Quality and Safety Improvement Strategy 2016-2021
Quality and Safety Improvement Strategy 2016-2021

1. **Purpose of this Strategy**

Patient safety and quality of care are at the heart of the NHS agenda. Treating and caring for people in a safe environment and protecting them from avoidable harm is one of the five ‘outcome’ domains outlined in the NHS Outcomes Framework.

There have been a variety of reports and consequently an increasing framework of regulation and performance metrics which has shaped the way we structure, set and monitor our quality outcomes. The following figure references the key reports and data sources that have supported the development of this Strategy.

**Figure 1**

High-quality care is defined by the NHS to be in three dimensions:\(^1\):

- **Clinically Effective**: was the patient’s care or treatment successful and did it achieve the best possible result for the patient?
- **Safe**: treating and caring for people in a safe environment and protecting them from avoidable harm.
- **Good Patient Experience**: ensuring patients, relatives and carers have as positive experience as possible at every stage of the care or treatment that is being provided, not just the results that were achieved at the end.

Quality care is not achieved by focusing on one or two aspects of this definition; rather, high quality care encompasses and balances all three aspects.

The Care Quality Commission's Intelligent Monitoring System and new insight model focuses on key areas of quality and safety. Their assessment of services is based on the following five questions which are based on the things that matter most to people:

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\(^1\) [https://www.england.nhs.uk/about/our-vision-and-purpose/imp-our-mission/](https://www.england.nhs.uk/about/our-vision-and-purpose/imp-our-mission/)
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- **Are services safe?** People are protected from abuse and avoidable harm

- **Are services effective?** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

- **Are services caring?** Staff involve and treat people with compassion, kindness, dignity and respect

- **Are services responsive?** Services are organised so that they meet people's needs

- **Are services well-led?** The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

The purpose of this Strategy is to provide a structure for high quality clinical governance to ensure on-going improvement in the quality and safety of patient care. It provides clarity on those outcomes where efforts will be primarily focussed. Additionally it recognises that developing a safety culture where improving safety is seen as everyone’s business from Board to Ward, and that this is at the heart of quality and safety improvement. This safety culture will be supported by accurate and relevant data, and a comprehensive information and communication technology programme. Further, it recognises the importance of having a safe and sustainable workforce in delivery of the quality and safety agenda. The Strategy also provides the context and governance for establishing, implementing and enhancing all actions that are aimed at improving quality and safety.

This Strategy supports the Trust's vision: **To put compassionate care, safety and quality at the heart of everything we do.**

The document builds on the Clinical Quality Strategy (CQS) 2013-16, taking into account the progress made, with the aims and priorities mapped to ensure a continuing journey towards a better quality of patient care. It also takes into account lessons learnt from within the Trust and from others, emerging best practice and national quality improvement initiatives, in particular The Health Foundation guidance on measuring and monitoring safety and work being taken forward by Imperial College Health Partners on patient safety and quality improvement, regulatory and other inspections, as well as the national and local priorities. It sets out how we create a culture of continuous improvement to increase and sustain the quality of our services for our patients, people and stakeholders, and is informed by the Trust's Quality and Safety Committee’s own review of effectiveness and recommendations arising from the Trust’s CQC inspection in October 2014, which resulted in an overall rating of ‘requires improvement’.

2. Delivering our Quality and Safety Strategic Aims

The overarching strategic aim is to be “good” as defined by the CQC, meet our key performance indicators where these are defined, rate “green” where outcomes are based on a RAG rating, and ensure we have positive feedback from staff and patients on our safety culture. A change in Quality Improvement Governance (see Section 3) will ensure that the strategy is joined up from Board to Ward with clear lines of sight and with monitoring and accountability of all relevant Committees being consistent and clear.

With reference to all the reports and indicators outlined above, we will over the next five years focus on a few key areas which will define the high quality and safe service that we aim to deliver for our patients. This includes:
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1. Developing a safety culture in which safety is everyone’s business
2. Safer staffing
3. Working towards no preventable deaths
4. Proactively improving systems to reduce harm
5. Improving patient experience as defined by our patients
6. Achieving the best possible outcomes for patients
7. Ensuring people receive care in the right place

Aims 1 and 2 on culture and safer staffing are pillars in delivering many of the other aims as this will reinforce and sustain a clinically effective, safe and good patient experience. Efforts will be focussed on developing a safety culture and safer staffing that can tangibly affect an improvement in the other five aims. In addition, effective team work and understanding the impact of human factors on care delivery are of overarching importance and this needs to be recognised at every level of the organisation. Over the past three years it has also become increasingly apparent that the physical environment of care is critical for safe care and improving patient experience.

A key component of this Strategy is to ensure that our staff have the right skills to support a cultural change that drives the trust’s workplace learning and leadership programmes. Our staff need to feel cared for and valued so that they feel confident and competent to do their work. They also need to feel empowered to take responsibility and to take action with learning from errors and feedback. This Strategy will support an increased level of engagement and a culture of learning together with regard to multidisciplinary and team development opportunities.

Quality priorities will be aligned to the above aims, informed by emerging best practice, national quality improvement initiatives and determined on an on-going basis by the Board and documented annually in the Trust’s Operational Plan. We need to ensure that the operational challenges and key quality concerns such as safer staffing and the condition of the Trust’s estate are considered.

We will align the priorities in the annual quality report to the Q&SI strategy. KPIs will be developed and used in the annual reports to show progress.

We will use the Health Foundation Framework for the measurement and monitoring of safety, building on the key elements over the next three years. This approach is summarised in Appendix 1 – A framework for the measurement and monitoring of safety.

In order to achieve these aims, we have to understand the key drivers for change and what are the key components that underpin each of these seven objectives. These are best summarised Figure 2:
Figure 2: Driver diagram for delivering key outcomes of the Strategy

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Drivers for change</th>
<th>Key components</th>
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<tbody>
<tr>
<td>No Preventable Deaths</td>
<td>Quality &amp; Safety Improvement</td>
<td>• Clarity of strategy&lt;br&gt;• Ambition of strategy&lt;br&gt;• Implementation of strategy&lt;br&gt;&lt;br&gt;Transformational Leadership –Board to Ward&lt;br&gt;Leadership at all levels / champions&lt;br&gt;Visible and felt leadership by all&lt;br&gt;Open, just, reporting, learning, informed culture</td>
</tr>
<tr>
<td>Reduced Harm</td>
<td>Leadership and Safety Culture</td>
<td>• Rhythm of communication&lt;br&gt;• Two-way fruitful discussions&lt;br&gt;• Relevant and focussed for audience&lt;br&gt;• Valuing feedback&lt;br&gt;• Ensuring strong voice for patient&lt;br&gt;• Involvement of patients and their families to support patient choice</td>
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<tr>
<td>Improved patient experience</td>
<td>Communication and Engagement</td>
<td></td>
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<tr>
<td>Best clinical outcomes</td>
<td>Learning and Improvement</td>
<td>• Improvement Science teaching and culture&lt;br&gt;• Effective learning systems and audit&lt;br&gt;• Partnership/Multi-Disciplinary Team working&lt;br&gt;• Building local capability</td>
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<tr>
<td>Care in the right place</td>
<td>Personal Safety Behaviour and Attitudes</td>
<td>• Encourage and build resilience, energy, commitment, pride, people power&lt;br&gt;• Enable focus; remove distractions&lt;br&gt;• CARES culture and values&lt;br&gt;• Support and supervision</td>
</tr>
<tr>
<td>Mature Safety Culture</td>
<td>Structures, Procedures and Processes</td>
<td>• Improvement Methodology&lt;br&gt;• Decision Making, Reporting, Processes, Compliance&lt;br&gt;• Project Management&lt;br&gt;• Quality Improvement dedicated resource</td>
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<tr>
<td>Safer staffing</td>
<td>Infrastructure and Environment</td>
<td>• Improving the working environment especially A&amp;E, Theatres, Resuscitation, Paediatrics&lt;br&gt;• IT systems that enable and do not hinder&lt;br&gt;• Right staffing and introduction of new roles&lt;br&gt;• Cross organisational working and collaboration</td>
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<td></td>
<td>Reward and Recognition</td>
<td>• Positive re-enforcement&lt;br&gt;• Involvement and seeking ideas&lt;br&gt;• Education and investment for long term&lt;br&gt;• PDR/appraisal&lt;br&gt;• Revalidation and maintaining registration</td>
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<tr>
<td></td>
<td>Suite of Projects</td>
<td>• Sign Up to Safety/Foundations of Safety Best Practice Forum&lt;br&gt;• Whole Systems Integrated Working&lt;br&gt;• Better Care Fund&lt;br&gt;• CQUINS&lt;br&gt;• Ward safety huddles and walkarounds</td>
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Aim 1 – Developing a safety culture in which safety is everyone’s business

The key underpinning need is to have a strong management and clinical leadership with staff and patient involvement in an empowering culture that ensures that staff and patients report incidents and raise concerns about quality and patient safety in an open, just working environment. Only in this way can we identify and implement what needs to be done to reduce harm incidents and preventable deaths. The culture and values of the Trust CARES framework exemplify this.

The Trust has joined the ‘Sign up to Safety’ campaign with a commitment to reduce avoidable harm by 50% by April 2018. The Trust has developed actions in response to the five Sign up to Safety pledges to:

- Put safety first
- Continually learn
- Honesty and transparency
- Collaboration
- Support

<table>
<thead>
<tr>
<th>Strategy Aim 2016-21</th>
<th>Quality Priorities</th>
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| Developing a safety culture | • Align actions with CQC Root Cause Analysis outputs to ensure a strong accountability framework  
• Further embed the “S” in CARES and focus on safety in all staff appraisals /PDRs  
• Implement Sign up to Safety pledges  
• Agree trajectories for incident reporting in key areas  
• Implementing a Quality Exception Reporting system which includes Committee feedback for all Quality/Governance meetings  
• Identify/support patient safety champions on key aims of the Strategy  
• Develop a dedicated quality improvement resource - introduce a hub of ‘Q’ fellows to lead on quality and safety  
• Support Board involvement in patient safety by ensuring that the programme of safety walkarounds is robust and that themes are reviewed at Board and at the Patient Safety Committee  
• Review of all quality dashboards and improving data quality  
• Implementation of ICT strategy to support EWS, clinical handover etc.  
• Involve patients and carers of the “Lay Strategic Group” |

Aim 2 - Safer staffing

Aim 1 is complemented by having a safer and more stable workforce able to provide high quality care seven days per week. Safer in this context means not just numbers but correct skill mix matched to our bed base and activity, using newer staffing roles (such as clinical nurse specialists and Physician Associates), and less reliance on a temporary workforce. Safer also means staff being trained to have the necessary competencies to look after patients in their care, and continuing to embed our CARES values for all staff members.
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| **Safer staffing**   | • Reduce vacancies and use of temporary staffing  
                      • Further develop staff recognition and staff engagement strategies  
                      • Deliver improved staff retention strategy  
                      • Improve all staff survey metrics to national average  
                      • Develop an engagement and transformation development programme  
                      • Multi-professional clinical handover in all areas  
                      • Promote development of clinical nurse specialists & Physicians Associates  
                      • STaM training compliance  
                      • Achieving improvement in relation to seven day working priorities |

Aims 3 - Working towards No Preventable Deaths

We have to identify and implement best practice, evidence-based and innovative solutions to reduce patient harm and preventable death as well as address the cross-cutting themes such as leadership, teamwork, communication and culture which are often identified in patient safety incident investigations and mortality reviews and these potentially affect safer patient care.

We will measure success with our own and comparative standard statistics such as the NHS England avoidable mortality information, Hospital Standardised Mortality Rates (HSMRs), Dr Foster Mortality Alerts, Never Events, and reductions in repeated causes for serious incidents.

<table>
<thead>
<tr>
<th>Strategy Aim 2016-21</th>
<th>Quality Priorities</th>
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</table>
| **No Preventable Deaths** | • No variability between weekday and weekend HSMR  
                              • Implement NHSE Mortality Governance Framework with surveillance group to identify and learn from all potentially avoidable deaths  
                              • Use of simulation laboratory to deliver scenario based learning from serious incidents and critical events |

Aim 4 - Proactively improving systems to reduce harm

It has to be recognised that we cannot achieve a 100% guarantee of no harm. What is required is that we:

- Follow best practice processes and procedures in all our activities, documenting and check listing what we do;
- Have a positive patient safety “Just” culture such that when unwanted outcomes occur they are reported and openly investigated to determine the non-negligent causes; and
- Implement action plans to update procedures such that the specific event is avoided in the future.

The initial focus on harm reduction for 2016/17 will be to reduce avoidable harm by 20% of the 2015/16 levels. We will focus on the following key areas:

1. Achieving NEWS compliance to support early escalation of the deteriorating patient
2. Reduce the number of hospital acquired pressure ulcers
3. Reduce the number of inpatient falls
4. Improve medication safety; and
5. Improve the care of the acutely ill older person.
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### Strategy Aim 2016-21

**Proactively improving systems to reduce harm**

Reducing key harms by 50% by 2018 in line with Sign up to Safety pledges, with care provided in an environment which minimises risk of patient harm.

- Deliver requirements of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment to ensure requirement notice for infection prevention and control is lifted
- Achieve HCAI objectives via HCAI annual action plan and HSCA/Hygiene Code requirements as outlined in the IPC assurance framework (includes environmental cleaning and environmental estate risks)
- Achieve NEWS compliance to support early escalation of the deteriorating patient through an improved performance reporting structure
- Ensure safety huddles are embedded in practice across all wards and in the A&E department
- Reduce the number of hospital acquired pressure ulcers through improved education and appropriate utilisation of specialist equipment
- Reduce the number of inpatient falls via an improved prevention and management of inpatient falls action plan
- Improve medication safety to ensure incident reporting is above national average and that lessons learnt are shared to improve practice
- Improve the care of the acutely ill older person focusing on nutrition and delirium.
- Deliver incident reporting and management training to include Human Factors training to Band 6 level and above
- Two day serious incident and RCA investigation training for lead managers
- Extreme risks relating to the estate / environment on the corporate risk register are managed and mitigated to an agreed acceptable level.

### Aim 5 - Improving patient experience as defined by our patients

We aim to be a listening and learning organisation, in which concerns that are raised by patients are understood, shared and responded too. Listening to feedback enables our staff to gain a real insight into the patient’s experience of care and to target where improvements need to be made. In addition involving the patient, and their carers, as much as possible in their care supports an improved experience and assists in maintaining patient safety and effective communication.

We use a number of different approaches, all of which provide us with information about what we are doing well and where we need to improve:

- National and local surveys
- Friends and Family Test
- Compliments/Complaints
- PALS concerns

We aim to ensure that there is continuing focus on improving the patient experience and that services that are delivered are truly responsive to individual patient needs.

### Strategy Aim 2016-21

**Improving patient experience as defined by our patients**

- Delivering compassionate care and improving communication objectives as outlined in the Annual Quality Report
- Implement Friends and Family Test in all areas, increase proportion of FFT responses, achieve .96% satisfaction and apply lessons learned into practice.
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- Improve accessibility of information for patients as per Accessible Information Standard
- Agree strategy for improved metrics in national and local patient surveys
- Improve patient and family experience by applying learning from complaints & patient stories and the annual bereavement survey
- Reduce number of complaints related to key themes
- Implement patient listening challenges into improvement actions
- Implement the nursing and midwifery action based strategy 2016-19
- Better end of life care with earlier identification of such patients, and improved outcomes with regard to dying in the place of choice – joining up with NWL work-stream

### Aim 6 - Achieving the best possible outcomes for patients

“Best” here has to balance the clinical outcome against the risks and side effects. We have to work in partnership with patients, their families and carers so they understand and accept the care pathways that are agreed, and then that we deliver this in a safe a manner as possible with respect and active communication. In addition, working in tandem with other care providers gives us an opportunity to deliver more efficient and streamlined services and will help the Trust tackle the significant challenges ahead in relation to an ageing population and a tighter financial envelope. The Borough’s Whole Systems Integrated Care project and Hillingdon’s Accountable Care Partnership are key examples of collaboration ensuring that health and care services are planned by focusing on the needs of our local community and achieving the best possible outcomes for them.

We will measure success with many of the regulatory required statistics such as waiting times, patient-related outcome measures and the Family and Friends Test.

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<thead>
<tr>
<th>Strategy Aim 2016-21</th>
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| **Achieving the best possible outcomes for patients** | - Safer staffing – improved recruitment and retention to ensure delivery of safe care  
- Develop innovative models of acute care provision including new staff roles that support cross organisational working and integration  
- Implement individualised Care Plan for Care of Dying Person as standard for all patients in last hours of days of life at THH  
- Use of technology to support timely provision of data to clinicians on operational performance data and patient condition outcomes, such as sepsis, pneumonia etc.  
- Ensure learning from clinical audit findings with delivery of robust action plans  
- Ensure implementation of NICE Quality Standards and NCEPOD recommendations  
- Work with patients to better understand expectations for the delivery of acute care and to set realistic goals |

### Aim 7 – Ensuring people receive care in the right place

This means ensuring that care is delivered quickly and close to home, avoiding unnecessary hospital admissions. The Trust will continue to work collaboratively with Hillingdon Clinical Commissioning Group, Hillingdon Borough Council, Hillingdon Community Health and the third sector to develop an Out of Hospital Strategy with Ambulatory Care Pathways and Whole Systems
of Integrated Care, This should ensure that admissions to hospital are avoided where possible, and that time spent in the A&E department is reduced. The Trust will also ensure that the care that it provides to patients is in the right place within the organisation in relation to specialty and patient group to support more timely and effective treatment and interventions.

<table>
<thead>
<tr>
<th>Strategy Aim 2016-21</th>
<th>Quality Priorities</th>
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| Ensuring people receive care in the right place | • Ensure patients are given choice on their preferred place of treatment providing them with the right information on local care services  
• Roll out key ambulatory & outreach service models across clinical specialties  
• Continue to work with health and social care colleagues to review reasons for admissions and ensure robust admission avoidance schemes  
• Continue to review re-admissions to ensure learning and actions by hospital staff and partners in health and social care to reduce incidence  
• Ensure a clear, agreed, written strategy for End of Life Care to drive sustainable, permanent change and to sustain ongoing continuous improvement as evidenced by the attainment of agreed milestones  
• Ensure End of Life care pathways are clearly understood by our staff and fully supported  
• Ensure sharing of patient information across the health and social care economy supported by integrated communication and information systems including advance care plans for patient in last phase of life  
• Ensure patients are cared for in an environment which is fit for the purpose to which it is being put to support right care being delivered in the right place. |

3. Quality Improvement Governance

The Trust Board declared compliance against Monitor’s ‘Well-Led Framework’ in January 2016 and committed to continuing compliance with the governance requirements outlined in the framework.

The Executive Director of the Patient Experience and Nursing (DPEN) is the executive lead for Integrated Governance and is accountable for ensuring the delivery of a robust clinical governance system throughout the Trust which itself then ensures that the Trust delivers against its quality priorities and improvement strategy. In this the DPEN is supported by the Medical Director who in turn appoints a Clinical Director of Quality and Safety.

The Trust Board receive monthly performance information against key quality and safety performance indicators, and any quality concerns which merit focused attention are highlighted by the DPEN and Medical Director.

The Quality and Safety Committee (QSC) is a sub-committee of The Hillingdon Hospitals NHS Foundation Trust (THH) Board of Directors. It provides the Trust Board of Directors with assurance that quality and safety within the organisation is being delivered to the highest standards and that there are appropriate processes in place to identify gaps and manage them accordingly.

Cost Improvement Programmes (CIPs) and Quality Improvement Programmes (QIPs) are developed by the Divisions and Executive Leads. These are reviewed by a Clinical Assurance Panel chaired by the Medical Director with additional Clinical and Nursing representatives, and a formal report is submitted to the Trust Board annually.
Clinical divisions review their quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis at their divisional governance boards; a divisional exception report is received by the Patient Safety Committee and any concerns on quality are escalated via this committee to the QSC.

The Trust continually strengthens its governance arrangements and its compliance with the Health and Social Care Act regulations through a programme of internal peer review and mock inspection ensuring there is evidence of progress of improvement against refreshed CQC action plans, in particular to ensure improvement to areas of outstanding compliance notices.

Details are in Appendix 2 – Quality governance structures and processes.

4. Leadership for Safety

In order for the Trust to achieve high quality care we need to ensure that we have the right structures and processes in place allied to an appropriate culture with supporting values and behaviours and staff who are appropriately trained. The Trust will ensure that there is strong clinical leadership by involving clinicians and staff in transforming the way we deliver services and listening to their views on the improvement of clinical quality and being clear about what high quality care looks like in all specialties and reflecting this in a coherent approach to the setting of standards.

Improving quality and healthcare outcomes is the responsibility of everyone working in the NHS, no matter what their position or level of authority in the organisation; this is the culture that all of our staff must adopt to ensure patients are kept safe and are well-looked after. Individual health care professionals, their ethos, behaviours and actions, are the first line of defence in maintaining quality and therefore it is expected that all employees will:

- Participate in the delivery of the quality and safety agenda thus ensuring that the clinical quality assurance process is delivered from ‘Board to floor’
- Work professionally in accordance with the Trust and where appropriate, professional Code(s) of Conduct
- Provide safe clinical practice in the treatment and care of patients in accordance with Trust policies and protocols
- Report concerns regarding the treatment of patients and the quality and safety of care.

The leadership and quality governance structure and the responsibilities of key management staff are outlined in Appendices 3 and 4. We will ensure that we support our staff to deliver effective leadership in quality and patient safety by equipping them with the right knowledge and skills so that there is a cultural shift to strengthen local ownership and empower front line clinical leaders.

We will ensure that the patient safety champion role is introduced to the Trust so that quality and safety are championed within clinical areas and divisions and that there is a strong voice for safety across the organisation; this will include involving patients and the public as champions in our endeavours to improve patient safety.

We will ensure that quality improvement ‘fellows’ champion the cause for improvement and create a social movement for change. These fellows will be part of a local quality and safety improvement ‘hub’ that will need support and training to be able to strongly influence individuals and multidisciplinary teams.
5. Indicators and Reporting

Indicators in the monthly integrated quality and performance report that is presented to the Board on a monthly basis reflect the core principles of the five Domains set out in the Care Quality Commission’s Intelligent Monitoring System and Insight Model (i.e. Caring, Well-led, Effective, Safe and Responsive). The aims outlined in this strategy map to the domains as follows:

1. Developing a safety culture in which safety is everyone’s business (well led domain)
2. Safer staffing (well led domain)
3. Working towards No Preventable Deaths (safety domain)
4. Proactively improving systems to reduce harm (safety domain)
5. Improving patient experience as defined by our patients (caring domain)
6. Achieving the best possible outcomes for patients (effective domain)
7. Ensuring people receive care in the right place (responsive domain)

Relevant indicators are also reflected in a balanced scorecard produced by each clinical division. These indicators are used at a board level to assess progress against strategy and highlight areas of risk or non-compliance. At the divisional level, they inform action points and focus attention on immediate priorities. Where particular challenges are highlighted, the board arranges follow-up meetings and working groups to address areas of concern. The outcomes from this process informs the Trust’s risk register, which is updated regularly.

Quarterly, a board report highlights performance against the outlined year’s strategic objective, which provides a narrative on the priority information of the quality and safety areas.
Appendix 1 – A Framework for the measurement and monitoring of safety

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Has patient care been safe in the past?
Ways to monitor harm include:
• mortality statistics (including HSMR and SHMI)
• record review (including case note review and the Global Trigger Tool)
• staff reporting (including incident report and ‘never events’)
• routine databases.

Are our clinical systems and processes reliable?
Ways to monitor reliability include:
• percentage of all inpatient admissions screened for MRSA
• percentage compliance with all elements of the pressure ulcer care bundle.

Is care safe today?
Ways to monitor sensitivity to operations include:
• safety walk-rounds
• using designated patient safety officers
• meetings, handovers and ward rounds
• day-to-day conversations
• staffing levels
• patient interviews to identify threats to safety.

Will care be safe in the future?
Possible approaches for achieving anticipation and preparedness include:
• risk registers
• safety culture analysis and safety climate analysis
• safety training rates
• sickness absence rates
• frequency of sharps injuries per month
• human reliability analysis (e.g. FMEA)
• safety cases.

Are we responding and improving?
Sources of information to learn from include:
• automated information management systems highlighting key data at a clinical unit level (e.g. medication errors and hand hygiene compliance rates)
• at a board level, using dashboards and reports with indicators, set alongside financial and access targets.

Source: Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation, 2013
Appendix 2 – Quality governance structures and processes

The key quality governance structures that support the Trust in ensuring that the quality of care is being routinely monitored across all services and that poor performance or variation in quality is challenged are as follows:

- There is monthly reporting to the Board via the integrated quality and performance report with exception narrative.

- At each QSC meeting a clinical division, presents on clinical and quality governance issues, discusses areas of risk, reviews performance against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit.

- There is a deep dive review at each QSC meeting on the key aims of a new Quality Improvement Strategy. Any external quality and safety intelligence is presented at the QSC on a bi-monthly basis, and a summary of performance against KPIs in the Annual Quality Report “Look forward” section are also reported with escalation to the Board where required.

- The Trust’s Patient Safety Committee (PSC) receives bi-monthly reports from each clinical division outlining areas of risk, providing a review of patient safety incidents, key patient safety indicators, clinical effectiveness and patient experience data.

- The Regulation and Compliance Committee (RCC) is a management committee which forms part of the Trust’s quality & risk reporting structure. It ensures that there are effective and robust systems and processes in place for ensuring quality governance and regulatory compliance. It receives a bi-monthly report from each division on local compliance and assurance.

- A detailed quarterly overview of complaints in terms of themes and lessons learned and actions taken; claims and litigation data; incidents numbers, severity and themes by clinical division and medium and high risks and actions being taken to address is also received at CGC with performance exception reporting at QSC.

- Clinical divisions review their quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis at their divisional governance boards; a divisional exception report is received by the PSC and any concerns on quality are escalated via this Committee to the QSC.

- There is a structured process of reporting the investigation of Serious Incidents and the follow up of outcomes and action plans resulting from Serious Incidents (Sis). Sis have a named executive lead and panel reports are presented to the Board with resulting actions reviewed bi-monthly until complete. Root cause analysis is used and forms the basis of the report together with the creation of action plans.

- There is a programme of regular inspections of clinical areas by the DPEN, Chief Executive and other Board members giving them the opportunity to talk to staff and patients about their experience. In addition, Patient Safety walk-arounds, involving Board members, are undertaken.
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- ‘Clinical Fridays’ allow the corporate nursing team and divisional senior nurses, alongside the DPEN, to work with clinical staff on wards and in departments to experience the environment and delivery of care, engaging with staff and patients and their carers. Any issues or concerns are escalated accordingly to the Executive Team and Trust Board.

- There is a robust framework to ensure that all service changes have a Quality Impact Assessment (QIA) which is then reviewed by the Medical Director. Any schemes where there are quality concerns are reviewed at a multi-professional Clinical Assurance Panel (CAP), with the project leads presenting the scheme and the actions being taken to mitigate any associated risks to quality.

- Listening to Patients/Governors: it is important that there is a range of opportunities to support patients in providing feedback and raising their concerns.

- Patients can complete local patient experience surveys, including the Friends and Family Test, provide feedback via NHS Choices, in person directly to department managers and matrons or via the PALS/Complaints offices.

- There is opportunity for patients and members of the public to attend the Trust’s People in Partnership (PiP) meetings, Council of Governors meetings and the Trust Board meeting. There are also specialty-based focus and support groups where patient feedback can be obtained.

- The Board receives patient stories as part of understanding the patient experience; this ensures that the voice of the patient and their families/carers is heard first hand by Board members; stories are captured directly from patients via 1:1 interviews, complaints and PALS feedback.
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Appendix 3 – Quality and Risk Reporting Structure

**BOARD**
- Quality and Safety Committee report – bi-monthly
- Audit and Risk Committee report - quarterly
- Integrated Quality and Performance report - monthly
- Serious Incident reports and action plans
- Risk Register – bi-annual
- Board Assurance Framework – bi-annual

**Quality and Safety Committee (Bi-monthly)**
- Quality Improvement Strategy aims – deep dive
- Integrated Quality and Performance report – exception reporting
- Divisional presentations (risk, safety, quality, compliance)
- Care Quality Commission compliance
- Annual Quality Report and monitoring
- Clinical Audit programme
- External intelligence and assurance
- Exception report from PSC and RCC

**Audit and Risk Committee (Quarterly)**
- Internal audit – clinical and non-clinical
- External audit
- Board Assurance Framework
- Corporate Risk Register
- Challenge on adequacy of governance arrangements, financial systems and compliance with legislation
- Annual Report and Accounts

**Patient Safety Committee (PSC)**
- Clinical Risk Register
- Divisional governance reports
- Integrated patient safety and quality report (complaints/claims/incidents/PALS)
- MDA/PSA reporting
- Policy ratification

**Regulation and Compliance Committee (RCC)**
- Care Quality Commission compliance report and action log
- Clinical audit/NICE/NCEPOD Guidelines, policies & AVIA monitoring
- Safeguarding compliance
- Infection Prevention & Control compliance

**Exception reports from external meetings**
- External Services Scrutiny Committee
- Healthwatch engagement meetings
- CCG Clinical Quality Group
- CCG Quality, Safety and Risk Committee

**Report/minutes from:**
- Experience and Engagement Group

**Reports/minutes from:**
- Blood Transfusion Committee
- Resuscitation Committee
- Divisional Governance Boards
- Mortality Surveillance Group
- Medication Safety Committee
- Dementia Steering Group
- Organ Donation Committee
- Falls Group
- Cancer Board
- End of Life Care Board

**Reports/minutes from:**
- Clinical Audit & Effectiveness Committee
- Research and Development Group
- Clinical Records Committee
- Medical Education Committee
- Safeguarding Committee
- Infection Control Committee
- Hillingdon Medicines Management Committee
Appendix 4 - The Leadership of Clinical Quality and Patient Safety

The leadership of the Trust must ensure that the right systems and processes are in place across the organisation to support staff in driving quality improvement and to allow them to raise any concerns about quality that they may have. The following outlines the role and responsibilities of key individuals and committees that support the governance and leadership of clinical quality and patient safety at the Trust.

The Trust Board
The Trust Board is responsible for setting the culture and overseeing the quality of care being delivered across all the services within the Trust and assuring itself through relevant evidence that quality and good health outcomes are being achieved throughout the Trust. Effective governance means that the Board pays as much attention to the quality of care as they do to the management of the Trust’s finances. The Trust has reviewed its quality governance to ensure that it has in place a robust framework that is meeting best practice and that the quality of care is continually improved.

The Chief Executive
The Chief Executive has overall accountability for Quality Governance, delegating the executive responsibility to the Director of Nursing and Patient Experience and the Medical Director who in turn are responsible for reporting to the Trust Board on the quality governance agenda and ensuring that any supporting strategy documents are implemented and evaluated effectively.

The Medical Director
The Medical Director, working with the Director of Nursing and Patient Experience, has delegated responsibility to drive forward the patient safety agenda, ensuring that a harm free culture is explicit within divisional business plans and within clinical working practices. The Medical Director will positively influence the medical workforce to ensure that clinical leadership has a strong voice within divisions and that the clinical governance agenda is seen as a business critical priority.

The Director of Nursing and Patient Experience
The Director of Nursing and Patient Experience, working with the Medical Director, has delegated responsibility for managing the strategic development and implementation of effective clinical quality governance and organisational risk management, ensuring that clinical and corporate teams are demonstrating a real commitment to the quality agenda and its assurance process.

Executive Directors
Every Executive Director has a responsibility to uphold the Trust’s vision and to ensure that clinical quality is a priority for the Trust. The Executive Directors are pivotal in influencing senior operational management teams, corporate services and support teams, and in ensuring that the quality of patient care is always considered in business discussions and strategic and operational decision-making.
Divisional Directors, Divisional Management Teams and Speciality Leads and Matrons

Divisional Directors, Management Leads, Speciality Leads and Matrons are accountable for the delivery of patient safety and quality of care within Divisions and to ensure that quality governance values are embedded; this means:

- **Awareness**
  All staff should know that quality improvement and patient safety are key priorities for the Trust and understand how they can contribute to the agenda. All staff should be aware of what CQC compliance is and the purpose of the Fundamental Standards of Quality and Safety. All staff should be aware of the key Trust policies and processes and should comply with them.

- **Compliance**
  Each Division should use the standards to plan a programme of quality governance work to ensure improvement year on year (and build this into their business plan) and ensure the CQC registration and compliance requirements applicable to them are met.

- **Assurance**
  Each Divisional Management Team should be ‘assured’ (i.e. by evidence collation, walkabouts, surveys, audits etc.) of, and able to demonstrate, compliance with the standards and other relevant accreditation requirements.

- **Sharing and learning**
  Divisions should be sharing areas of good practice and learning across the Trust, both when things go well and when things could be improved.

**Divisional Governance Boards**

Each Division is required to have a Divisional Governance Board which meets regularly to discuss and oversee all governance issues within the Division, represented by the divisional management staff outlined above. To ensure accountability, the Divisions are required to submit a summary of their meetings to the PSC and RCC as part of a rolling programme of divisional reports. Care groups also have their own governance groups which report into the Divisional Governance Boards. Divisions are required to ensure there is sufficient clinical representation within the Divisional Governance groups.

**The Quality and Safety Committee**

The Quality and Safety Committee (QSC) is the key Board Committee that monitors and reviews on behalf of the Board, the Trust’s patient safety and quality governance arrangements. It ensures there are clear and robust accountability arrangements at all levels of the Trust for quality governance. The committee ensures that there is rigorous review of clinical governance and quality reports which include Patient Safety, Patient Experience, Patient Outcomes and Clinical Effectiveness, and Regulatory Assurance. The QSC ensures that intelligent information is available to support decision-making
and through its reporting arrangements that there is effective operation of the Trust quality governance framework at all levels and that organisational learning takes place.

The Audit & Risk Committee
The Audit and Risk Committee has responsibility for overseeing and providing an independent review of the systems of internal control. The ARC reviews the establishment and maintenance of integrated governance, risk management and internal control across the whole of the Trust’s activities both clinical and non-clinical. The Committee Chair is responsible for ensuring the Board is provided with independent and objective review of the assurances available on the adequacy of governance arrangements, financial systems and compliance with legislation and codes of conduct; this includes reviewing and challenging the BAF.

The Patient Safety Committee
The Patient Safety Committee (PSC) ensures that there is clear responsibility for divisional clinical leads and managers for clinical quality and patient safety to assist the Trust in working towards clinical excellence and high quality care. It sets clear performance standards and provides a level of scrutiny regarding patient safety holding the Clinical Divisions, and where relevant other Trust wide groups and departments, to account for the delivery of the clinical governance agenda. The PSC escalates any areas of concern to the Quality and Safety Committee as appropriate.

The Regulation and Compliance Committee
The Regulation and Compliance Committee (RCC) is a management committee which forms part of the Trust’s quality & risk reporting structure. It ensures that there are effective and robust systems and processes in place for ensuring quality governance and regulatory compliance. It recognises that the Trust must meet its obligations under national, regional and local quality standards and statutory and regulatory requirements and therefore its purpose is to provide evidence and assurance on the processes and structures that support this governance and comprehensive evidence of compliance.

Patient Safety and Quality Team
Whilst the main delivery of clinical governance and quality occurs within each of the Clinical Divisions and corporate departments, the Patient Safety Team has a crucial role in providing direction and impetus for action, interpreting and acting on national guidance and facilitating change within divisions, providing the divisions with the tools, skills and methodologies. The team provides intelligent information on incidents, near misses and investigation outcomes and ensures consistency of approach to patient safety strategies and work-streams, encouraging linkages between divisions and corporate departments.