Trust Board
29th September 2011

National Inquiries & External Reports

EXECUTIVE RESPONSIBLE	Vicky Morris, Director for Quality and Safety/Chief Nurse
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STRATEGIC DOMAIN	C. Quality and Safety
ORGANISATIONAL OBJECTIVE	This paper relates to all objectives within the Quality and Safety Domain of our Strategy: C1. Ensure that we learn from mistakes and embrace what works well C2. Design care around patient needs C3. Provide the right care, right time, right place, right professional C4. Deliver services that offer safe, evidence-based practice C5. Meet regulatory requirements and healthcare standards C6. Ensure our patients suffer no avoidable harm
SUMMARY	The Board have received two briefing papers to establish a position against the SHA regional tracking tool on national reports and recommendations. The work undertaken subsequent to the last Trust Board report has been progressed by Executive Directors. Assigned Directors will continue to progress actions required in all areas and Quality and Safety Committee will track progress quarterly
RECOMMENDATION	The Board is asked to **NOTE** the current position and ongoing review by the Quality and Safety Committee.

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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 an update paper in May 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 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

3.1 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 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.

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

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

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

4.0 Conclusion and recommendations

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

National reports and recommendations

Area 1

Detecting a deteriorating Patient & Mortality

Medical Director

Mortality Group Committee

Trusts Safety Plan

Area 2

Patient Safety Recommendations

Chief Nurse

Hospital Executive Committee

Trusts Safety Plan

Area 3

High Impact recommendations

Chief Nurse

Nursing and Midwifery Forum

High Impact actions plan / CQUINs

Area 4

Infection Control Recommendations

Chief Nurse

Infection Prevention and Control

Infection Control Annual Plan

Area 5

Medications Recommendations

Medical Director

Trusts Drugs and Therapeutics Committee

Medicines Policy Care

Area 6

Quality review process recommendations

Medical Director and Chief Nurse

Monthly Quality review (Internal and PCT)

Quality Improvement Strategy

Area 7

Managing Emergency Flow Patients

Chief Operating Officer

Hospital Executive Committee

Value Stream work on Unscheduled Care

Area 8

Management of Medical Patient Flow

Chief Operating Officer

Hospital Executive Committee

Value Stream on Unscheduled Care

Area 9

Staffing recommendations

Chief Operating Officer

Hospital Executive Committee

Staffing reviews / HR Policy Framework

Area 10

Patient Experience

Chief Nurse

Patient Experience and involvement Board

Quality Improvement Strategy

Area 11

Trust wide Governance arrangements

Chief Executive

Trust Board / Audit Committee

Board Assurance report

Area 1   - Detecting a Deteriorating Patient and Mortality

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 Medical Director is leading this work and the LIPS programme has created organisational awareness across both hospitals. Specific streams of work looking at the use of the early warning score, response to treatment, particularly out of hours and at weekends is a clear focus with options for improvement being developed in the next few weeks.

VTE performance has improved but will need to be further improved to achieve the end September target of 90%.

Briefing papers to Clinical Centre Chiefs and Clinical Leads on care issues with elderly patients is being presented in September and will underline specific actions and areas for audit, to facilitate progress in this area.

Following the commissioned review of our Incident Management systems and processes, the timely review of Datix recorded incidents is being undertaken and monitored closely. Case note reviews using the GTT will be followed up through the mortality groups being established in the Clinical Centres.

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 Quality Account for 2011/12.

The only area where there has been no work undertaken is on the use of a suicide prevention toolkit. With A&E being the main area where awareness is key for these patients being admitted, joint work with the Mental Health Trust will be progresses in Quarter 4.

Area 2   - Patient Safety Recommendations

- Safer surgery checklists have been simplified across both theatres and progressed through the Productive Theatre programme. Audit processes are in place to progress this.

- Reconfiguration of services are planned and through the Outline Business Case stage address a number of clinical services where sustainable rota's and critical mass of clinicians is key.

- Centre Chiefs with their operational teams will need to develop clear strategies for sustainable services, with the formation of the Hospital Executive Committee to support robust governance arrangements.

- 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.

- The Patient Safety Plan has been agreed through the LIPS programme with specified streams of work monitored monthly. The National Team will support LIPS 2 the next cohort to maintain momentum of enhancing patient safety.

- The Corporate Nursing Team structure addresses the fundamental progress required for incident management and leadership required to support the reporting and management of serious incidents. The Centre Chiefs will through their structures enhance their reporting systems.

Area 3   - High Impact Actions

The recommendations across these sections relate to the National High Impact Actions. These area are being progressed through the LIPS programme and also through the Trust wide groups. The lack of progress in 10/11 has been progressed in the early part of 11/12 but the pace of improvement will be needed to meet the agreed degree of improvement.

Area 4   - Infection Control Recommendations

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 Control Committee

Area 5   - Drugs and Therapeutics Committee

The Centre Chief for Pharmacy leads the Trusts CQUIN on care plans required for patients who have high risk drugs. The area around medicine reconciliation is in place and the D&T Committee monitor these practices closely.
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

The Trust is working closely with the PCT, cluster and SHA around the process of quality assurance, whilst the Trusts reconfiguration process will enable progress on services that need to be sustainable, site specific and rota compliant.

A process of staff engagement / staff conversations to identify Quality Improvements commenced in September, which will commence the process towards a Quality Improvement Strategy. Key performance indicators (KPIs) across the range of Quality and Safety are monitored at Board with enhanced Ward to Board reporting commencing in October.

Area 7   - Managing Emergency Flows of Patients

The range of objectives / recommendations made by the Mid Staffs review have been picked up through the Hospital Executive Committee. 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.

A transitional team has been put in place for the next 3 months 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 is a priority for the Trust to support timely management of the cases where they can be supported back home in a timely manner.

Area 8   - Management of Medical Patient Flows

The recommendations made through two national reports (2010, 2011) on the care of the older patient have been considered with the PCT, Quality and Safety Committee and the Hospital Executive Committee.

Significant work to improve stroke services has been undertaken over the last nine months and on a range of KPIs are now leading performance against a range of West Midland Trusts.

Progress on care of patients with dementia is being progressed through the Local Health Economy Steering Group with external agencies involved in this work. General flow issues are being picked up with Centre Chiefs and the transitional team. Key performance indicators are in place to monitor progress.

Area 9   - Staffing recommendations – Chief Operating Officer

The range of recruitment processes and support for Consultants and Centres to ensure explicit responsibilities service by service is clear and clear accountability arrangements are in place. Centres are finalising their governance arrangements to ensure Quality and Safety and performance are monitored closely.

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.

Arrangements for clinical supervision will need to be refined and confirmed through the new Clinical Centres and training baselines undertaken.

The staff conversations will need to be focused into explicit areas of Quality Improvement culminating in a Quality Improvement Strategy.

Area 10 - Patient Experience

Progress has been made within the Trust to purchase a process whereby real time questionnaires and Quality Indicators can be used by senior practitioners to enable a true picture of care delivery at Board.

The Patient Experience and Involvement Board has been formed and will develop through its induction phase over the next two months with a programme of activity commencing in January 2012.

Significant Improvements are required across the complaints and PALS services to enhance the support given to patients and their family and triangulate with serious incidents and clinical indicators.

Area 11 - Trust Wide Governance Arrangements – CEO Lead

- The Board have reviewed the full range of recommendations made externally through 3 Board papers, with the work led by Executive Directors and follow up reports made on progress.

- The Board have reviewed its governance arrangements, Corporate Risk Register and Assurance Framework and Internal Audit have reviewed those processes.

- The Board also have a development programme in place to review progress on governance arrangements and late in 2010 revised formal subcommittees to reflect appropriate scrutiny on all aspects of governance.

- Moving forward the revised Centre Chief structures will need to be fully involved in the development of a Quality Improvement Strategy.

ACTION: Particular focus will be needed through Centre Chiefs to ensure written protocols are in place for procedures which should not be normally carried out, so that explicit arrangements are in place against which exceptions may be individually justified.

ACTION: Significant work is still required to ensure adequate capacity to see our patients in a timely manner according to our constitutional obligations.

ACTION: 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.

ACTION: A communication plan is in place to manage patient / family concerns should these arise.

ACTION: An explicit policy development / review programme for policies is required.

Director of Quality and Safety/ Chief Nurse
September 2011