The Clatterbridge Cancer Centre NHS
NHS Foundation Trust

2013 - 2015

Quality and Quality Governance Strategy

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2013 – 2015

Introduction

This Strategy aims to support the delivery of the Trust's vision to provide the best cancer care to the people we serve.
It is an overarching strategy which outlines the plans for the continued development of Quality Governance at the Trust and identifies key areas of development for continual quality improvement. It has been developed to reflect our own organisational aims together with responding to external drivers. Key external drivers include:

- The Francis Report and the Department of Health response to this report
- Monitor's Quality Governance Framework
- Proposed changes to the CQC regulatory framework
- Proposed changes to how the NHSLA assesses risk
- Monitors Risk Assessment Framework (consultation)
- Quality Governance: How does a board know that its organisation is working effectively to improve patient care? (Monitor April 2013)
- High Quality Care for All

In High Quality Care for All (DH 2008) Darzi states that quality is the organising principle for the NHS with emphasis on patient safety, patient experience and the effectiveness of care.

The changes to how the CQC regulates, inspects and monitors care are developed around 5 key questions which reflect this statement. The Quality Strategy is developed around these key questions which ask about care services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

The Quality and Quality Governance Strategy:

Aims:

To continually improve the quality of our services
To ensure that our governance arrangements for quality are robust
To ensure that staff (including the Board) are accountable for the quality of care they deliver and the use of public funds

Objectives:

To ensure our care services are safe
To ensure our care services are effective
To ensure our care services are caring
To ensure our care services are responsive to people's needs
To ensure our care services are well led

Underlying principles:
To be transparent about the quality of care we provide
To actively listen to our patients and work in partnership with stakeholders to improve services
To learn from others and ensure best practice
To continually innovate and develop
To ensure we have robust processes for assurance and escalation
To ensure all staff are accountable for the care they deliver

Supporting Strategies:
HR+OD
IM+T
Infection control
Financial strategy

Contents:

Quality Governance Framework

Introduction
Quality Governance is the overarching framework which provides assurance on compliance with standards and statutory obligations, continuous quality improvement and enables a risk and escalation process.

This section of the Quality Strategy outlines the current Quality Governance Framework and the Quality Governance Strategy to further develop the framework.

Background:
'High Quality Care for All' (DH: Darzi 2008) states that quality is the organising principle for the NHS with emphasis on patient safety, patient experience and effectiveness of care.
NHS governance consists of multiple strands which as integrated governance enable the Board to ensure it is complying with its legal and regulatory requirements as well as meeting its strategic objectives (Audit Commission 2009).

Monitor's Quality Governance Framework was published in 2010 in response to the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust. Monitor has recently published further guidance 'Quality Governance: How does a Board know that its organisation is working effectively to improve patient care? (April 2013). Both of these reports have been used to frame with Quality Governance Framework and Strategy.

Capabilities and Culture:
The Trust Board is committed to ongoing Board development to ensure it has the necessary leadership, skills and knowledge to ensure the delivery of the Quality Agenda.

The Trust has in place a policy for the appointment of non executive directors which includes a skills analysis exercise by the Board prior to advertising any vacancy and when considering any re-appointment.
The Trust has developed, with staff, a set of values and underpinning behaviours.

Processes and Structures:
The Trusts corporate strategy clearly focuses on improvement in quality. This is supported by the Trusts Quality Strategy.

The Trust has in place a Quality Risk Assessment and Impact Tool for service development and QIPP initiatives.

The Trust has in place a comprehensive Risk Management Strategy which aims to minimise risks through a comprehensive system of internal controls whilst maximising potential for innovation and best practice.

The Trust has revised the committee structure to ensure a clear Quality Governance Framework and reporting through to the Board to ensure the delivery of the strategy and the provision of assurance and escalation of risk (appendix 1).

The Board actively engages with patients, staff and other key stakeholders through:

- Patient Safety Leadership Rounds
- Review of patient video stories at each Board Meeting
- Executive job shadowing
- Engagement with the Council of Governors and the Trusts membership
- Regular events with representatives from Healthwatch and Overview and Scrutiny Committees in relation to the Quality Strategy
- Staff forums
- Start of the Year events.

Measurement:
The Trust has a programme of data validation for the quality metrics in the Quality Accounts and data sign off by the Director of Nursing and Quality and the Medical Director.

The Roles and Accountability for Quality Governance

Board

- The ‘duty of quality’ is held by the organisation through the Board of Directors.
- The Board is responsible for the development of strategy and for ensuring risks to quality are mitigated and quality improvement is promoted and all required standards are achieved
- It is responsible for promoting an open culture which promotes learning and is supported by ‘Being Open’ and ‘Raising Concerns’ policies.

Chief Executive

- The CEO carries responsibility for assuring the quality of services within the Trust and that regulatory requirements are met.

Director of Nursing and Quality

- Developing the Quality and Quality Governance Framework and Strategy
- Ensuring the Trust has robust quality assurance processes in place
- Ensuring regulatory compliance
- Develop the Quality Account / Report
- Ensure the Trust has in place an accredited Quality Management System (ISO 9001:2008)
- Development of and monitoring of CQUINS

Executive Directors:

- Ensure that all Senior Managers deliver the requirements of the Quality and Quality Governance Framework and Strategy
- Regular review of the Board Assurance Framework and risk register

Clinical Governance Support Team

- Lead on the delivery of quality and safety initiatives
- Provide quality reports to the Board and other committees
- Manage the delivery of the Risk Management Strategy

Senior Managers

- Ensure that good governance is adopted throughout the Trust
- Comply with all relevant policies and procedures
- Continually strive for quality improvement.

All Staff

- Comply with all relevant policies and procedures
- Continually strive for quality improvement

Assurance and escalation framework

Introduction

The Trust has developed a range of strategies, policies, systems and processes which together comprise and integrated assurance and escalation framework.

This document describes the Framework and demonstrates how the Trust's Quality systems and organisational learning is monitored by an effective committee structure. This framework also ensures compliance with Monitor's Quality Governance requirements and as such is structured around the four themes of strategy, capability and culture, processes and structures and measurement.

Purpose

The Framework describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns / risks to the quality of services, performance targets, quality KPI's and delivery of its strategic objectives. It addresses under performance and ensures these are identified early and are rectified.

Receiving Assurance and Identifying Concerns

The Trust has a number of systems and processes which support the delivery of high quality care and ensure good governance. These processes enable those responsible for delivering, monitoring and receiving care can provide assurance to the Board and also identify and raise concerns.

Staff Involvement:
The Trust has a number of policies and systems which encourage staff at all levels to be involved in monitoring quality and performance and to raise concerns about any issues. In addition to the Trust's strong culture of openness and accountability delivered through effective line management, these include:

- Risk Management Strategy
- Quality Strategy
- Incident reporting policy
- Being Open Policy
- Raising Concerns policy
- Safeguarding policy
- HR policies
- Information management / governance policies
- Patient Safety Leadership rounds
- Executive director job shadowing
- Partnership forum
- Health and safety committee
- Staff surveys
- Induction programme
- Anniversary CEO lunches
- PDR processes
- Performance review meetings
- Corporate and departmental performance dashboards

Patient, carer and public involvement.
The Trust has a number of policies and systems which encourage patients, carers and the public to be involved in monitoring quality and performance and to raise concerns about any issues. These include:

- PALs
- Complaints
- Council of Governors
- Trust membership
- Patients Council
- Patient story programme
- Internal patient surveys
- CQC patient surveys
- Healthwatch
- Local authority health overview and scrutiny (OSC)
- OSC and Healthwatch quality engagement meetings
- PEAT and PLACE assessments

Commissioners
Formal mechanisms for commissioners to raise concerns include:

- Contract and performance review meetings
- CQUIN monitoring

Internal and External Sources of Assurance
There are numerous sources of internal and external assurance. These are provided in appendix 2 and are mapped against the Quality Strategy Outcomes / CQC key questions.

Internal Systems for Monitoring Performance and Escalation.

The Trust has in place systems and processes for monitoring performance and for escalating concerns and risk. These currently include the following and will be reviewed following the consultation on the Management re-structure. This will provide a clear assurance and escalation framework for the Trust within its new directorate structure.

The Trusts monitoring / assurance processes

Trust wide:
- The risk register

Board and its committees
- Board assurance framework
- Monitoring of the delivery of strategic objectives
- Assignment of monitoring functions to a committee

Departments
- Performance review

Committee Structure

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established. The terms of reference of these committees are reviewed each year to ensure robust governance and assurance is in place.
To support Quality Assurance a new committee structure to inform the Integrated Governance Committee will be developed and embedded (see appendix 1).

Quality Governance Strategy:

Action	Lead	Deadline
To embed the assurance and escalation framework	Executive directors	September 2013
Formal regular and independent evaluation of the Boards effectiveness and governance arrangements in accordance with the Monitor Risk Assessment Framework requirement (TBC).	CEO	TBC
Further develop the scope and frequency of quality reporting on the Trusts website.	Director of Nursing and Quality	October 2013
Review and develop the use of external benchmark clinical and non clinical indicators of quality.	Director of Nursing and Quality	January 2014
Improve quality data reporting throughout the Trust	Director of Nursing and Quality	April 2014
Development of a new assurance and escalation framework within the new Management Structure	Director of Nursing and Quality	January 2014
Update and revise the Corporate Governance Manual within the new Management Structure	Director of Nursing and Quality / Corporate Governance Manager	January 2014

Quality Strategy

Ensuring our care services are safe

Initiative	Lead	Deadline
Develop and embed revised Quality and Risk management standards (to replace NHSLA risk management standards) – appendix 3	Director of Nursing and Quality	April 2014
Implementation of supernumerary ward managers	Head of Nursing	December 2013
Review of Schwartz rounds These provide a monthly, one-hour session for staff	Head of Clinical and	October 2013

from all disciplines to discuss difficult emotional and social issues arising from patient care.	Information Governance	

Ensuring our care services are effective

Initiative	Lead	Deadline
Inclusion of review of weekend deaths into mortality review programme	Head of Clinical and Information Governance	October 2013
Reporting against NHS Outcomes framework 5 quality domains	Director of Nursing and Quality	October 2013
Develop internal and external benchmarking	Director of Nursing and Quality	January 2014

Ensuring our care services are caring

Initiative	Lead	Deadline
Implement hourly intentional rounding	Head of Nursing	October 2013

Ensuring our care services are responsive to people's needs

Initiative	Lead	Deadline
Develop the patient story programme (Patient Experience Committee Governors) Use patient stories to inform clinical practice and develop understanding at Board level	Head of Clinical and Information Governance	March 2013
Friends and Family test roll out	Head of Clinical and Information Governance	March 2013

Ensuring our care services are well led

Initiative	Lead	Deadline
Climate / culture survey	Associate director of HR	October 2013
Minimum training standards / competencies for healthcare support workers	Head of Clinical and Information Governance	December 2013
6 monthly Board endorsement of staffing levels	Associate director of HR	December 2013

Use of established acuity tool (AKUH) to determine ward staffing levels	Head of Nursing	December 2013
Further develop leadership training	Associate director of HR	December 2013
Embed the assurance and escalation framework in accordance with Monitors Quality Governance guidance	Executive directors	September 2013
Amend the format and content of the Quality Accounts	Director of Nursing and Quality	April 2014
Develop and internal inspection programme around the revised Quality and Risk Standards	Director of Nursing and Quality	April 2014
Develop reporting and accountabilities for the new NHSLA system	Director of Nursing and Quality	TBC
Develop reporting and accountabilities for the new CQC regulatory approach	Director of Nursing and Quality	TBC

Transparency of care

Initiative	Lead	Deadline
Review of information on public website to include complaints and 'agreed' data set	Director of Nursing and Quality	November 2013
Implementation of Duty of Candour into incident reporting policy and guidance and ensure delivery of education and training	Head of Clinical and Information Governance	September 2013
Development of improved, open and honest reporting of quality and performance on our website	Director of Nursing and Quality	November 2013

Learning from others

Initiative	Lead	Deadline
Further develop the process of learning from relevant NICE Quality standards	Director of Nursing and Quality	January 2014

Quality Key Performance Indicators

*: CQC proposed metrics

Ensuring our care services are safe

Reporting of safety events*
Number of reported harm events:

- VTE
- Pressure ulcers
- Falls
- HCAI
- Catheter associated bacteraemia

% of patients receiving 'harm free care' as per Safety Thermometer
Days between harm as per Safety Thermometer
Days between HCAI
Improved performance in risk assessment:

- Waterlow
- MUST
- VTE
- Dementia

Never events*
Avoidable infections*

- C diff
- MRSA
- MSSA
- E.coli

Ensuring our care services are effective

Number of clinical audits completed
Number of process audits completed
Protocol compliance
Cardiac arrest rates
Emergency transfers to acute hospital
Use of Step Up Beds
Review of re-admissions
'Door to needle' audit
Mews audit
In patient mortality*
Weekend in patient mortality*
Sepsis (primary or secondary diagnosis code)*
End of life care*
Cancer pathway* (*NB no detail provided*)

Ensuring our care services are caring

% of complaints responded to in the agreed timeline
Complaints submitted to providers*

Complaints investigated by the Ombudsman*
Ministerial correspondence unit: complaints and whistleblowing*
Improved Friends and Family response rate and performance
8 existing CQC inpatient survey questions*:

- How was your overall experience
- How likely are you to recommend our ward to friends and family (FFT)
- Did you have confidence in the nurses and doctors treating you
- Were you involved as much as you wanted to be in your treatment and care
- Did you find someone in the hospital staff to talk to about your worries and fears
- Did you get enough help from staff to eat your meals
- Do you think the hospital staff did everything they could do to help control your pain
- Overall, did you feel you were treated with respect and dignity while you were in the hospital

Ensuring our care services are responsive to people's needs

Access measures*:

- 18 week admitted pathway
- 18 week non admitted pathway
- Diagnostic waiting times (6 weeks)
- 62 day from GP referral
- 62 day cancer screening referral
- 31 day from diagnosis
- Number of patients not treated within 28 days of last minute cancellation due to non clinical reason

Discharge and integration*:

- Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds

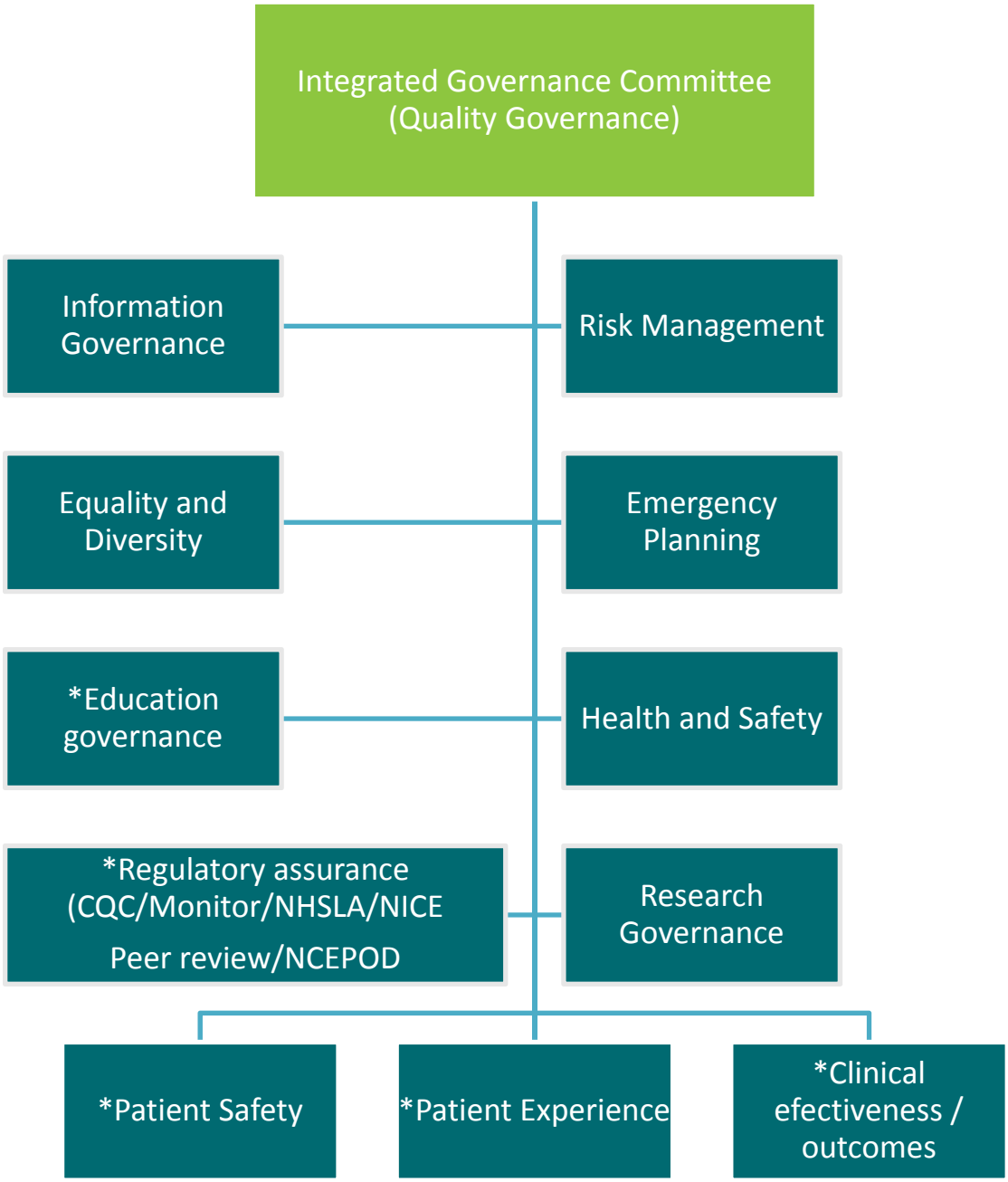
Ensuring our care services are well led

Staff surveys*

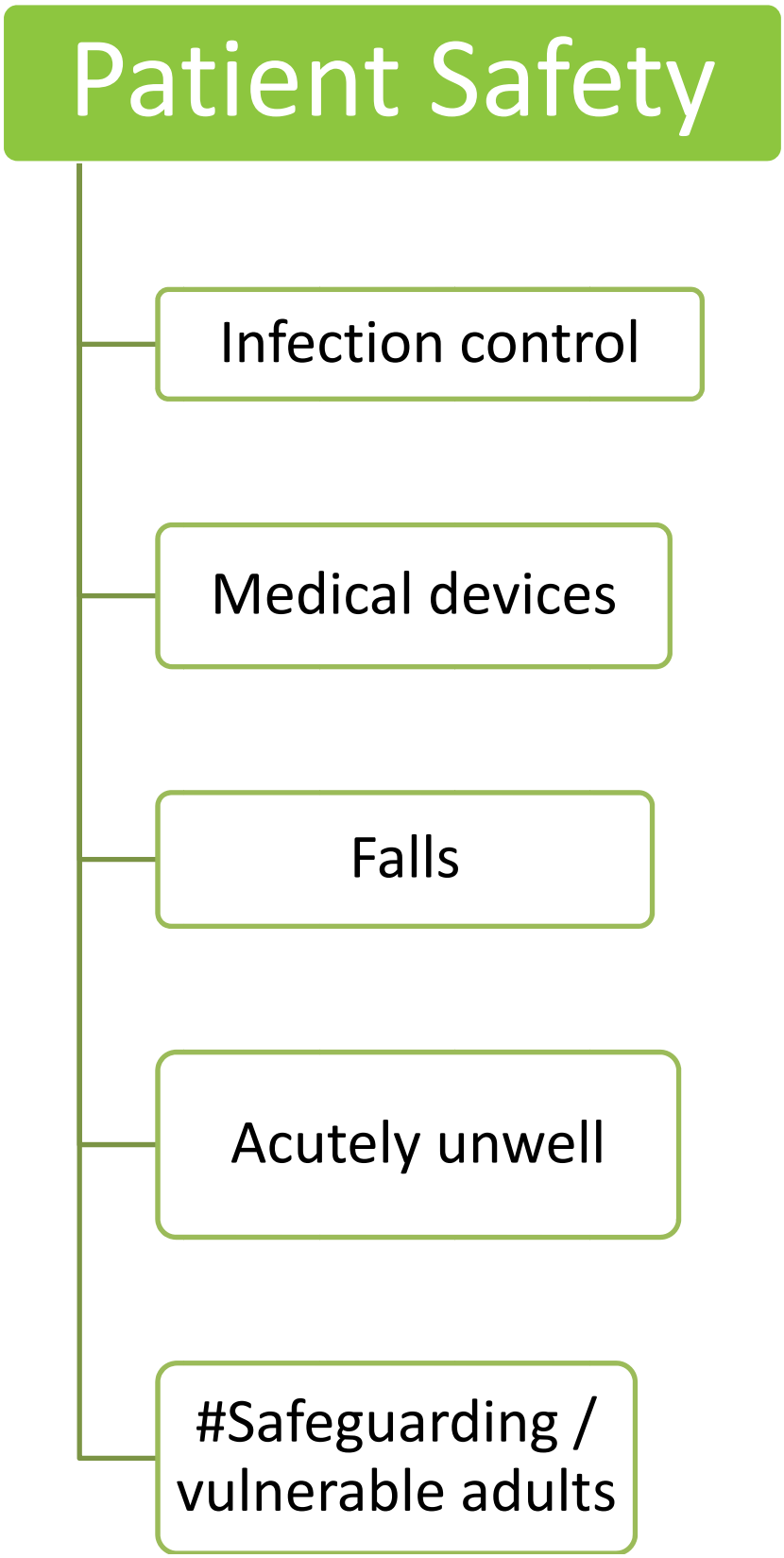
- NHS staff survey: care of patients is top priority
- Junior doctor survey: overall satisfaction score
- Survey of trainee nurses (TBD)

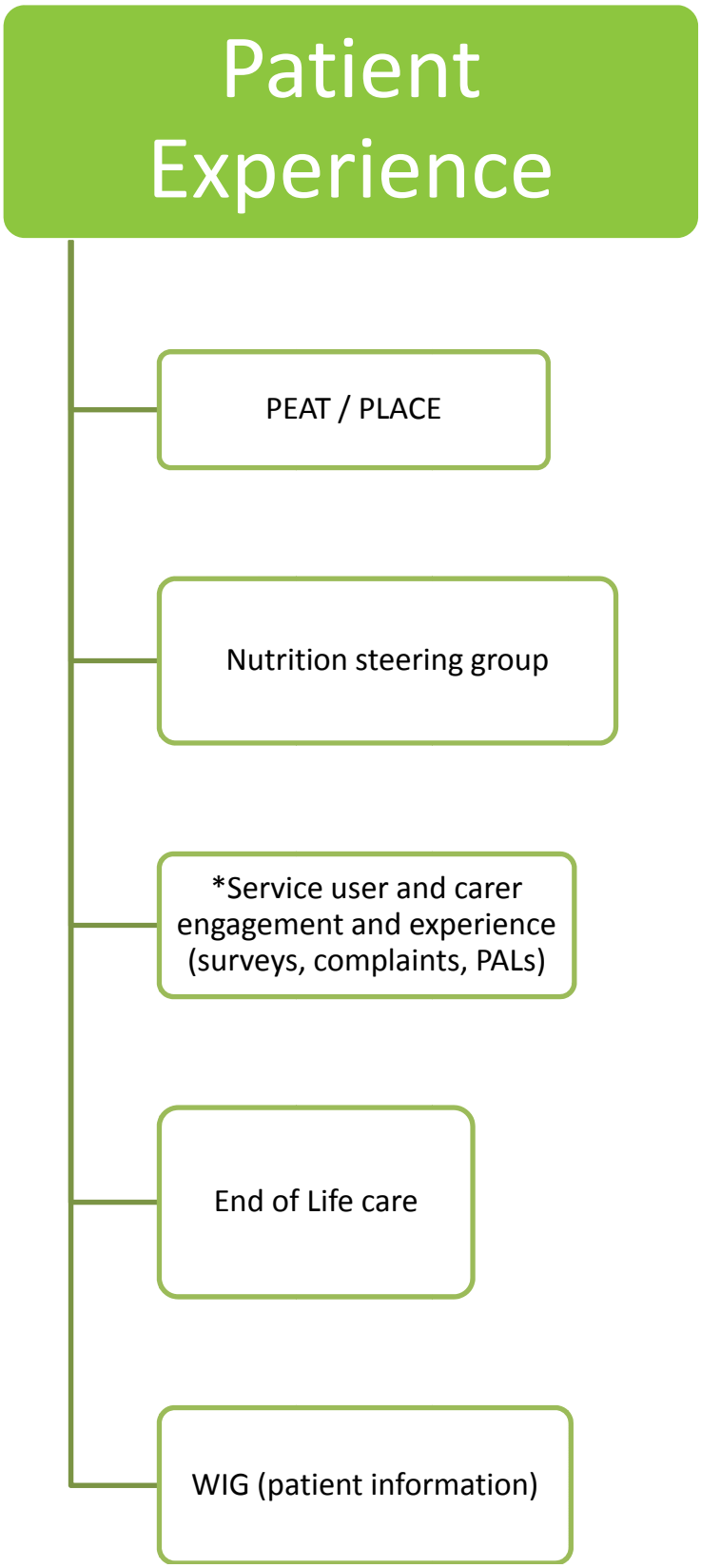
Staff sickness rates*
Bed occupancy*
Monitor governance risk rating*
Monitor finance risk rating*

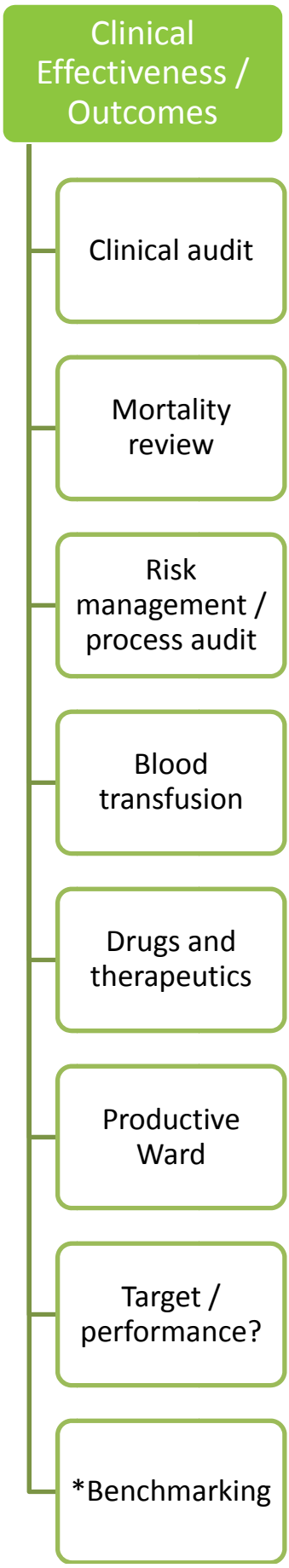
Appendix 1: Revised Quality Reporting Structure



*: new committee


Patient Safety
Infection control
Medical devices
Falls
Acutely unwell
#Safeguarding / vulnerable adults


Patient Experience
PEAT / PLACE
Nutrition steering group
*Service user and carer engagement and experience (surveys, complaints, PALs)
End of Life care
WIG (patient information)


Clinical Effectiveness / Outcomes
Clinical audit
Mortality review
Risk management / process audit
Blood transfusion
Drugs and therapeutics
Productive Ward
Target / performance?
*Benchmarking

Committee	Reporting Mechanism to IGC	Meeting Frequency	Lead
Information governance	Annual IG toolkit return	Monthly	Kate Smith
Equality and diversity	Annual report	Six weekly	Pauline Hammond
Education Governance	TBC	TBC	Heather Bebbington
Regulatory assurance	Template report after each meeting	6 monthly and by exception	TBC
Risk Management	Bi monthly risk report. Annual report	Bi monthly	Vicky Davies
Emergency Planning	Annual Report	Bi monthly	Steve Povey
Health and Safety	Annual Report	Bi monthly	Steve Povey
Research Governance	Template report after each meeting	Quarterly	Jenny Almond
Patient Experience	Template report after each meeting	Quarterly	Patient Experience Manager
Patient Safety	Template report after each meeting	Quarterly	TBC
Clinical Effectiveness / Outcomes	Template report after each meeting	Quarterly	TBC

Committee	Reporting Mechanism to Patient Safety	Meeting Frequency	Lead
Infection Control	Template report after each meeting	Quarterly	Debbie Kretzer
Medical Devices	Template report after each meeting	Bi-monthly	Judi Ebbrell
Falls	Template report after each meeting	Quarterly	Vicky Davies
Acute oncology TSG	Template report after each meeting	Quarterly	Judi Ebbrell
Safeguarding / vulnerable adults	Annual report		Pauline Hammond

Committee	Reporting Mechanism to Patient Experience	Meeting Frequency	Lead
PEAT/PLACE	TBC	Monthly/Annually	Judi Ebbrell
Nutrition steering	Template report	Tri-monthly	Pauline

group	after each meeting		Hammond
End of Life Care		Quarterly	Pauline Hammond
WIG (patient information	Template report after each meeting	Monthly	Luke Scott

Committee	**Reporting Mechanism to Effectiveness / Outcomes**	**Meeting Frequency**	**Lead**
Clinical audit	Template report after each meeting	Monthly	Helen Wong
Mortality	Template report after each meeting	Monthly	Kate Smith
Risk management / process audit	Template report after each meeting	Monthly	Vicky Davies
Blood transfusion		Quarterly	Sarah Jones
Drugs and Therapeutics	Template report after each meeting	Six weekly	Helen Clark
Productive Ward	Template report after each meeting	Quarterly	Kate Smith
Benchmarking	TBC		
Performance Management Group	TBC	Weekly	

Quality committee report template

Report from XXX Committee following its meeting of x.x.xx:
Decisions / approvals made *e.g. policy approval, financial / resource approval*
Assurances provided to the Patient Experience / Safety / Effectiveness steering group
New / mitigated risks
Progress on objectives
Areas of non delivery
Audits / KPIs

Recommendations

Quality Governance Assurance Reporting Framework

Trust Board	• Board assurance framework High level risks • Integrated perfocence report Quality report • Infection control report
Integrated Governance Committee	• Patient safety Patient experience • Compliance (CQC, NICE, NCEPOD, Peer Review, BSI) • Finance Approvals • Workforce Annual reports
Information Governance	• IG toolkit compliance IG toolkit action plan • IG incidents Approvals
Risk Management	• Risk register Risk policies and audits • Risk report (incidents, alerts, complaints, claims, inquests, external reports • External visit tracker Incident reviews
Equality and Diversity	• Delivery gainst the Equality Action Plan • Compliance (The Equality Act 2010)
Emergency Planning	• Emergency plans Exercises • Training Incidents
Health and Safety	• Policies Fire safety • COSHH Infection control • Raditation safety Risk report • Manual handling Secutiry • Environment / estates KPIs Health promotion
Research Governance	• Research governance workplan • Audit and monitoring • Approvals
Patient Safety	• Reports from safety committees • Progress on Safety Strategy • Reports from committees
Patient Experience	• Reports from experience committees • Progress on Experience Strategy • Reports from committees
Clinical effectiveness / outcomes	• Reports from outcome / effectiveness committees • Progress on Outcome / effectiveness Strategy • Reports from committees

Appendix 2: Sources of Internal and External Assurance

1: To ensure our care services are safe
2: To ensure our care services are effective
3: To ensure our care services are caring
4: To ensure our care services are responsive to people's needs
5: To ensure our care services are well led

Source of assurance	Type	In QRP	Objectives
Cancer waiting times	E	Y	2
Clinical audit	I	N	2
CQC Outcomes	I	N	1,2,3,4,5
CQC inspections	E	Y	1,2,3,4,5
CQUINS	E	N	1,2,3,4
Estates Return Information Collection (ERIC)	E	Y	1,2,5
External audit	E	N	variable
Inspections and visits	E	N	variable
Fire safety annual statement (DH)	E	Y	1
HPA C diff and MRSA surveillance	E	Y	1
Internal audit	E	N	variable
IG toolkit	E	Y	2
Information Centre for health & Social care secondary uses service (SUS) data quality dashboard	E	Y	
MHRA inspections (pharmacy)	E	N	1,2
Monitor annual plan and review	E	N	5
Monitor Quarterly Returns	E	N	5
National audits (e.g. LUCADA)	E	N	2
NCEPOD reviews	E	N	1,2
NHSLA	E	Y	1,2
NPSA Central Alerting System	E	Y	1
NRLS reports	E	Y	1
NHS Institute for Innovation and Improvement: Better care, Better Value indicators	E	Y	
Patient surveys (CQC / NCAT)	E	Y	3,4
Patient surveys (internal)	I	N	3,4

PBR coding audits	E	Y	2
PEAT (internal)	I	N	1,4,5
Peer review (cancer)	E	?	2
PLACE	E	?	1,4,5
Process audits			2
Quality Accounts	E	N	1,2,3,4,5
Quality and risk profile	E	Y	1,2,3,4,5
Quality NW (pharmacy)	E	N	1,2
Radiotherapy dashboard	E	N	
Staff surveys (CQC)	E	Y	5
Staff surveys (internal)	I	N	5
Trust internal inspection programme	I	N	1,2,3,4,5
VTE risk assessment	E	Y	

Appendix 3 Quality and Risk Management Standards

Standard ⇨ Criterion ⇩	1 Safe	2 Effective	3 Caring	4 Responsive to people's needs	5 Well led
1	Identifying and managing risks to quality of care (QIPP)	VTE	Sickness absence	Concerns and complaints	Risk Management Strategy (including high level risk committees)
2	Maintenance of Medical Devices	Medicines Management	Staff and patient Surveys (including FFT)	Being Open / Duty of Candour	Claims management
3	Transfusion	Sepsis	Violence and aggression	Screening procedures	Root cause Analysis
4	Secure environment	Deteriorating Patient	Stress	Diagnosis (source documentation)	Dealing with external recommendations
5	Slips, trips and falls	PDR	Supporting staff (incidents, claims, inquests, complaints) ? whistle blowing	Investigations	Professional registration (clinical and non clinical)
6	Moving and handling	Clinical audit	Harassment and bullying	Incident reporting	Risk Register and risk management processes
7	Inoculation risk	NICE (including quality standards)	Intentional rounding	Consent	Procedural documentation
8	Medical devices training	NCEPOD	Dementia / additional needs	Patient ID checks	Training needs analysis
9	Discharge	Health records management	Communication skills training	Patient information	Mandatory training
10	Clinical handover of care	Health record keeping standards	Nutrition	Learning lessons	Induction