The Shrewsbury and Telford Hospital NHS
NHS Trust

Report to:	Trust Board 31st January 2013

Title	External reviews and recommendations
Sponsoring Executive Director	Director of Quality and Safety/ Chief Nurse
Author(s)	Director of Quality and Safety/ Chief Nurse
Purpose	To update the Board on the impact of new and emerging recommendations from national reviews/ reports
Previously considered by	The Trust Board in May 2011 and September 2011.

Executive Summary

In 2011 the Board considered the key themes and actions arising from a series of national reports and recommendations.

The last Board report in September 2011 provided the key themes for the Boards attention and an outline of the Executive Directors who would progress these recommendations. Since that time there have been some key changes in Chief Executive and Executive Director roles and the previous Board paper has been updated and refreshed for these new Executive posts and the paper also includes consideration of additional reviews published since the Autumn of 2011.

New review reports considered include:-

- The Winterbourne view report

The key governance themes from this report have been included in this Board update and Quality and Safety Committee will monitor the required actions which the Trust needs to make to ensure that vulnerable people, particularly those with learning disability and autism, receive safe, appropriate, high quality care.

Quality and Safety Committee have programmed a review of the overall actions identified in this report (six monthly) and will receive a full briefing on any new national report (including the Francis Report due in early Spring 2013) and the Board will receive an overview of any new national reports.

Related SATH Objectives	SATH Sub-Objectives
We will always provide the right care for our patients	QS1. Ensure that we learn from mistakes and embrace what works well QS2. Design care around patient needs QS3. Provide the right care, right time, right place, right professional QS4. Deliver services that offer safe, evidence-based practice to improve outcomes QS5. Meet regulatory requirements and healthcare standards QS6. Ensure our patients suffer no avoidable harm

Risk and Assurance Issues (including resilience risks)	Provide key themes of concern from national reports for Board consideration.
Equality and Diversity Issues	National reports do pick up issues of inequality and recommendations to address those.
Legal and Regulatory Issues	Supports the Equality and Health Act requirements and regulatory requirements established by CQC.

Action required by the Trust Board
The Trust Board are asked to **note** the additional national report reviewed as part of the Trust Boards ongoing process of considering the impact of national recommendations and to also **note** the progress made since the last report to the Board in September 2011.

National Inquiries & External Reports
31st January 2013

1.0 Introduction

The Board received a briefing paper and a copy of the West Midlands Strategic Health Authority tracking tool on National reports and recommendations in January 2011 and two update paper in May and September 2011. The original document provided a national and regional reference point to ensure recommendations have been reviewed, considered and actions put in place across the organisation, where applicable.

2.0 Background of consideration

2.1 The Quality and Safety Committee have previously considered the full range of recommendations and removed those that were applicable to the Strategic Health Authority and Primary care Trust.

2.2 With an extensive list of recommendations, the Committee then themed the recommendations into 11 key work areas.

2.3 The Committee has reviewed these themes and analysed the work currently being undertaken within the Trust to assess how these recommendations can be embedded into Governance and operational systems whilst still being tracked at Board level.

3.0 Current position and implementing and monitoring progress

The most recent national review report was published in Dec 2012; “The Winterbourne View Report”. The Executive team and the Quality and Safety Committee have received a full briefing report on the Winterbourne report from the Chief Nurse. In essence for the Board, the report sets out a clear programme of national and local actions to ensure that we provide better care for, and reduce the health inequalities suffered by, people who have a learning disability or autism and whose behaviour is regarded as challenging. A new NHS and local government –led improvement programme is being established to support the transformation that will be necessary to achieve the required improvements.

3.1 This paper provides the Board with a current position against the full range of national reviews/recommendations with table 1 providing a current high level overview of progress. Appendix 1 provides the original high level summary, with appendix 2 providing the full source of recommendations from the original review in 2011 and updated to include the Winterbourne view recommendations. It is recommended that the original actions identified in 2011 continue, to ensure that the national recommendations are all followed through and established in our Governance processes**.**

3.2 The Lead Directors have reviewed each of these recommendations and provided an update on where these have been placed into main stream work and where particular work is required.

3.2.1 The overview position/ balanced score card presented in this paper provides the ongoing accountability arrangements for tracking the work through, with an Executive lead and Trust Committee through which the recommendations will be formally considered and tracked.

3.2.2 The Quality and Safety Committee will retain the delegated Board overview on the full range of recommendations through a bi annual review.

3.2.3 It is proposed that annually the Quality and Safety Chair and Audit Committee Chair formally review the progress against recommendations made for Trust wide Governance arrangements

3.2.4 The Board will receive an annual update which will be reflected through the Quality Account and contribute to the Statement of Internal Control.

Enclosure 07

Table 1; National reports and recommendations

Area 1	Area 2	Area 3	Area 4
Detecting a deteriorating Patient & Mortality Medical Director Trust wide Mortality Committee and Clinical Governance Committee Trusts Safety Plan	Patient Safety Recommendations Chief Nurse Clinical Governance Committee (CGC) & Quality and Safety Committee Trusts Safety Plan	High Impact recommendations Chief Nurse CGC & Nursing and Midwifery Forum Quality Improvement Strategy/ Quality Account	Infection Control Recommendations Chief Nurse Infection Prevention and Control Committee & Q&S Infection Control Annual Plan
Area 5	**Area 6**	**Area 7**	**Area 8**
Medications Recommendations Medical Director Trusts Drugs and Therapeutics Committee Clinical Governance Committee (CGC)	Quality review process recommendations Medical Director and Chief Nurse Monthly Quality review (Internal and PCT) Clinical Governance Committee and Quality and Safety Committee	Managing Emergency Flow Patients Chief Operating Officer Hospital Executive Committee Value Stream work on Unscheduled Care	Management of Medical Patient Flow Chief Operating Officer Hospital Executive Committee Value Stream on Unscheduled Care
Area 9	**Area 10**	**Area 11**	
Staffing recommendations Chief Operating Officer/ Workforce Director Hospital Executive Committee/ Clinical Governance Committee/Workforce Committee Staffing reviews / HR Policy Framework	Patient Experience Chief Nurse Patient Experience and involvement Panel and Quality and Safety Committee Quality Improvement Strategy	Trust wide Governance arrangements Chief Executive Trust Board / Audit Committee Board Assurance report	

4.0 Current appraisal of Trust progress in each domain area

Area 1 - Detecting a Deteriorating Patient and Mortality- Executive lead- Medical Director

A range of national reports have highlighted recommendations on the management of deteriorating patients, with timely audit and review processes for mortality and morbidity reviews.

The Trust is actively participating in the Regional Mortality work streams and has introduced in the last year the Pneumonia bundle and the Sepsis Bundle (originally introduced in 2011) to support more effective management for all patients.
The LIPS programmes have provided some baseline work on the Global Trigger Tool, which has supported an understanding of potential harms in care pathways, further work is required through an ongoing process and the Trust Mortality Committee which is commencing in early 2013 will progress this work. To date the Medicine Centre has reviewed all mortality cases. The Trust's original aim of a 20% reduction in crude Mortality rates is on course to be achieved in April 2013. Significant work has been undertaken in the last year to improve the senior medical cover at weekends and out of hours and specific streams of work looking at the urgent care pathway as well as the elderly frail pathway across the local health economy. However, the work on detecting and managing a deteriorating patient, the use of the early warning score, response to treatment will continue to be one of the Trust's priorities in 2013 to ensure

VTE assessment performance has improved to achieve the target of 90%; however the systems and processes to achieve 95% in 2013/14 will require significant work.

A Clinical Governance Committee has been formed as part of the Trust's Governance structure to ensure that on an ongoing basis all Clinical leaders are provided with briefing papers on care issues from NCEPOD or Royal College reports/ reviews. Specific actions and areas for audit to facilitate progress in any required areas will be monitored and regular reports on progress provided through Clinical audit Committee to the Quality and Safety Committee for assurance.

The review of Incidents and root cause analysis is key to the ongoing learning for staff providing care for patients. The action plans for improvements arising from Serious Incidents and complaints will be monitored through Governance processes.
Case note reviews using the GTT will be followed up through the mortality groups being established in the Clinical Structures.

One significant stream of work required is to embrace the care of patients with a learning disability or with patients with a reduced mental capacity. This work has been prioritised as a key objective in the last couple of years with the Board being able to sign off the 6 key criteria for Learning Disability in the summer of 2012, the patient passport introduced across the local health economy and significant progress being made during 2012/ 13 on the Dementia Strategy.

Further work is now required with the Winterbourne View report providing clarity on joint work with Commissioners and local authorities to support the care of people with a learning Disability and autism. The Patient experience and Involvement panel (PEIP) are recruiting patient representatives who represent these vulnerable groups who are providing the challenge and support to ensure we can meet the needs of these patient groups and they will be supporting the patient information developments required to support vulnerable patients and their carers/ families.

Area 2 - Patient Safety Recommendations- Executive Director lead- Director of Quality and Safety / Chief Nurse

Significant work was undertaken with refining the safer surgery checklists in line with best practice and a significant audit process undertaken to ensure full compliance. Recent work has identified refinements in the pre-briefing element of emergency surgery and this will be progressed in early 2013. Significant audit tools have been developed following the Ophthalmology Never events in 2011/12 and a Royal College report which identifies the exemplars of best practice that these have

generated. The audit results in Ophthalmology continue to provide assurance that the required practice has been embedded.

Reconfiguration of services continue to be implemented in line with the full business case to support safe sustainable services

A Quality Improvement Strategy was approved by the Trust Board in March 2012 and each Clinical Centre has developed their own Quality Development plan to underpin the implementation of Trust wide safety objectives as well as sub specialty safety objectives

The Trust has prioritised Vulnerable Adults and the work required to create an enhanced knowledge of reduced Mental Capacity and DOLS processes. Increased training programmes have been put in place and the Dementia Steering Group reformed to progress the Dementia Care Bundle to ensure the fundamentals of care are in place.

A Patient Safety Plan was agreed through the LIPS programme in 2011 with specified streams of work identified. The LIPS programme and embedding the safety plan into main stream work and governance processes needs to be developed in 2013/14.

Work to provide enhanced monitoring of actions arising from RCA's and policy and standard development is key to ongoing improvements to demonstrate effective incident management and benchmarking.

Area 3 - High Impact Actions- Executive lead- Director of Quality and Safety/ Chief Nurse

The recommendations across this section relate to the National High Impact Actions. These areas are being progressed through the LIPS programme and also through the Trust wide groups. Many of the High Impact Actions have been transferred into key ambitions for improvement at regional and national level. Examples of this would be the four safety areas included into the Safety Thermometer (pressure ulcer eradication, reduction in falls, reduction in VTE and reduction in Catheter acquired Infections).
The Clinical centres now have their governance meetings where the safety issues are discussed and a collective review through Nursing and Midwifery Forum to ensure robust actions agreed where continuous improvement required. The key issues and outcomes from the full range of High Impact actions will need to be programmed into the new Clinical Governance Committee.

Area 4 - Infection Control Recommendations- Executive Lead- Director of Quality and Safety/ Chief Nurse

The focus against the range of recommendation in this section of the report are fully integrated into the annual programme of activity and are being monitored closely through the Trust's Infection Prevention & Control Committee, providing assurance at Quality and Safety Committee and the Board.

Area 5 - Drugs and Therapeutics Committee- Executive lead- Medical Director

The governance arrangements for safe and effective management of medicines are in place with the Accountable officer for CD's being the Centre Chief for Pharmacy, who also leads the Trusts medication CQUIN. The Drugs and Therapeutics Committee is also supported by a safe medicines group and the Medical Director and Chief Nurse meet with the Centre Chief for Pharmacy on a monthly basis to review audit results and key safety incidents. Further work around training and awareness support to improve effective medication management will be ongoing.
The medicines alert process and NICE guidance are regularly reviewed and minuted actions required through the above governance arrangements.
Systems for controlled drugs are well established and monitored by the Accountable officer as well as being reviewed in the Local Involvement Network. Progress will be required to ensure a safe and effective 7 day service.

Area 6 - Quality Review Processes- Executive leads- Chief Nurse &Medical Director

The Trust has been developing systems and processes with Commissioners and staff within the Trust to provide assurance on the care standards provided for all patients.
A Quality Improvement Strategy was approved by the Trust Board in March 2012 and all Clinical Centres have a supporting Quality development plan to implement objectives at a local level. These plans are now being incorporated into the annual business planning cycle and the Strategy will be updated on an annual basis as well as evaluating the effectiveness of the Strategy through the Quality account.
An Integrated performance report has been refined at the Board which uses a series of metrics to demonstrate outcomes against Key performance indicators (KPIs) across the range of Quality and Safety.
Detailed ward to Board metrics and patient experience metrics support the high level KPI's and provide the ability to drill into detail when required.
The Quality and Safety Committee undertake a detailed review of assurances determined through a range of reports through their annual programme and undertake clinical ward/ Dept reviews prior to the Committee business to be able to test staff and patient feedback to support written information.
A "Patient Safety walkabout" programme in place in line with NPSA guidance.
A Clinical Governance Committee is being formed in January 2013 will support the detailed work required on the full range of standards and enable the Quality & Safety committee to review assurances at a higher level.
The Patient experience and Involvement panel (PEIP) are involved with Quality reviews of clinical areas as well as Commissioners and Educational representatives.

Area 7 - Managing Emergency Flows of Patients- Executive Lead- Chief Operating Officer

The range of objectives / recommendations made by the Mid Staffs review had been picked up through the Hospital Executive Committee previously. The process of clinical engagement and desire for clinical leadership has resulted in a revised structure with the Clinical Centre model, with a clear focus on an Emergency Care Centre and Value Stream Leads for unscheduled and scheduled care. This is being evaluated currently to seek the most effective way to progress emergency flow of patients.
Unscheduled care is being prioritised within the Trust and a detailed action plan in place to effect the changes required & to ensure the pace of change for patient flow is realised to enable adequate capacity and clinical efficiencies to be created.
An Ambulatory Care Unit, along with improved senior consultant cover for out of hrs and weekend cover have been introduced in 2011/ 12 and have resulted in significantly different working arrangements to ensure that emergency patients receive a senior decision making review. This is consistently being reviewed with acknowledged significant improvements still required to support timely management of emergency cases where they can be supported back home in a timely manner.
Work programme to improve the care and support to frail/ complex patients including vulnerable adult patients is in place with proactive support through the introduction of RAID, Dementia bundle, Dementia Strategy and Learning Disability patient passport.

Area 8 - Management of Medical Patient Flows- Executive Lead- Chief Operating Officer

Significant work has been undertaken across the health economy to support improvements in care for older/ frail and complex patients. This includes the urgent care network and the variety of patient flow workstreams. The Clinical Governance Committee formed in January 2013 will provide a clear framework to review national reports and standards which will need to be reflected in local policies, training and practice. Previously the recommendations made through two national reports (2010, 2011 and 2012) on the care of the older patient have been considered with the PCT, Quality and Safety Committee and the Hospital Executive Committee.
Streams of work to assess stroke services with Commissioners have been undertaken along with other medical pathways.
Progress on care of patients with dementia is being progressed through the Local Health Economy Steering Group with external agencies involved in this work. Joint work with the mental health Trust to introduce RAID and the training to support this and the Dementia care bundle have been progressed in 2012.

Emergency medical and surgical pathways are being refined and reviewed to continually improve the effectiveness of care provision but also to improve the capacity to deal with the unscheduled patient flow. A detailed action plan is in place and under consistent review. Patient experience “real time patient feedback” and net promoter being rolled out to include A&E in addition to AMU to support ongoing improvements.

Area 9 - Staffing recommendations – Executive Lead -Chief Operating Officer with support from Workforce Director

Accountability arrangements and recruitment processes were put in place during 2011 to move to the Clinical centre structure and to enhance Clinical leadership. A transitional leadership team (TLT) was formed to support Clinical leaders with the ability to raise and discuss clinical or Governance issues with the CEO and Executive team. The Clinical Centre structure is currently being evaluated and subject to review to maximise effective governance processes.
Leadership programmes commissioned to support middle and senior clinicians and managers.
Staffing reviews have been undertaken and a Dependency and Acuity Process is in place with Ward to Board process agreed for the Board to be able to triangulate staffing against Quality and Safety criteria. Significant sickness levels are still being noted by the Board and an action plan to support a poor staff survey is in place
Arrangements for clinical supervision will need to be refined and confirmed through the new Clinical Centres and training baselines undertaken.
A training needs analysis and workforce requirements to meet the future needs of patients in the most effective way need further work and a Workforce (People) strategy is being developed
Staff engagement processes are in place in addition to “Listening into Action” which was implemented for a limited time in 2011/ 12. Staff engaged in Quality improvement themes through workshops held to develop a Trust Quality Improvement Strategy in 2011/12. The Clinical centres have developed Quality development plans on an annual basis to support quality improvements at a local level.

Area 10 - Patient Experience- Executive Lead- Director of Quality and Safety/ Chief Nurse

Progress has been made within the Trust to implement real time process of gaining patient’ reflections of their experience whilst an Inpatient / Outpatient and the introduction of the net promoter question has supported a variety of assurance for patient experience.
The Patient Experience and Involvement Panel (PEIP) formed in the summer of 2011 and has increased its membership to include representation of diverse and vulnerable patient groups. A training programme and concordat has provided a framework for proactively gathering real time patient feedback through patient stories and diaries and observations of care. This programme will need to include an increasing range of clinical areas so that by 2015 all patients are able to provide real time patient feedback.
Patient representatives have provided support for inspecting clinical area where the triangulated information has provided an early warning of concerns that care delivery may not always be of a consistent standards. They have undertaken reviews alongside Commissioners, University representation and senior nurses to provide a level of assurance through a Quality Improvement framework.
A high risk scrutiny meeting was established in late 2011 to triangulate complaints with serious incidents and clinical indicators. Significant improvements still required across all stages of the complaints process to ensure a proactive and supportive response to patients and their carers/ family are made.

Area 11 - Trust Wide Governance Arrangements – CEO Lead

The Board have reviewed the full range of recommendations made externally through four Board papers, with the work led by Executive Directors and follow up reports required on progress.
The Board have reviewed its governance arrangements, Corporate Risk Register and Assurance Framework and Internal Audit have reviewed those processes on a number of occasions in the last 3 years.

The Board also have a development programme in place to review progress on governance arrangements and late in 2010 and 2012 revised formal subcommittees to reflect appropriate scrutiny on all aspects of governance. A revised Risk Committee was formed in November 2012 to ensure robust link between Centre risk registered and the Board assurance Framework
Systems and processes to provide ward to Board measures to identify Board level assurance on the care provided in all clinical areas has been developed during 2011/ 2012 & 2012/13 and have provided an early indication of clinical areas which need improved support or leadership to improve care provision. The recent Winterbourne view report reinforces the importance of a Boards ability to understand the quality of care provided as well as well established Whistle blowing process for staff to raise concerns
The Quality Governance Framework was approved in March 2012 to provide a baseline for improved Governance processes with an update provided to Quality and Safety Committee in December 2012 and to the Board in January 2013.

Particular focus on systems and processes to enhance the review of requests for implementing new procedures/ equipment requests is in place and will be formally noted through the Clinical Governance Committee.

Significant work is still required to ensure adequate capacity to see our patients in a timely manner according to our constitutional obligations. A detailed plan is in place and tracked regularly. Identification and management processes to support and mitigate clinical risks are and will need to continue to be a clear priority where delays are still explicit. Examples of when a communication plan is in place to manage patient / family concerns should these arise can be provided. An explicit policy development / review programme for policies is in place and referenced through the appropriate Committees.

5.0 Conclusion and recommendations

5.1 The Board are asked to **Note** the current position and ongoing review by the Quality and Safety Committee

Director of Quality and Safety/ Chief Nurse
January 2013

Appendix 1

National reports and recommendations- original baseline

Area 1	Area 2	Area 3	Area 4
Detecting a deteriorating Patient & Mortality	Patient Safety Recommendations	High Impact recommendations	Infection Control Recommendations
Medical Director	Chief Nurse	Chief Nurse	Chief Nurse
Trust wide Mortality Committee	Clinical Governance Committee (CGC) & Quality and Safety	CGC & Nursing and Midwifery Forum	Infection Prevention and Control Committee & Q&S
Trusts Safety Plan	Trusts Safety Plan	Quality Improvement Strategy/ Quality Account	Infection Control Annual Plan
Area 5	**Area 6**	**Area 7**	**Area 8**
Medications Recommendations	Quality review process recommendations	Managing Emergency Flow Patients	Management of Medical Patient Flow
Medical Director	Medical Director and Chief Nurse	Chief Operating Officer	Chief Operating Officer
Trusts Drugs and Therapeutics Committee	Monthly Quality review (Internal and PCT)	Hospital Executive Committee	Hospital Executive Committee
Quality Improvement Strategy/CQUIN	Quality Improvement Strategy/ CQUIN	Value Stream work on Unscheduled Care	Value Stream on Unscheduled Care
Area 9	**Area 10**	**Area 11**	
Staffing recommendations	Patient Experience	Trust wide Governance arrangements	
Chief Operating Officer/ Workforce Director	Chief Nurse	Chief Executive	
Hospital Executive Committee/ Clinical Governance Committee	Patient Experience and involvement Panel	Trust Board / Audit Committee	
Staffing reviews / HR Policy Framework	Quality Improvement Strategy	Board Assurance report	

Appendix 2

Source of Recommendation	Detecting a deteriorating patient & Mortality Executive lead- Medical Director Hospital Executive Committee Reporting through Quality and Safety Committee
(1) Patient Safety First Priorities NPSA 2008 (June) (2) Ten for 2010 programme (Feb 2010) (3) Mid Staffs Review - Professor Alberti 2009 (April) (4) Colin Norris Inquiry 2010 (Jan 2010) (5) Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC) (6) Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010 (7)Winterbourne View (2012)	<u>Recommendations made:</u> • Limit mortality from in-hospital cardiac arrests through earlier recognition and treatment of deteriorating patients • Regular, timely audits should be put in place for all patients who die in hospital • Reduce harm associated with the deteriorating patient • Review the internal processes and practices for certification of death in line with best practice. Trust; • Review processes in place for mortality and Morbidity review; agree a consistent model for this, including reviewing all deaths and implement in all specialty areas and directorates • Trusts should standardize their procedures for morbidity and mortality meetings, including the presentation of information on trends in clinical outcome, record keeping and links with the clinical governance mechanism. Trusts should standardise its procedure on giving families an estimate of the difficulties and the risks of prospective surgery, and should standardise its procedure for explaining to families after a death, the options for a post mortem. The SHA should review the training of junior doctors to improve their knowledge and understanding of Certification of Death and equip them to understand the importance of managing risk and the associated processes as a key facet of clinical practice. All patients should receive a risk assessment of venous thromboembolism (VTE) upon admission to hospital (Template published 2008, and NICE guidance Jan 2010) Commissioners and local authority need to provide robust systems and processes to identify people with LD/Autism and ensure a locally agreed joint plan of care to ensure high quality care and support for all children, young people and adults with learning disability or autism to ensure patients stay in acute hospitals is minimised.
The Operating Framework for the NHS in England	<u>Recommendations made:</u> PCT's should continue to use the national set of 'Never Events' as part of their contract agreements with providers. Never Events should be reported to the

2010/15	National Patient Safety Agency (NPSA) and publically reported as part of the annual reporting on quality and safety.
HealthSelect Committee Report 2009(Oct)	<u>Recommendations made:</u> Patient harm rates must be measured by regular reviews of samples of patients' case notes.
Ten for 2010 programme Winterbourne View report 2012	<u>Recommendation made:</u> • Reduce the number of suicides in community health, mental health, prisons and acute care using a suicide prevention toolkit • Reduce harm for people with learning disabilities with a focused campaign to raise awareness • Enhance Whistle blowing systems and processes • Ensure robust training and awareness created for staff to be able to support meeting the needs of patients with LD/ autistic/ challenging behaviour. • Ensure leadership programmes in place to support staff competencies in leading the care standards for supporting patients with LD/ Autism and challenging behaviour
Source of Recommendation and Status	Ensuring best practice safety checks generally and also before Operations Executive lead: Director of Quality and Safety/ Chief Nurse Review through Hospital Executive Committee Reporting to Quality and Safety Committee
(1) Patient Safety First Priorities NPSA -2008 (2) Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust- 2010 (3) Ten for 2010 programme	<u>Recommendations made</u> • Reduce preoperative harm through elective surgical site infection prevention and usage of the WHO's "Safe Surgery Checklist • Trusts should ensure that all staff in the surgical team take part in a team brief and use the 2008 theatre checklist before surgery commended by WHO as good practice. • Reduce harm during the peri-operative process using the five steps of safer surgery - briefing, sign in, time out, sign out and debriefing.

Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	<u>Recommendations made</u> • Arrangements can be put in place that will create a critical mass of clinicians who, working as a single team and dealing with an adequate caseload, can maintain their expertise. • This might require some mix of both expanding the Trust's service and forging robust links with another centre.
Colin Norris Inquiry 2010 (Jan 2010) Winterbourne View report (2012)	<u>Recommendations made</u> Review and update as necessary the Trust policy on safeguarding vulnerable adults in light of the latest guidance following the "No "Secrets" consultation process. Safeguarding Committee' to review the full range of actions required from the Winterbourne view report particularly for the safeguarding systems and processes. PEIP to formally consider the report and ensure through the advocacy representation that the action plan has considered the full scope of the report before implementation. Develop and actively use evidence-based measures of the quality and safety of patient care, focusing on the Releasing Time to Care and patient safety programmes that are being implemented across the Trust.
(1) Colin Norris Inquiry 2010 (Jan 2010) (2) Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust (July 2010) (3) Winterbourne View report (2012)	<u>Recommendations made and Trust position:</u> Review the process for the timely inputting of incident data into Datix and the sharing of lessons learned from incidents Trusts should act to ensure that staff can indentify serious untoward incidents, for which there is then an explicit responsibility to devise and implement an action plan, including timely notification of relevant individuals, the Trust Board and external bodies when appropriate. Trusts should strengthen their approach to incident reporting, based on a just and open culture, to promote full reporting by responsible clinicians (including consultant medical staff), analysis and promulgation of lessons learned. Audit compliance with the Trust's Serious Untoward Incident (SUI) policy to ensure that following incidents there is effective communication with and support to patients, their relatives and staff. Review how the central risk team is formally co-ordinated with and supports the devolved directorate structures; use wealth of experience and knowledge more effectively. Ensure that comprehensive joint action plan is developed with Commissioners and local authority to identify all LD/ autistic people who are likely to need care by acute providers and ensure that patients are provided with the LHE pt passport to ensure that all needs are met during an inpatient or outpatient episode.

	Ensure comprehensive patient information developed to support appropriate information to support the patient group understanding of their care/ consent.
Source of Recommendation and Status	High Impact Actions- Personalised & safe care Executive lead: Director of Quality and Safety/ Chief Nurse Nursing and Midwifery Forum Reporting to Quality and Safety Committee
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC) Winterbourne View (2012)	<u>Recommendations made:</u> The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard. Assessing patients who are vulnerable with LD/autism/ challenging behaviour that a joint plan of care is in place and patients are supported with their patient passport and the acute providers can support patients and carers/ family with appropriate information to ensure a personalised plan of care. Identification of patients with LD/Autism to review outcomes of care for that client group
High Impact Actions for Nursing and Midwifery Nov 2009 Ten for 2010 programme	<u>Recommendations made:</u> Your skin matters - No avoidable pressure sores in NHS provided care. Reduce patient deaths and harm associated with pressure ulcers. Reduce patient deaths and harm associated with pressure ulcers
High Impact Actions for Nursing and Midwifery Nov 2009	<u>Recommendations made:</u> Preventing falls -demonstrate year on year reduction in the number of falls sustained by older people in the NHS provided care. Reduce patient deaths and harm associated with falls.
High Impact Actions for Nursing and Midwifery Nov 2009	<u>Recommendations made:</u> Keeping nourished - Stop inappropriate weight loss and deterioration in NHS provided care
High Impact Actions for Nursing and Midwifery Nov 2009	End of life choice - Avoid inappropriate admission to hospital and increase the numbers of people who are able to die in the place of their choice.

Source of Recommendation and Status	Infection Control Recommendations Executive lead: Director of Quality and Safety/Chief Nurse STICC Reporting to Quality and Safety
Patient Safety First Priorities NPSA 2008 (June) High Impact Actions for Nursing and Midwifery Nov 2009 Ten for 2010 programme (Feb 2010) The Operating Framework for the NHS in England 2010/11 Health Select Committee Report 2009(Oct)	<u>Recommendations made:</u> • Improve critical care through more reliable application of central line and ventilator care bundles • Protection from infection - Demonstrate a dramatic reduction in the rate of Urinary Tract Infections for patients in NHS provided care • Vital Signs - Meeting National Cleaning Standards • Reduce bacteraemia associated with central lines • Quick implementation of proven technologies which can improve safety
Source of Recommendation and Status	Medications Recommendations Executive lead: Medical Director Drugs and Therapeutics Committee Reporting to Quality and Safety Committee
Patient Safety First Priorities NPSA 2008 (June) Ten for 2010 programme Feb 2010	Reduce harm from high-risk medicines (e.g. anticoagulants, injectable sedatives, opiates and insulin). The Trust should consider whether doctors should be required to review prescription charts and clinical records when examining patients and to review the content of the doctors and nurses induction courses to ensure scope of professional practice is covered. Complete review of pain management guidelines, including the assessment and management of “irregular pain” Review specific pharmacy procedures: “Scheduled visits by pharmacists to wards” and “Policy on clinical pharmacy practice”, ensure the role of the ward based visiting pharmacist is reviewed in

The Airedale Inquiry Colin Norris Inquiry 2010	this to include monitoring compliance with the Trust's Medicines Code as a key component of the visit. Review Terms of Reference and membership for the Trust Drugs & Therapeutics Risk Management sub-committee; clarify reporting arrangements within the Trust's clinical governance and committee structure. Review clinical pharmacy support to the wards and ensure that provision is sufficient to meet ward needs – Review and place a higher priority on the implementation of technological solutions in medicines management to improve the audit trail of drug use and reduce patient risk of harm from medicines.
Colin Norris Inquiry 2010	Undertake an audit of the omission of prescribed drugs in conjunction with the introduction of the new drug treatment chart: address specifically the reasons why the drug has been omitted, what actions were taken to obtain the drug and who authorised the non administration. Review the current controlled drugs checking procedures and ensure audits are up to date, including the specific aspects covered in the 3 monthly checking procedures (to broaden to include receipt signature monitoring). The content of the CD Accountable Officer report presented to the Trust Drugs & Therapeutics Risk Management Sub-Committee to be reviewed, and consideration given to a process which can highlight actions agreed in those areas where audits are not undertaken or where audit identifies concern; including this on Trust risk register. CD audits should include an audit of compliance of the receipt section of the CD order book bearing a signature to verify receipt has occurred and by whom.
Source of Recommendation and Status	Quality review processes Joint Executive lead: Medical Director and Chief Nurse PCT Quality review meeting and internally Quality and Safety Committee
Mid Staffs Review - Dr David Colin Thomé 2009 (April) Mid Staffs Review - Professor Alberti 2009 (April) Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC) The Operating Framework	<u>Recommendations made:</u> All hospital providers including foundation trusts must allow PCT's ready access to review their services. In the medium term the needs of the local population should be clearly enumerated by the PCT and the Acute Trust and these should be reflected in the 5-year strategy for the Foundation Trust. The focus should be on what can be done safely and well by the Trust and what should be left for other Trusts to do. The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust. Vital Signs - Improving Health and Reducing Health Related Inequalities

for the NHS in England 2010/12 Dec 2009	

Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (Robert Francis QC)	The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to delivery up-to-date and high-class standards of service provision and professional leadership.
Source of Recommendation and Status	Managing Emergency flows of patients Executive lead: Chief Operating Officer Hospital Executive Committee Reporting to Finance and Performance Committee
Mid Staffs Review - Professor Alberti 2009 (April)	• An emergency care directorate should be established in the Trust encompassing all acute specialties with responsibility for the rapid, effective delivery of care from the patient's admission throughout the whole of the patient's care pathway to discharge. • The number of emergency physicians should be reviewed to ensure sufficient cover is achieved • Protocols for common conditions should be introduced in A&E. • Equipment deficiencies in the Emergency Admissions Unit and on the medical wards should be reviewed and appropriate purchases made. • The Trust should allow direct admission of suitable patients to the Emergency Admissions Unit, once patient flows have been improved. • Lengths of stay on the Emergency Admissions Unit should be limited to 48 hours. The institution of a short-stay ward should be considered.
Source of Recommendation and Status	Management of Medical Patient Flows Executive lead: Chief Operating Officer Hospital Executive Committee Reporting to Finance and Performance
Mid Staffs Review - Professor Alberti 2009(April) Independent Inquiry into Care Provided by Mid Staffordshire NHS	A new model of care for medical patients who are admitted should be implemented which provides for much earlier consultant contact. The Trust should not pursue the development of a hyper-acute stroke service. Care of the elderly services should be enhanced and a care of the elderly network established across primary, secondary and community care. All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.

Foundation Trust January 2005 - March 2009 (Robert Francis QC Mid Staffs Review - Professor Alberti 2009(April) Mid Staffs Review - Professor Alberti 2009(April) High Impact Actions for Nursing and Midwifery Nov 2009	Plans should be put in place forthwith to improve bed management with a bed management team and early review of all patients in the hospital on a daily (7 days) basis. The intermediate care capacity in the community should be reviewed with the PCT and increased if necessary. Managed Discharge - Increase the number of patients in NHS provided care who have their discharges managed and led by a nurse or midwife where appropriate.
Source of Recommendation and Status	Staffing Recommendations Executive lead: Chief Operating Officer Hospital Executive Committee Reporting to Workforce Committee & Finance Committee
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that all new members of staff receive appropriate induction on joining the Trust. The nature of the induction will depend on the nature of the post, but for consultant staff must include relevant clinical governance and multidisciplinary team working systems. The Trust should ensure that all newly appointed consultant staff have access to an appropriate mentoring arrangement. The nature of this will vary according to the nature of clinical practice, but for technically demanding specialties such as paediatric cardiac surgery must include arrangements that facilitate joint operating. The Trust should ensure that the effect of appointing a new consultant on clinical practice is identified before arrival, together with any consequences for equipment provision and potential impact on other members of the multidisciplinary team. Expectations of how the new consultant will work with other consultant members of the team must be explicit and agreed from the outset.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010 Mid Staffs Review - Professor Alberti	Trusts should implement clinical governance systems that set out explicit responsibilities service by service with a single line of accountability to the Trust Board. The Trust Board should ensure that Human Resource policies and procedures are followed including staff appraisal, development planning and HR department resources to deliver the organisational development programme. Ensure that the developments of the Scope of Professional Practice includes clear lines of accountability, training and development plans are fit for purpose, evaluation of the role and that there is effective dialogue with patients, carers and the public.

2009(April) Colin Norris Inquiry 2010 Jan 2010 The Airedale Inquiry June 2010 Review of the early warning systems in the NHS Winterbourne View report (2012)	Minimum staffing levels policy must be considered to ensure skill mix is achieved which meets patient dependency. The complement of nurses in the Trust who provide care to patients in the emergency care pathway should be adequate according to need and the training of nurses and other ward workers enhanced. Review the effectiveness of the current model for the supervision of nursing and other clinical staff. Raise awareness as part of patient safety training amongst staff of the potential for malicious action against patients by healthcare professionals Professional bodies must encourage openness and transparency amongst all healthcare professionals, including supporting them in raising concerns early. The guidance should alert organisations to the need to give effective support to those who are giving witness statements. The trust should ensure that its nurses work to a published set of principles, focusing on safe patient care. Steps to improve workforce skills and strengthening safeguarding arrangements
Colin Norris Inquiry 2010 High Impact Actions for Nursing and Midwifery Nov 2009	Introduce a policy statement and standards for multidisciplinary working throughout the Trust and audit practice against these. Fit and well in care - Reduce sickness absence in the nursing and midwifery workforce to no more than 3% Establish a process for auditing personal files in order to ensure that ; (a) Trust recruitment processes are complied with; (b) performance of staff is assessed effectively through appraisal; (c) individual and collective training needs are identified from the appraisal process. Develop a co-ordinated education and training programme for staff to respond to the training needs identified through staff appraisal; development of clinical supervision Establish effective workforce information, including ward establishments, vacancies and sickness and absence levels and actively use this to support management at both Trust and divisional level.
Source of Recommendation and Status	**Patient experience** **Executive lead: Director of Quality and Safety/ Chief Nurse** **Patient Experience and Involvement Board** **Reporting to Quality and Safety Committee**
Mid Staffs Review - Professor Alberti 2009(April)	A member of the Board should be given responsibility as patients' champion and he/she or another Board member should have the same role specifically for older people.
Mid Staffs Review - Professor Alberti	More use should be made of real-time patient questionnaires

2009(April)	
Mid Staffs Review - Professor Alberti 2009(April)	Patient/public representatives should be included on all Board committees and sub-committees
Review of the early warning systems in the NHS Feb 2010	National Quality Board are to undertake a review of patient engagement and feedback mechanisms to understand how their outputs are connecting with trust boards and the decision making process.
Health Select Committee Report 2009(October)	Ensuring harmed patients and their families always receive full and frank information about incidents of harm
The Operating Framework for the NHS in England 2010/13 2009(Dec)	Vital Signs - Reputation, Satisfaction and Confidence in the NHS
Colin Norris Inquiry 2010 Jan 2010	Clarify the roles and responsibilities of Matrons in relation to communicating with Patient Relations Department to ensure clarity regarding responding to patients concerns.
Colin Norris Inquiry 2010 Jan 2010	Review the Trust complaints process and handling, to ensure that there is sufficient independence in investigations and that action is taken in response to issues raised.
Colin Norris Inquiry 2010 Jan 2010 Winterbourne View report (2012)	Raise awareness of the Trust complaints policy; review the process for ensuring that staff listen to and formally record information and concerns expressed by relatives and carers so that they are included as part of the care planning process and review. Ensure that the Concordat (specific actions) are reviewed by all appropriate governance Committees to review the full range of required actions to support the best experience whilst in acute care
Source of Recommendations	Trust wide Governance Arrangements Trust Wide lead: Chief Executive Audit Committee and Trust Board
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	All NHS Trusts and foundation Trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.
The Airedale Inquiry June 2010	Periodic reviews should take place of corporate governance arrangements should take place at Trust Board level.

Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support, and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.
Mid Staffs Review - Professor Alberti 2009(April)	Clinical governance arrangements should be enhanced with strong Board level support.
The Airedale Inquiry June 2010	The Trust Chief Executive should ensure the management structure is under review to respond to changing organisational needs.
The Airedale Inquiry June 2010	Governance systems in NHS provider organisations needs to be designed to reflect the Board's 24 hour a day responsibility for all areas of service delivery.
Review of the early warning systems in the NHS Feb 2010	Provider – trust board is given further guidance on how best to govern for quality. The NQB will lead a piece of work during 2010 which will help boards to develop robust governance for quality.
Review of the early warning systems in the NHS Feb 2010	Develop closer alignment of compliance frameworks for different types of provider (e.g. Monitor's Compliance Framework for FT's and NHS Performance Framework for NHS Trusts)
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should ensure that there is a written protocol setting out those procedures which should not normally be carried out in their Trust, but for which patients should be transferred for surgery elsewhere, taking into account the outcome data for procedures carried out less often. It is recognised that there will be exceptions in practice, but it is considered important that there is an explicit norm against which exceptions may be individually justified.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that management decisions about clinical services are subject to a proportionate appraisal of relevant facts and information, and include a risk assessment that takes clinical risks into account
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust	Trusts should ensure that there is effective clinical and managerial leadership at each level to deliver an organisational culture that promotes openness, cooperation and high standards of service.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS	The Trust should ensure that there is effective operational planning for clinical service changes that takes account of the expected impact on the capacity and capability of the relevant clinical teams, the level of support services required and the provision and utilisation of facilities such as theatres and intensive care.

Trust July 2010	
The Airedale Inquiry	Develop a communication plan for patients and families should events as identified in the Airedale report occur at any Trust in future.
Health Select Committee Report 2009(October)	Boards and senior management make patient safety the top priority
Colin Norris Inquiry 2010 Jan 2010	Review the effectiveness of the Trust's Assurance Framework and other mechanisms for the Board to evaluate Trust performance in relation to clinical quality
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC) Winterbourne View report (2012)	The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard of safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight. Trust Boards having robust systems for ensuring that warning signs are robustly reviewed to identify mistreatment and abuse within the Trust and Whistle blowing systems are reviewed and audited to demonstrate effective processes. Spring report due out in early2013 to identify how the DH can tighten up the accountability of management and corporate Boards for what goes on in their organisation. The need to assess the quality of care and outcomes being delivered across all areas of the Trust and with specific patient groups particularly the vulnerable patients.
Colin Norris Inquiry 2010 Jan 2010 Winterbourne View report (2012)	Embed the new approach to governance across the Trust, ensuring that this is effective in meeting the needs of both the Trust as a whole and individual clinical areas such as the ortho-geriatric service. Ensure that appropriate joint work is undertaken with Commissioners and local authority to support vulnerable patients and their carers and support the identification of all LD patients and ensure hospital stays are as short as possible to support care nearer to home.
Colin Norris Inquiry 2010 Jan 2010	Address the gap between the development of policies and their implementation, ensuring that policies are regularly reviewed and that they are audited to check that they are working in practice
Colin Norris Inquiry 2010 Jan 2010	Establish an effective, standardised system of audit where directorates feed into a coherent Trust audit programme, resulting in consistent collection of information, action in response to recommendations and assurance mechanisms. The audit programme should include a specific audit of clinical records to assure the Board that the quality of record keeping meets clinical and legal requirements
Independent Inquiry into Care Provided by Mid Staffordshire NHS	The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance. Ensure the effective implementation and utilisation of the patient passport and that required audits of notes of this client group are reviewed to provide

Foundation Trust January 2005 - March 2009 (Robert Francis QC) Winterbourne View report (2012)	assurance on care provided
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.
Colin Norris Inquiry 2010 Jan 2010	Actively promote the new whistle blowing policy through communication and training, supporting a culture of openness
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report
Health Select Committee Report 2009(0ctober)	Commissioning, performance management and regulation arrangements must be clarified and rationalised to become more effective
Health Select Committee Report 2009(Oct)	Better and more explicit patient safety education for healthcare workers
Health Select Committee Report 2009(Oct)	The introduction without delay of the NHS Redress Scheme.

Updated in January 2013

Director of Quality and Safety/ Chief Nurse