Title Quality Strategy	
What is being considered?	Policy ☐ Guideline ☐ Decision ☐ Other (please state) ☐ Strategy Y
Is there potential for an adverse impact against the protected groups below? Age Disability Gender Reassignment Marriage and Civil Partnership Pregnancy and Maternity Race Religion and Belief Sex (Gender) Sexual Orientation Human Rights articles	Yes ☐ No x
If you are unsure, please contact the Equality and Diversity Specialist - 5229	
On what basis was this decision made?	

National Guidelines e.g. NICE / NSPA / HSE / DH (other)	☐
Committee / Other meeting	x
Previous Equality screening	☐

With regard to the general duty of the Equality Act 2010, the above function is deemed to have no equality relevance
Equality relevance decision by
Date

The Equality Act 2010 has brought a new equality to all public authorities, which replaced the race, disability and gender equality duties.
This Equality Relevance Assessment provides assurance of the steps Warrington and Halton Hospitals NHS foundation Trust is taking in meeting its statutory obligation to pay due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

For further information or guidance please contact - Joe O'Grady, Equality and Diversity Specialist x 5229
joe.ogrady@whh.nhs.uk

DOCUMENT INFORMATION BOX

Item	Value
Type of Document	Strategy
Title	Quality Strategy
Published Version Number	1
Publication Date	October 2014
Review Date	October 2015
Author's Name + Job Title	Alison Lynch, Deputy Director of Nursing, Quality and Patient Safety Rosamund Harvey CNPM Hannah Gray CEM
CQC Standard Measure	Outcomes 1,2,3,4,5,7,8,9,16,17,18,19,
NHSLA General Standard	Standards 1,2,4,5,
NHSLA Maternity Standard	Standards, 1,2,3,4,5
Consultation Body/ Person	Quality in Care Committee; Governance Committee; DON; MD; CE Medical Lead; NED; Board Secretary; ADG & Patient Experience Matron.
Consultation Date	August 2014 – October 2014
Approval Body	Trust Board
Approval Date	November 2014
Ratified by	Trust Board
Ratification Date	November 2014
Author Contact	Rosamund Harvey
Librarian	Hannah Gray
Division	Corporate
Specialty (if local procedural document)	N/A
Ward/Department (if local procedural document)	N/A
Readership (Clinical Staff, all staff)	All Staff
Information Governance Class (Restricted or unrestricted)	Unrestricted

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/177

BOARD OF DIRECTORS

Paper Title	Safety Walk Rounds
Date of Meeting	November 2014
Director Responsible	Karen Dawber
Author(s)	Millie Bradshaw, Associate Director of Governance
Purpose	To update the Board on the status of Serious Incident Investigations

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Quality Governance Committee	November 2014
	Clinical Governance, Audit and Quality Sub-committee	November 2014
	Safety and Risk Sub Committee	On Agenda for December 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
•	Aims	Para 3 Page 2
•	Process	Para 4, page 2
•	Actions	Para 5, page 3
•	Data and Review 12 months Findings	Para 6, page 3
•	Appendix 1 Completed Actions as at 19th November date of production of the Board Report	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board to receive and note the Paper for additional recommendations.

SAFETY LEADERSHIP WALKROUNDS

SITUATION

To update the Board of Directors, Quality Governance Committee, Clinical Governance, Audit and Quality and Safety and Risk Sub Committees to the themes, trends and action resulting from the introduction of the Safety Walkround within WHHFT as of 26th November 2013.

BACKGROUND

The publication of the Francis 2 High Level Enquiry requires organisations to demonstrate quality and safety checks at Executive and Senior Manager Level which is also aligned to the CQC Quality and Safety Standards.

By using Safety WalkRounds, executives and senior managers further demonstrate to staff their commitment to building and further enhancing the culture of safety in the Trust.

WalkRounds are conducted in patient care departments but can also be expanded to other areas within an agreed timetable. This provides an informal method for executives and senior managers to talk with staff about safety issues and show their support to the need for staff to report any incidents.

The Concept was introduced in 2006 as part a two year project as part of the Safer Patients Campaign of which there were 15 sites in the UK. The campaign expanded to form the introduction to the NHS National Safety Campaign which has been superseded by the Sign up to safety campaign

AIMS OF THE WALKROUND

- Demonstrate commitment to safety.
- Further enhance the culture for change pertaining to safety.
- Provide opportunities for Executives and Senior Managers to continue to learn about safety concerns of their staff.
- Identify opportunities for improving safety.
- Establish lines of communication about patient safety among employees, executives, managers, and employees.

SAFETY LEADERSHIP WALKROUND PROCESS

Pre - work

1. Leadership Safety WalkRounds should initially be scheduled to take place on a one per week basis.
2. A set of dates, times and locations are established for the year
3. A Timetable is populated with the information by the Governance Department Support member .

4. Two weeks in advance of the chosen date the ward/Dept the Team will be emailed to confirm WalkRound by the Governance Support member to give areas time to inform relevant colleagues and to make any changes if necessary.
5. The WalkRound letter and leaflet is attached to the email for the wards/depts to display.
6. The Governance Support member will log the agreed Outcomes in CIRIS (web based compliance system)
7. The Divisional Clinical Governance Managers/Coordinator will update in CIRS following review at DIGG meetings. The evidence will form the Clinical Contract and CQC Essential Standard s of all the information and to the Outcome of the Walkrounds

ACTIONS FOLLOWING THE WALKROUND

At the end of the Walkround the ward/dept. staff are asked by the Executive and or managerial lead for up to 3 actions they wish the Lead and or nominated manager to take away and resolve. All are tracked on CIRIS to monitor and to the timescale for completion of 6 months.

The Walkrounds should be reviewed at the Divisional Integrated Governance Groups as part of the annual work plan to monitor and progress the actions in the areas.

A full review of the year will be included into Team Brief, Risky Business newsletter and used for demonstrating compliance with the CQC Standards for Quality and Safety.

DATA AND REVIEW OF 12 MONTHS

A total of 38 Walkrounds have been conducted. Of the 38 walkrounds there were 74 actions of which:

- 32 actions have been completed
- 37 actions in progress
- 3 actions awaiting sign off
- 2 actions aborted

The themes identified within the actions includes:

- 18 lack of staff
- 18 availability of equipment (medical devices)
- 8 environment and image presented (Estate of the Trust-paintwork, flooring as examples)
- 6 equipment repair
- 3 additional IT required
- 5 review and completion of documentation (amount of documentation to be completed)
- 3 equipment maintenance
- 2 additional administrative support required
- 3 Implementation (WHO Checklist, review of ward move B12, new menu)
- 3 patient/ staff safety (car park, speed bumps around site, security)
- 2 additional space required

- 2 relocation of a department
- 1 Ward Leadership

As the Reader will see staffing and availability of equipment are the key themes in addition to the Estate aesthetic of painting and flooring to which present to staff a poor image.

With the major financial investment in nurse staffing; particularly in Unscheduled Care, the impact of this will be monitored as part of the 2015 requested actions in the Walkround Scheduled.

With the recent launch of the Trust Estates Strategy and that this is communicated widely to staff they will see the future plans and the vision of the Trust to enhance the premises.

Staff trying to find equipment is another key theme to which is also part of the Estates Plans to try and include a central equipment library. This is conjunction with tagging of devices as part of the enhanced wireless network will help staff to get equipment at the right time for the patient.

Please see **Appendix 1** to some of the examples of the actions completed

RECOMMENDATIONS

1. The Executive Team to review and consider what they feel is the effectiveness of the Walkrounds and identify any changes they would wish to see
2. To review the findings of the recent staff safety culture survey to see if the Safety Walkround has made an impact
3. That the findings of the Walkrounds are reported via DIGG'S and Speciality meetings
4. The Board of Directors, Quality Governance Committee, Clinical Governance, Audit and Quality and Safety and Risk Sub Committees to receive and note the Paper for additional recommendations.

Safety Walk round identified Actions Report 84 Items

Division / Department of Walk Round equals:

Action Status equals: "Completed"

Days Overdue greater than or equal to:

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Walk Round: AED Main							
All staff stated department not safe- Review A&E	Review staffing and base on skill mix and activity	Lack of staff	TASK 16162	Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD	Completed as at 04/04/2014	12/12/2014	Care and quality review undertaken with in AED. Action plan to be monitored through AED governance meetings and DIGG. Budget increases for staffing approved in 04/14. Recruitment underway.
	Review staffing and base on skill mix and activity			Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD			
Walk Round: Antenatal Day Unit							
Window pole needed in toilet on Antenatal day unit	To prevent injury from trying to reach window	Availability of Equipment	TASK 19590	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	Completed as at 06/11/2014	31/12/2014	Window pole to be provided.
Walk Round: Cardiac Catheter Suite							
Review allocation of medical staff for the Cardiac Catheter lab department	Staff said not enough medical cover	Lack of staff	TASK 18138	Seddon, Helen; Assistant General Manager – Cardiology & Respiratory; UCD	Completed as at 04/11/2014	12/02/2015	No longer an issue as patient now go to the Interventional Radiology Suite.
	Staff said not enough medical cover			Seddon, Helen; Assistant General Manager – Cardiology & Respiratory; UCD			
Walk Round: Childrens AED							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Review and Repair of Floor	To prevent injury in addtion to better looking enviroment	Environment imag e of ward/dept	TASK 11085	Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 14/04/2014	24/06/2014	Capital bid not approved for funding of replacement flooring. The flooring will be taped as required to maintain safety. When funds are made available the complete flooring will need to be replaced, meaning the unit would have to vacate for a period of time.
	To prevent injury in addtion to better looking enviroment			Wardley, Darren; Operational Estates Manager - Estates; EST			
Repair of Light in Cubicle 1	To mimimise risk of harm and enhanced ligh source	Equipment Repair	TASK 11084	Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 09/04/2014	09/07/2014	The fitting has been repaired.
	To mimimise risk of harm and enhanced ligh source			Wardley, Darren; Operational Estates Manager - Estates; EST			
Walk Round: Clinical Decisions Unit (CDU)							
Bed rails availabilty in AED	To prevent patient harm	Availability of Equipment	TASK 16168	Cresswell, George; Associate Director of Estates; EST	Completed as at 30/10/2014		Separate Bed rails cannot be purchased anymore as all now all come integral to electrical profiling bed, Estates try and repair the ones they have. Trust wide Business Case to look at Bed Replacement Programme in place
	To prevent patient harm			Cresswell, George; Associate Director of Estates; EST			
Staffing issues on AED	To review safe levels of care	Lack of staff	TASK 16158	Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD	Completed as at 04/08/2014	12/12/2014	Care and quality review undertaken with in AED. Action plan to be monitored through AED governance meetings and DIGG. Budget increases for staffing approved in 04/14. Recruitment underway.
	To review safe levels of care			Edge, Karol; Divisional Head of Nursing - Unscheduled Care; UCD			
	To review safe levels of care			Hughes, Paul; Medical Director; WHH			
	To review safe levels of care			Hughes, Paul; Medical Director; WHH			
Walk Round: Endoscopy Unit warrington							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Addtional Admin support required for increased Endoscopy sessions	to enhance patient flow	Additional administrative support	TASK 11807	Smith, Karen; Ward Manager - Endoscopy; ENDO	Completed as at 27/01/2014	01/07/2014	Admin support for 3 session day- we have recruited a new evening receptionist (just waiting her induction date to be confirmed). As this post is 20 hours per week, should make a real difference in the flow of case notes both pre and post procedure.
	to enhance patient flow			Smith, Karen; Ward Manager - Endoscopy; ENDO			
To review to having a second Prep Room	To enhance patient flow	Additional Space	TASK 11808	Smith, Karen; Ward Manager - Endoscopy; ENDO	Completed as at 27/01/2014	01/07/2014	Considering a further prep-room- whilst recognising the difficulties in delay for patients whist waiting for enema preps, in our existing environment, we have no actual space to create a further prep-room, unless we choose to loose bed capacity- which itself cause us a patient flow problem. This situation may be greatly improved with the re-introduction of gastro back into Halton Endoscopy, as this is our intention.
	To enhance patient flow			Smith, Karen; Ward Manager - Endoscopy; ENDO			
Walk Round: Intensive Care Unit (ICU)							
Staffing review	To review safe levels of care	Lack of staff	TASK 16772	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	Completed as at 11/07/2014	24/12/2014	STAFFING REVIEW COMPLETED AND RECRUITMENT
	To review safe levels of care			Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD			
	To review safe levels of care			Crosby, Natalie; Matron - ICU; ICU			
	To review safe levels of care			Crosby, Natalie; Matron - ICU; ICU			
Walk Round: Labour Ward							
1 more carer needed on labour ward	To review for safe levels of care	Lack of staff	TASK 19563	Brown, Richard; Divisional Manager - WCSS; WCSS	Completed as at 18/11/2014	01/04/2015	Staffing audit presented at Departmental meeting 18/11/14. Associate Director of Nursing will complete a staffing review to identify if further support can be identified. Birthrate + to commence in January 2015
	To review for safe levels of care			Brown, Richard; Divisional Manager - WCSS; WCSS			
Walk Round: Main Theatres - Warrington							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Beds and brake	Beds coming to theatre with patients not fit, steering poor due to brakes. Theatre staff tell ward staff to get them checked and repaired Patients coming down t theatre on beds with backrests broken shows not being checked	Equipment	TASK	Rigby, Mark; Theatres Manager - Warrington; W-TH	Completed	10/02/2014	If the beds are unfit for patients the housekeepers labels the bed and make arrangements for the bed to be repaired by
	Beds coming to theatre with patients not fit, steering poor due to brakes. Theatre staff tell ward staff to get them checked and repaired Patients coming down t theatre on beds with backrests broken shows not being checked			Rigby, Mark; Theatres Manager - Warrington; W-TH			
	Beds coming to theatre with patients not fit, steering poor due to brakes. Theatre staff tell ward staff to get them checked and repaired Patients coming down t theatre on beds with backrests broken shows not being checked			Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD			
	Beds coming to theatre with patients not fit, steering poor due to brakes. Theatre staff tell ward staff to get them checked and repaired			Browning, Rachel; Associate Director of			

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
maintenance including back rests	Patients coming down t theatre on beds with backrests broken shows not being checked	maintenance	10596	Nursing - Scheduled Care; SCD	as at 14/05/2014		estates.Porters double check the beds prior to transfer to theatre to ensure that they are fit for patient to be transferred.
Ensure WHO checklist is completed correctly at all times	Ownership of WHO Checklist (its done at SPIRE why not at WHHFT?)	Implementation	TASK 10598	Halliwell, Mark; Clinical Lead - Oral Surgery and Orthodontics; OS-O	Completed as at 24/01/2014	10/05/2014	SOP agreed at DIGG
	Ownership of WHO Checklist (its done at SPIRE why not at WHHFT?)			Halliwell, Mark; Clinical Lead - Oral Surgery and Orthodontics; OS-O			
	Ownership of WHO Checklist (its done at SPIRE why not at WHHFT?)			Warbrick, Kate; Divisional Manager - Scheduled Care; SCD			
	Ownership of WHO Checklist (its done at SPIRE why not at WHHFT?)			Warbrick, Kate; Divisional Manager - Scheduled Care; SCD			
Ensure all patients are prepared on arrival to Theatre with all appropriate documentation from the ward areas	Patients not being ready for Theatre and this delays the list	Documentation to be completed properly	TASK 10597	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	Completed as at 14/05/2014	23/05/2014	Matron to discussed the action at her meeting with ward managers and also sent a follow up email to ward managers to reinforce the action with their staff.
	Patients not being ready for Theatre and this delays the list			Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD			
	Patients not being ready for Theatre and this delays the list			Rigby, Mark; Theatres Manager - Warrington; W-TH			
	Patients not being ready for Theatre and this delays the list			Rigby, Mark; Theatres Manager - Warrington; W-TH			
Walk Round: Maxillofacial Department							
Report air con not working in maxillofacial department to estates	Staff said department can become too hot	Equipment maintenance	TASK 17847	Porter, Hilary; Orthodontic Department Manager; SCD	Completed as at 24/10/2014	29/10/2014	
Walk Round: Radiology Department - Warrington							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Safety cover for plug socket (Halton xray waiting room)	To minimise risk of harm	Equipment Repair	TASK 17211	Matthews, Gill; Radiology Governance Lead; RAD	Completed as at 11/11/2014	01/01/2015	
	To minimise risk of harm			Matthews, Gill; Radiology Governance Lead; RAD			
Free radiator from wall in Central Booking Office (radiology)	For good room temperature	Environment imag e of ward/dept	TASK 17208	Matthews, Gill; Radiology Governance Lead; RAD	Completed as at 11/11/2014	04/01/2015	No longer applicable. When worktop and cupboard removed it showed that the radiator had previously been removed.
	For good room temperature			Matthews, Gill; Radiology Governance Lead; RAD			
Increase computers and desks in Central Booking Office (radiology)	additional IT to work more effectively	Availability of Equipment - IT	TASK 17207	Matthews, Gill; Radiology Governance Lead; RAD	Completed as at 11/11/2014	04/01/2015	Have been able to increase the workstations by one e.g. one computer and one desk.
	additional IT to work more effectively			Matthews, Gill; Radiology Governance Lead; RAD			
Walk Round: Ward A4							
Provide interventional radiology beds	to enhance patient experience and reduce cancellations of procedures	Patient and Staff Safety	TASK 13591	Brown, Richard; Divisional Manager - WCSS; WCSS	Completed as at 18/06/2014	14/09/2014	Work has started on the interventional radiology suite to create a 5 bedded area for mixed sex use. This capital scheme will be completed by the end of August 2014. In the interim ward A4 has moved to the old urgent care centre (former Endoscopy unit) and 4 beds have been allocated to IR on a daily basis. This arragement effective from Wednesday, 18 June.
	to enhance patient experience and reduce cancellations of procedures			Brown, Richard; Divisional Manager - WCSS; WCSS			
Walk Round: Ward A5							
Medicine lockers repair	medicines security	Equipment Repair	TASK 13594	Burgess, Judith; Surgical Matron; WHH	Completed as at 14/05/2014	07/04/2014	14/05/14: Medicine lockers have been repaired.
	medicines security			Burgess, Judith; Surgical Matron; WHH			

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Relook at SAU bed allocations		Relocation of Ward / Department	TASK 13593	Warbrick, Kate; Divisional Manager - Scheduled Care; SCD Warbrick, Kate; Divisional Manager - Scheduled Care; SCD	Completed as at 23/10/2014	31/10/2014	The SAU was reviewed and the review was presented to the executives at the Divisional Bi-Lateral meeting. Initial approval for SAU to move to ward A4. The move will provide an improved patient and staff environment.The action will continue to be reviewed as A4 moving to daresbury temporarily to facilitate window works to be completed by Estates. 23/07/14: Windoe work in progress. A4 is still located on UCC. 22/09/14: SAU will be relocated to original A4 in October.
Walk Round: Ward A7							
Stand Aid for Bariatric patients A7		Availability of Equipment	TASK 16174	Hatton, Deborah; Ward Manager - Cath Lab; CCS Hatton, Deborah; Ward Manager - Cath Lab; CCS	Completed as at 04/11/2014	17/11/2014	Funding from risk reserve fund available do has been ordered
Walk Round: Ward A9							
Additional bed space for the bedded area by the doors to the cubicles		Additional Space	TASK 13767	Finney, Cheryl; Matron - A9; A9 Finney, Cheryl; Matron - A9; A9	Completed as at 26/09/2014	30/09/2014	The layout of the area is such that there is a corrider leading to the bed areas and the floor plan cannot be changed physically. The door does not open unto a bed spqace.
Walk Round: Ward B10							
Apply metal plate to doors on PAU		Equipment Repair	TASK 13771	Wardley, Darren; Operational Estates Manager - Estates; EST Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 22/07/2014	22/07/2014	22/07/2014 - Checking with Staff, which doors require plates and whether these can be fitted without replacing the complete door set, type and size of plate requires confirmation and appropriate funding required to complete.
To have hot water geyser		Availability of Equipment	TASK 13770	Wardley, Darren; Operational Estates Manager - Estates; EST Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 05/08/2014	30/09/2014	05/08/2014 - Location of hot water boiler agreed and boiler purchased by Ward. Estates to fit the boiler in the agreed location
Walk Round: Ward B11							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Implementation of new menu		Implementation	TASK 14754	Cresswell, George; Associate Director of Estates; EST	Completed as at 15/05/2014	16/06/2014	New menu now in use.
				Cresswell, George; Associate Director of Estates; EST			
Walk Round: Ward B12							
Review B12 operationally after 3 months of moving to new ward	to monitor effectiveness of the change	Implementation	TASK 14657	Hammond, Deborah; Ward Manager - B12; A2	Completed as at 18/08/2014	16/10/2014	Monitoring of FMU via the forget me not steering group. KPI's are also monitored via the CQUIN meetings. Ward working well and appropriately
	to monitor effectiveness of the change			Hammond, Deborah; Ward Manager - B12; A2			
Review of bed numbers to avoid confusion	B12 numbering was different for the rest of the wards and this caused confusion	Serious Untoward Incidents	TASK 14656	Hammond, Deborah; Ward Manager - B12; A2	Completed as at 18/08/2014	16/10/2014	Bed numbers have been reviewed and the number of bed is 21. Ward working well and monitoring continues via steering group.
	B12 numbering was different for the rest of the wards and this caused confusion			Hammond, Deborah; Ward Manager - B12; A2			
Walk Round: Ward B14							
Alarm on fire door		Equipment Repair	TASK 14651	Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 29/08/2014	30/09/2014	05/08/2014 - Checked with department and the alarms need to be re-enabled. A job has been placed on the Estates team to complete.
				Wardley, Darren; Operational Estates Manager - Estates; EST			
Walk Round: Ward B19							
to increase computer	allow staff greater access to complete work	Availability of Equipment - IT	TASK 15852	Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD	Completed as at 29/04/2014	29/07/2014	
	allow staff greater access to complete work			Browning, Rachel; Associate Director of Nursing - Scheduled Care; SCD			
Walk Round: Ward C20							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Review Staffing issues CA	To review safe levels of care	Lack of staff	TASK 16186	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	Completed as at 18/11/2014	04/12/2014	Monitoring of staffing levels on C20 is ongoing. WH Strategy day highlighted the need for dedicated gynaecology beds on C20 and restrict admissions of out liers. This action will be closed and monitored under the project actions from the strategy day
	To review safe levels of care			Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS			
Review staff rest area C20	Staff having breaks in Managers office as there is nowhere else for them to go	Environment imag e of ward/dept	TASK 16154	Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS	Completed as at 18/11/2014	04/12/2014	Poor environment identified as a problem during the WH Strategy day. Unable to provide rest facilities on the ward at present due to limited space and availability of rest rooms. Canteen and rest facilities are provided in the hospital main entrance as an al alternative provision
	Staff having breaks in Managers office as there is nowhere else for them to go			Hudson, Melanie; Divisional Head of Nursing - WCSS; WCSS			
Walk Round: Ward C21							
Call bell moved C21	To minimise risk of falls	Availability of Equipment	TASK 16184	Cresswell, George; Associate Director of Estates; EST	Completed as at 05/08/2014	29/11/2014	05/08/2014 - Estates visited Ward and a job has been put in for the pull chord switch to be moved over to the next tile. This work will be completed within 2 weeks.
	To minimise risk of falls			Cresswell, George; Associate Director of Estates; EST			
New shower to bath area C21	For better patient experiance	Environment imag e of ward/dept	TASK 16183	Cresswell, George; Associate Director of Estates; EST	Completed as at 22/07/2014	29/11/2014	22/07/2014 - This needs to be a Capital bid put in by the Department for this to progress. A cost has been supplied by Estates to the Department and a Capital Business Case is required to secure the funding.
	For better patient experiance			Cresswell, George; Associate Director of Estates; EST			
Review of staffing C21	To review safe levels of care	Lack of staff	TASK 16182	Eatwell, Jim; Matron - Cohort Ward; COH	Completed as at 23/06/2014	29/11/2014	
	To review safe levels of care			Eatwell, Jim; Matron - Cohort Ward; COH			
Walk Round: Ward C22							

Action	Rationale	Action Type	ID	Action Lead(s)	Action Status	Due Date ▲	Last Review / Outcome
Window repair C22	Window unsafe	Environment imag e of ward/dept	TASK 16176	Wardley, Darren; Operational Estates Manager - Estates; EST	Completed as at 17/11/2014	20/11/2014	22/07/2014 - Estates to confirm with Ward Staff the exact location of the window for repair and a job request will be input to arrange for the window repair.
	Window unsafe			Wardley, Darren; Operational Estates Manager - Estates; EST			
	Window unsafe			Cresswell, George; Associate Director of Estates; EST			
	Window unsafe			Cresswell, George; Associate Director of Estates; EST			
Walk Round: Ward C23							
Review Staffing issues C23	To review safe levels of care	Lack of staff	TASK 15866	Brown, Richard; Divisional Manager - WCSS; WCSS	Completed as at 18/11/2014	27/11/2014	Associate Director monitors staffing levels in this area. Reduced staffing levels have been noted due to short and long term sickness absence. Extra midwives have been recruited and RGN staff support the midwifery compliment to provide safe standards of care.
	To review safe levels of care			Brown, Richard; Divisional Manager - WCSS; WCSS			