Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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Summary Report – Trust Board Meeting (Part 1)	**Date: 31 October 2012**
Report Title: Quality Assurance Framework Update	
Agenda Item: 17	**Enclosures:**
Sponsor: Director of Nursing	**Presenter: Director of Nursing**
Report Author	
Report discussed previously at:	EMT/TWMG/Professional Council

Purpose of the Report and Action required

The purpose of this report is to outline:

- The systems and processes currently in place, and the changes that are being made to ensure a robust quality assurance system across the Trust
- Proposals to improve the quality information management process through;
  - The establishment of an automated ward to board quality monitoring system based on key clinical quality indicators;
  - The production of a clinical quality dashboard;
  - Provision of more detailed quality information to Board members;
- Proposals for future Board quality assurance reporting based on SBU and area integrated quality reports using the same agreed clinical quality indicators.
- Immediate actions being undertaken to identify and agree quality priorities and hot spots and the actions being taken to address them;

Approval	x
Discussion	
Information	

Executive Summary of Key Issues

Quality is the organising principle of the Trust. The Board is clear that the quality assurance processes need to provide information that adequately enables the early identification of emerging quality concerns and that a coherent and comprehensive quality assurance framework needs to be in place to address issues as they arise. The framework as described is based on improving quality information and reflects the organisational restructure outlined in New Ways of Working.

Quality Assurance Framework Update

Which Strategic Objective does this paper address	
A sustainable value for money business	Y
Excellent service user access and experience	Y
Excellent partnership working with other organisations	N
Effective engagement and improvement in staff satisfaction	Y

Link to Fit for the Future Implementation Plan	
Objective 1	
Objective 2	

Corporate Impact Assessment	
Quality and Safety implications	The proposals will improve understanding of organisational quality issues and support quality improvements
Corporate Risk Register	*Type reference numbers only, separated by commas. Delete this row if not applicable.*

Recommendations to other committees
n/a

Recommendation/Decision
The Board is recommended to **approve** the recommendations at paragraph 8.1

Quality Assurance Framework Update

1. Introduction

1.1. The overarching context for the proposals in this paper is the Trust Fit for the Future Plan. The plan outlines the following commitments:

- put service users and carers at the centre of everything we do – every team, ward and staff member and the Trust Board;
- decentralise management and increase the local service authority of SBUs within a clear corporate accountability framework and governance;
- develop and implement a clinical engagement strategy to underpin local, SBU and Trust wide decision making and improve staff morale.

1.2 The Trust Board requires a more coherent and comprehensive quality assurance framework that works with other assurance systems. There needs to be increased use of evidence based assurance which is informed by the views of service users, carers and clinicians.

1.3 The test of an effective quality assurance framework would be its ability to provide the Board with advance information about the concerns identified, for example, in the SHA commissioned review of governance and management arrangements at AWP, the Wiltshire data quality issues, the North Bristol Recovery Team caseload management concerns and the CQC Lansdowne Unit review.

1.4 The quality assurance framework is constructed to meet the needs of the organisation, and in accordance with the challenges posed by the Monitor Quality Assessment Framework, and the Board Governance Assessment Framework.

1.5 The report from the National Commissioning Board published in August 2012 describes the principles of managing quality within the healthcare system. The report describes how improving quality is the responsibility of everyone working in the health service, both individually and collectively. Doctors, nurses and other health professionals, their ethos, values and behaviours are the first line of defence in maintaining quality. Whilst the leadership within organisations providing care is ultimately responsible for the quality of care provided to patients. The Quality Assurance process described in this document is aligned with these principles.

2 Quality Assurance Process

The Quality Assurance process is built on a structure of domains

- Setting and agreeing standards
- Assessing standards and diagnosing issues
- Managing improvements
- Auditing progress and change
- Escalation processes
- Enforcement processes.

2.1 Setting and Agreeing Standards

2.1.1 Organisational polices are agreed in accordance with CNST requirements. Policies need to be agreed with clinical and managerial input, and ratified by the relevant Board Committee. Policies need to be clear and 'user-friendly'. Policies are disseminated throughout the Trust using the Policy Alert system. The effectiveness of the Policy Alert system is monitored internally, reviewed as part of the Internal Audit work programme, and tested by CNST compliance.

2.1.2 Clinical Lead posts are currently being agreed across Care Pathways. These posts will be responsible for the 'affordable design' of the Care Pathways, for recommending standards to the organisation, and for identifying areas for improvement. This work will be done working closely with Professional Council and other professional groups in the Trust such as TMAG/TNAG.

2.1.3 Clinical Director roles will be responsible for ensuring the delivery of service standards in their area and for reporting on those standards to Board.

2.1.4 Professional Council is the organisational body with responsibility for agreeing service standards within the Trust's operating context.

2.1.5 Agreed service standards will align with the managerial, performance, and contractual requirements of the Trust, and with the Operating Framework.

2.1.6 Key Performance Indicators for quality will be agreed across the organisation, and ratified by Professional Council to underpin the structure of reporting across the organisation.

2.1.7 The revised Management Governance arrangements clarify responsibility for areas of work, and routes of accountability.

2.2 Assessing Standards and diagnosing issues

2.2.1 Professional Council will agree with Trust-wide Clinical Audit programme, and oversee the delivery of audits identified in local Quality Improvement Plans.

2.2.2 Clinical Leads will develop Clinical Networks and supporting audit programmes for their area of expertise.

2.2.3 Quality Management Information – including incidents, complaints, PALS, CQC information - will be available electronically at ward/team/area/Trust level.

2.2.4 The QUEST early warning trigger tool provides consistent information on a monthly basis to inform the organisation of current/potential issues of concern.

2.2.5 Patient Safety Walkabouts provide an opportunity for Board members to talk to teams/wards directly with a particular focus on patient safety.

2.2.6 Programme of unannounced visits by Senior Nursing Team, including night visits, provides an opportunity to 'test' quality issues across the Trust and to feed them into the improvement work.

2.2.7 Feedback from service users and carers, received through a variety of means – eg Service User Steering Group, Real-time surveys, direct to Board members etc – provides direct evidence of the experience of the service and its quality.

2.2.8 Action Plans resulting from CQC inspections will be monitored through the relevant service and reported to the Trust-wide Management Group.

2.2.9 SBU/areas/directorates will identify areas of risk and mitigating actions via their Risk Registers. Risks will escalate/de-escalate according to the Risk Management Framework. The Risk Management Framework is audited as part of the Internal Audit work programme. The Audit and Risk Committee scrutinises the Risk Register process, and the quality of individual Risk Registers.

2.2.10 Staff at all levels will deliver and receive supervision and appraisals to support them in the delivery of agreed quality standards.

2.2.11 Registration, re-registration, and medical revalidation require health and social care professionals to demonstrate competency of practice and acknowledge a personal responsibility for the delivery of quality care.

2.2.12 The Trust Accountability Framework provides a framework that enables staff to be clear and confident about their areas of accountability, and for that accountability to be challenged as required.

2.2.13 The Peer Review process will enable wards, teams, and service to review each others progress against agreed standards.

2.2.14 The Quality and Patient Safety report to Board will give an overview of current and emerging quality issues.

2.3 Management of Improvement.

2.3.1 Supervision structures will support staff to improve practice where individual issues are identified

2.3.2 Each SBU/area has a 'Practice Development' function to support service/team improvements.

2.3.3 SBU/area governance structures will monitor improvements.

2.3.4 SBU/areas will report improvements to the Board as appropriate as part of the agreed Quality Assurance Board reporting framework.

2.3.5 SBU/area/directorate Risk Registers will track the effectiveness of improvements in reducing/mitigating risks.

2.4 Auditing of Improvement

2.4.1 The Clinical Audit programme will focus on areas of agreed risk, or where development work has been needed.

2.4.2 The Quality and Safety Committee and the Risk and Audit Committee have roles in reviewing the effectiveness of Risk Registers across the Trust

2.4.3 The Nursing and Quality directorate works closely with SBU/areas to audit practice improvements to provide support and 'independent' assurance.

2.5 Escalation Processes

2.5.1 The management of Risk Registers at team, service/area, Trust level provides a process to escalate concerns.

2.5.2 SBU/area governance processes will monitor improvement actions and escalate concerns to TMG as appropriate.

2.5.3 Clinical Leads will escalate issues of concern to Professional Council.

2.5.4 If unable to resolve, Professional Council will escalate issues of unresolved concern to TMG

2.5.5 Individual practitioners will raise issues of concern through their management line, or through their professional line.

2.5.6 The Medical Director and the Director of Nursing are responsible for escalating unresolved clinical issues to Board.

2.5.7 Areas of concern as identified by the Board through quality assurance reports or any other process will be referred to relevant Board Committees for additional scrutiny.

2.5.8 The Trust has a 'Whistle-blowing' policy in place. The effectiveness of the policy/process is reported annually to Board.

2.6 Enforcement Process

2.6.1 To address issues of immediate patient safety or other identified significant risk not being addressed, the Medical Director and/or the Director of Nursing in consultation with the Chief Executive will instruct immediate action to be taken to reduce or mitigate the risk.

2.6.2 Services identified through inspection by the CQC as failing to meet standard/s to such an extent that the impact on service users is assessed as 'major' will be issued with an enforcement notice.

2.6.3 Known risks in the Trust that feature as 'high' on the Corporate Risk Register, and which existing management action appears unable to mitigate and/or reduce may be subject to an enforcement notice at the discretion of the Chief Executive.

2.6.4 Consistent non-delivery of quality standards by individual practitioners as identified and worked on as part of supervision processes will be managed through the Trust's HR processes.

Enforcement Actions are taken as a last resort, usually when AWP management action has been unable to resolve the situation. In this scenario, it is likely that the situation is beyond the internal control of AWP and that the Care Pathway and/or the service needs to be reviewed with external stakeholders.

3. Actions needed to deliver Framework as described.

Action	Directorate Responsible	Deadline for completion	Progress
Scope quality information management system, including initial proposals for Key Quality Indicators	IM&T	30 October 2012	Underway
Implement basic quality information management system	IM&T NCAS	30 November 2012	Awaiting outcome of scoping exercise
Implement more comprehensive quality information management system	IM&T NCAS	30 December 2012	Awaiting outcome of scoping exercise
Agree Key Quality Indicators to inform reporting, Quality Account etc	Professional Council/NCAS/ TMG	Mid-dec to inform above	Workshop agreed 5 domains.
Set Ourspace Quality Information pages	NCAS	31 January 2013	
Practice Development Team	Operations	As per New Ways of Working timetable	
Agree framework for quality Peer Review programme	NCAS	30 December 2012	
Establish quality Peer Review programme	Operations	As per New Ways of Working timetable	
Reprioritise clinical audit annual plan	NCAS	30 December 2012	
Introduce SBU and area integrated quality assurance reporting		As per New Ways of Working timetable	
Board agenda agreed to include Quality and Patient Safety paper.	HW/ER	For Dec Board	

4. Immediate actions to ensure existing quality concerns are identified and addressed.

4.1 SBU Clinical Directors and NCAS quality and governance leads met in October 2012 and identified and agreed a range of know quality concerns and organisational hotspots. A Trustwide quality sweep is now underway over the next month. SBU quality and governance leads will agree actions to address the concerns and will report progress to Trustwide Management Group. NCAS quality leads will support the SBUs in this process and will undertake independent monitoring and reporting. A fortnightly Quality and Patient Safety meeting will continue to monitor emerging concerns and organisational hotspots.

4.2 The Quality and Effectiveness Safety Trigger Tool (QuESTT) currently in use in inpatient and Crisis Teams is being reviewed and implemented across all community teams.

4.3 Clinical Directors recognise the potential risks to quality associated with the changes in the Trust New Ways of Working Plan. They will be monitoring the key quality indicators in relation to the changes. In addition they will be employing a quality handover tool to support those changes. This tool is based on the National Quality Board Quality Transition model.

4.4 An external consultant has been engaged to support the organisation to ensure its quality assurance processes are robust, and to make recommendations for improvements if identified.

5 Conclusion

5.1 Quality is the organising principle of the Trust. The Trust has an internal focus, and an external scrutiny on the quality assurance processes, and the delivery of a robust system is important.

5.2 Delivery of the quality assurance system is the responsibility of the Medical Director and the Director of Nursing. However, all parts of the Trust need to be sighted on the implementation plan, the alignment with the 'Fit for the Future' plan, and the implications for delivery.