Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Strategy: 2014-2019

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Foreword

Tees, Esk and Wear Valleys NHS Foundation Trust strives to continually develop and improve the services we provide to patients, their families and carers.

Our aim is to deliver the perfect patient experience, each and every time. This is not only about the effectiveness of our staff and the services they work in, but crucially is also about the way we work with each person who is referred to our services and, where appropriate their family and carers.

Our purpose is to improve lives by minimising the impact of mental ill health or a learning disability, and to help people lead a healthy, self determined life.

Martin Barkley Chief Executive

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What do we mean by quality?

We believe our services must:

- **Provide the perfect experience**- this means that the people who use our services consider that the way we work with them ensures that they are listened to, engaged with and treated with compassion, respect and dignity.
- **Be appropriate** – this means that treatment and care is safe, 'do no harm', be based on evidence and relevant to the needs of the individuals who use our services.
- **Be effective** – this means that what we do delivers the outcomes we expect and make a positive difference to people's lives.
- **Reduce waste** – this means we remove or minimise any activity that does not add value or is wasteful to people who use our services, our staff and our other stakeholders.
- **Build upon** the standards set by the Care Quality Commission and the other regulators we are accountable to.

Why do we need a Quality Strategy?

- To ensure we deliver the Trust's vision of being, **'a recognised centre of excellence with high quality staff providing high quality services that exceeds peoples expectations'.**
- To set a clear direction and expectations for our staff to deliver our vision for excellent quality of care.
- To ensure we provide excellent services, working with the users of our services and their carers to promote and deliver recovery and improved well being.
- To ensure that the quality and value of our work continues to improve.
- To ensure that TEWV remains clinically and financially sustainable.
- To ensure we are responding to national and local requirements and learning.*

* See national context and references section on page 8

Aims of this Quality Strategy

- To set the vision and direction for the further development and improvement of the quality care delivered by the Trust over the next 5 years.
- To communicate to staff the Trust‘s expectations in terms of their delivery of excellent patient experience and services.
- To provide frameworks for the development and monitoring of improvement work streams in the separate dimensions of quality care.
- To ensure there are clear processes for the assurance of care delivery and the performance of the governance systems.

Our ambition for quality

Our ambition is:

To ensure safe, patient centred and effective high quality care and treatment, delivered by valued individuals and teams.

Our Quality Goals and Objectives

Goal 1: Everyone who uses our services has a positive experience and feeds back that they were listened to, engaged in their care and treated with compassion, respect and dignity.

To deliver this we will ensure:

- That 90% of patients tell us that their overall experience of our services was excellent by 31st March 2017
- That all patients are given a choice of when and where their appointments take place by 31st March 2017
- A minimum of 90% of patients who require in-patient treatment are admitted to their local hospital or the hospital of their choice by 31st March 2016
- Each patient has a copy of their care plan, which they have been actively involved in developing, by 31st March 2015
- That by 2017/18 all our acute assessment and treatment beds will be in single en-suite bedrooms

Goal 2: We reduce to a minimum the harm that people who use our service suffer

To deliver this we will ensure:

- We reduce the incidence of harms caused to patients by at least 10% per year of this strategy
- That improvements to services and practice are made as a result of us learning lessons from audits, serious untoward incidents, complaints and feedback by 31st March 2016

Goal 3: We will deliver excellent outcomes as reported by patients and clinicians.

To deliver this we will ensure:

- Every team demonstrates a year on year improvement in patient reported outcomes
- Every team demonstrates a year on year improvement in clinician reported outcomes
- That all the services and treatments we deliver are evidence based.
- We have the right number of appropriately skilled staff to support the delivery of the improved outcomes

Goal 4: Our staff feel positively engaged with the Trust

To deliver this we will ensure:

- We will implement our Workforce Strategy and associated action plan.
- We deliver year on year improvement in local and national staff survey results throughout the lifetime of this strategy.

How will we deliver our Quality Strategy?

We will deliver this strategy through three frameworks:

- Patient Experience Framework
- Patient Safety Framework
- Clinical Effectiveness Framework

And through

- The Trust's Workforce Strategy.

- We will underpin the delivery of this strategy with the Clinical Assurance Framework and Frameworks for the Management, Assurance and Escalation of Risk.

- We will support the delivery of this strategy with the TEWV Quality Improvement System and implementation of a range of Trust strategies, notably the Recovery Strategy, the Estates and Facilities Management Strategy and professional strategies.

How do we know we are delivering our Quality Strategy?

- We will have a Quality Strategy Scorecard to measure the progress of the delivery of our Quality Strategy objectives, reviewed quarterly by the Quality and Assurance Committee and reported quarterly by the Board of Directors.
- We will have sub-groups of the Quality and Assurance Committee for patient experience, safety and clinical effectiveness that will monitor the delivery of the strategy through the Quality Strategy Scorecard metrics and the progress of the implementation plans of the relevant frameworks.
- We will measure the outputs of the Framework Implementation Plans and report progress to the Quality and Assurance Committee.
- We will have a Workforce Strategy Scorecard to measure the delivery of the Workforce Strategy, reported quarterly to the Board of Directors.
- We will use the Clinical Assurance Framework to ensure we are monitoring the quality of clinical care and providing assurance through our clinical and corporate governance systems.
- We will report progress against the annual quality priorities and publish that in the annual Quality Account

Quality Strategy Scorecard

No	Metric	Baseline 2013/14	Target 14/15	Target 15/16	Target 16/17	Target 17/18	Target 18/19
Patient Experience							
1	Percentage of patients surveyed reporting their overall experience as excellent	61%	70%	80%	90%	90%	90%
2	Percentage of patients who tell us they were given a choice of when their appointments was held	Not known	To collect baseline	TBD once baseline known	TBD once baseline known	TBD once baseline known	TBD once baseline known
3	Number of appointments cancelled by the Trust expressed as a rate per 10,000 total appointments	81.82	73.64	66.27	59.65	53.68	48.31
4	Percentage of patients admitted to the local hospital or hospital of their choice	84.47%	85%	90%	90%	90%	90%
5	Percentage of patients given a copy of their care plan	47.9%	100%*	100%	100%	100%	100%
6	Percentage of patients who report they have a copy of their care plan	65%	75%*	85%	90%	90%	90%
7	Percentage of community patients who state they have been involved in the development of their care plan	75%	80%*	85%	90%	90%	90%
8	Number of formal complaints received per 10,000 open caseload	32.97	29.67	26.71	24.03	21.63	19.47
Clinical Effectiveness							
9	Percentage of AMH inscope teams that achieve an improvement in the patient reported outcomes (SWEMWBS) for their patients	54%	60%	65%	69%	71%	75%
10	Percentage of MHSOP inscope teams that achieve an improvement in the patient reported outcomes (SWEMWBS) for their patients	38%	42%	46%	50%	55%	60%
11	Percentage of AMH inscope teams that achieve an improvement in the clinical reported outcomes (HoNOS) for their patients	50.60%	60%	70%	80%	83%	85%
12	Percentage of MHSOP inscope teams that achieve an improvement in the clinical reported outcomes (HoNOS) for their patients	15.79%	18%	21%	24%	27%	30%
13	Mean level of improvement in SWEMWBS (AMH)	5.69	5.97	6.27	6.58	6.91	7.26
14	Mean level of improvement in SWEMWBS (MHSOP)	3.35	3.52	3.67	3.88	4.07	4.28
15	Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis superclass (AMH & MHSOP)	38%	43%	48%	53%	58%	63%
16	Percentage of HoNOS ratings that have improved in the organic superclass (MHSOP)	25%	30%	35%	40%	45%	50%
17	Number of actions within NICE implementation plans showing as red	3	0	0	0	0	0
18	Percentage of audits of practice that demonstrate full compliance with NICE guidelines	54%	85%	85%	85%	85%	85%
19	Percentage of teams whose staffing levels are 20% or 2 WTE (which ever is highest) lower than plan	6.89%	6.0%	5.5%	5.0%	5.0%	5.0%
20	Percentage compliance with mandatory and statutory training (all not just core)	86.5%	90%	95%	95%	95%	95%
21	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	89%	95%	95%	95%	95%	95%
Patient Safety							
22	Percentage of practice change demonstrated following action taken as evidenced via audit	Not known	To collect baseline	TBD once baseline known	TBD once baseline known	TBD once baseline known	TBD once baseline known
23	Number of Level 3 and above patient related incidents (excluding self harm) expressed as a rate per 10,000 open caseload	81.32	73.19	65.87	59.28	53.35	48.02
24	Number of Level 3 and above self harm incidents expressed as a rate per 10,000 open caseload	63.95	57.56	51.8	46.62	41.96	37.76
Staff Engagement							
25	Staff Friends and Family scores**	Not known	To collect baseline	TBD once baseline known	TBD once baseline known	TBD once baseline known	TBD once baseline known

Notes

* The target shown is to be achieved by the month of March 2015 and not the financial year

** Absolute metric to be determined following national guidance being published

National Context and References for the development of the Quality Strategy:

- The need for the Trust to have an overarching Quality Strategy that clearly sets out the quality ambitions of the Trust and how those would be measured.

- The Care Quality Commission outcomes[1] set standards for the quality of care that we are required to demonstrate and these have been built into the Trust's Clinical Effectiveness Framework and systems.

- The NHS Outcomes Framework[2] re-emphasised the areas of quality improvement the NHS should be focussing on:

Domain	Area
Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Treating and caring for people in a safe environment and protecting them from avoidable harm

- These areas of quality have been incorporated into the strategy development through the implementation of our Recovery Strategy and the development of a Physical Health Care Strategy are part of our quest to improve the health, well being and outcomes for those who use our services.

- Several significant national developments have impacted on the strategy development– initially the feedback from the Keogh[3] reviews of patient safety and the report by Berwick[4] on Patient Safety in the NHS (2013), highlighted the need for clear quality statements about safety. Particularly the nature of harm and the aims to 'do no harm' and the focus on the important of learning lessons.

- 'Putting patients back in the picture' – Clwyd and Hart's 2013 review report[5] made a number of recommendations for management of complaints that will

need to be incorporated into the Trust systems. As complaints are such a key element of patient experience there are new issues for the Patient Experience Framework to incorporate. Again learning lessons is highlighted as a focus for organisations to use learning from complaints for improvement.

- Finally, the official government response to the public inquiry into the Mid-Staffordshire Trust, 'the Hard Truths'[6] focuses on the need for culture change to ensure the patient is placed first – built upon actions to ensure compassion, candour, transparency and continuous improvement. All these themes therefore are reflected in the vision and direction for this Quality Strategy – and will be evident in the work-streams and implementation plans.

- This Quality Strategy therefore sets out our ambition together with our integrated approach to improving and assuring quality and how we will measure our progress in achieving our ambition to improve quality to provide that perfect patient experience.

References

[1] CQC (2010) Essential Standards for Quality and Safety
[2] DH (2010) NHS Outcomes Framework
[3]NHS England (2013) Review of the Quality fo Care and Treatment in 14 NHS Hospital Trusts – Keogh B
[4] DH (2013) A promise to learn – A commitment to act: Improving the Safety of Patients in England – Berwick D
[5]DH (2013) Putting Patients Back in the Picture – A review of NHS hospital complaints systems – Clwyd A and Hart T
[6]DH (2013) The Hard Truths: The Journey to Putting Patients First

Patient Experience Framework: 2014-2019

Content

- What is the framework for?
- Why do we have a Patient Experience Framework?
- Aim of the Patient Experience Framework
- Quality strategy goals and objectives
- What do users of our service mean by quality of experience?
- How will we implement the framework?
- Patient Experience Systems
- Quality Strategy Scorecard Metrics for Patient Experience
- How will we know we are delivering our framework?
- National Context and references

What is the framework for?

- To enable the delivery of the Quality Strategy
- To help us provide the perfect patient experience to each and every person referred to our services.
- To ensure patient feedback is used to help continuous improvement of the services provided.
- To describe how we gather patient experience feedback on the quality indicators identified by users of our services as important in their experience.
- To set out how we assure that the services we provide are driven first and foremost by the outcomes and experiences of the people who use our services – that we, 'place the views and experiences of those that use services at the centre'.

Why do we have a Patient Experience Framework?

- To ensure that the achievement of our quality ambition is measured using information from people who use our services.
- To have effective processes that help us to understand the experiences of those who use our services so that we can improve them.
- To monitor the quality of our services from the experience of those who use them.
- To demonstrate how we learn from patient experience feedback.
- To ensure we respond to national and local learning about patient experience and expectations.

Aim of the framework

The aim of the Patient Experience Framework is to deliver the Quality Strategy Goal and Objectives for Patient Experience:

Goal 1:

Everyone who uses our services has a positive experience and feeds back that they were listened to, engaged in their care and treated with compassion, respect and dignity.

To deliver this we will ensure:

- That 90% of patients tell us that their overall experience of our services was excellent by 31st March 2017
- That all patients are given a choice of when and where their appointments take place by 31st March 2017
- A minimum of 90% of patients who require in-patient treatment are admitted to their local hospital or the hospital of their choice by 31st March 2016
- Each patient has a copy of their care plan, which they have been actively involved in developing, by 31st March 2015
- That by 2017/18 all our acute assessment and treatment beds will be in single en-suite bedrooms

What do users of our service mean by quality of experience?

Following consultation service users identified the top ten indicators of quality as:

- Attitudes of staff
- Respect and dignity
- Being involved in and informed about decisions
- The environment
- Safety
- Activities
- Care and treatment including treatment options
- Access and appointments
- Staff knowledge and expertise
- Type, choice and availability of food.

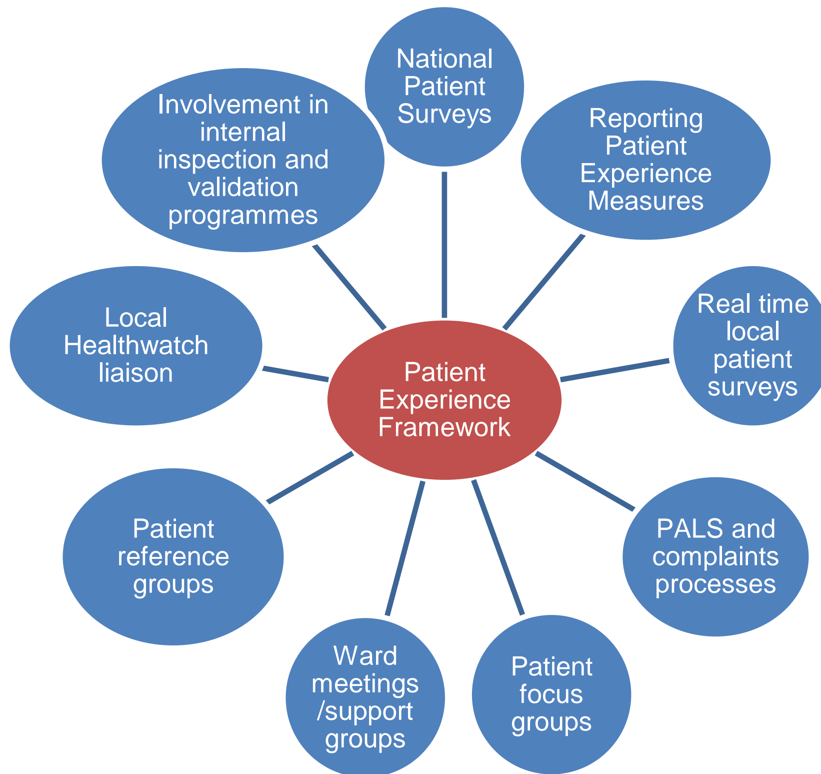
These are used to inform questions in local electronic patient surveys and we will continue to ask our patients what quality means to them as a basis for what we ask in the future.

How we will implement the framework?

We will:

- Develop and monitor the implementation plan to ensure delivery of the Framework
- Establish the Patient Experience Group as a Trust wide governance group reporting to the Quality and Assurance Committee
- Gather patient feedback on a periodic and real time basis, collecting feedback using a range of methodologies to meet patient need and access
- Manage comments, concerns, complaints and compliments through an effective and timely process
- Have systems to identify lessons learned from the review of concerns and complaints for dissemination and to take appropriate action
- Implement processes to publish patient experience and complaints information
- Have data management processes to ensure all patient experience information is collated and reported to services in a timely manner
- Have processes to review and learn from reflection upon information and take appropriate action
- Use systems to monitor that feedback is acted upon in a timely manner
- Follow up the implementation of actions taken to address lessons learned
- Monitor the use of patient feedback in service and practice improvement activity.

Patient experience systems



Quality Strategy Scorecard Metrics for Patient Experience

No	Metric	Baseline 2013/14	Target 14/15	Target 15/16	Target 16/17	Target 17/18	Target 18/19
Patient Experience							
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Note *The target shown is to be achieved by the month of March 2015

How will we know we are delivering our framework?

The Patient Experience Group will monitor the delivery of this framework by:

- Developing and monitoring the progress of the Framework Implementation Plan to achieve the objectives.
- Collating and monitoring the scorecard metrics for the relevant Quality Strategy goals and objectives.
- Reviewing the trends, risks and key issues from the patient experience information that is monitored by the Directorate Quality and Assurance Groups and the Locality Management and Governance Boards.
- Monitoring the key performance indicators for the corporate systems that support delivery of this framework.
- Monitoring information and managing the performance of the patient experience improvement projects and standing working groups.
- Producing monthly reports for the Quality and Assurance Committee to demonstrate progress and performance.
- Producing reports for the Council of Governors and its relevant working groups to demonstrate progress.

National Context and References

- The Department of Health (2011, Better Health, Better Experience, Better Engagement) suggests that engagement consists of:

  Patient Experience: engagement activities capture direct feedback from patients, service users, carers and the wider communities, which is used alongside information on clinical outcomes and other intelligence t inform quality improvements, reshaping of local services and contractual arrangements with providers.

- The NHS Confederation (2011) states that whilst good clinical outcomes and processes are important elements of patient experience it is far more than this: "*Experience is also determined by the physical environment patients are in and how they feel about the care they receive, including the way staff interact with them. Improving the experiences of all patients starts by treating each of them individually to ensure they receive the right care, at the right time, in the right way for them*" (NHS Confederation 2011)

- The complaints processes will be compliant with the NHS Complaints Regulations (2009) and the Health Service Ombudsman's Principles of Good Complaints Handling (2009).

- The complaints processes will reflect the learning and recommendations from the national review – DH (2013) Putting Patients Back in the Picture – A review of NHS hospital complaints systems – Clwyd A and Hart T.

- The Patient Experience systems will meet the requirements of the Care Quality Commission (CQC) to comply with Outcome 1 of Regulation 17, measuring whether the Trust is 'respecting and involving people who use services'.

- The Trust is committed to Section 242 of the NHS Act 2006 to consult and provide information to patients when new developments or proposals for change are being considered and this will demonstrated in the involvement processes.

Patient Safety Framework: 2014-2019

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- What is the framework for?
- Why do we have a patient safety framework?
- Aim of the patient safety framework
- Quality strategy goals and objectives
- The TEWV definition of harm
- How will we implement the framework?
- Patient Safety Systems
- Quality Strategy Scorecard Metrics for Patient Safety
- How will we know we are delivering our framework?

What is the framework for?

- To enable the delivery of the Quality Strategy
- To ensure that treatment and care should be appropriate, safe and 'do no harm'
- To reduce harm to the users of our services
- To provide excellent services, working with the individual users of our services and their carers to promote recovery and well being
- To support the continuous improvement of the safety and value of our services
- To describe how we will monitor and improve patient safety by working together with all staff and people who use our services to achieve the safest outcomes.

Why do we have a Patient Safety Framework?

- To help assure our services are safe
- To outline how we report on the safety of our services
- To clarify the relationship with all elements of harm reduction and increased safety
- To set out the steps we take to reduce harm to service users
- To demonstrate how these improvement steps inform each other
- To set out how learning from patient safety incidents, errors and omissions can be used to improve patient safety and the quality of our services.

Aim of the Framework

The aim of the Patient Safety Framework is to the deliver the Quality Strategy goal and objectives for Quality Strategy

Goal 2: We reduce to a minimum the harm that people who use our service suffer

To deliver this we will ensure:

- We reduce the amount of harms caused to patients by at least 10% per year of this Strategy
- That improvements to services and practice are made as a result of us learning lessons from audits, serious untoward incidents, complaints and feedback by 31st March 2016.

In delivering the goal the Framework aims to:

- **Communicate that we define a harm**, within mental health and learning disabilities, as a '*multifaceted concept which is best informed by the patient themselves, their family and carers and our clinicians'*
- **Ensure understanding** of the importance of engagement of patients, and where possible, their families and carers, in making decisions about health and treatment – ensuring they are fully informed about potential harms and risks and how best to manage them
- **Ensure** that we recognise that the patient's view of harm will evolve over time, and that it is, therefore, important that the target of harm reduction – and actions taken to reduce harm are revisited regularly
- **Recognise** that in ensuring safe services our clinicians, who have gathered and interpreted information come to the decision making discussions about health and treatment with their own views, emotions and professional judgements. It is expected that all clinicians however work in accordance with Trust policies and professional standards and that the discussions are open, honest, transparent, broad, multi-disciplinary (where appropriate) and accurately documented.

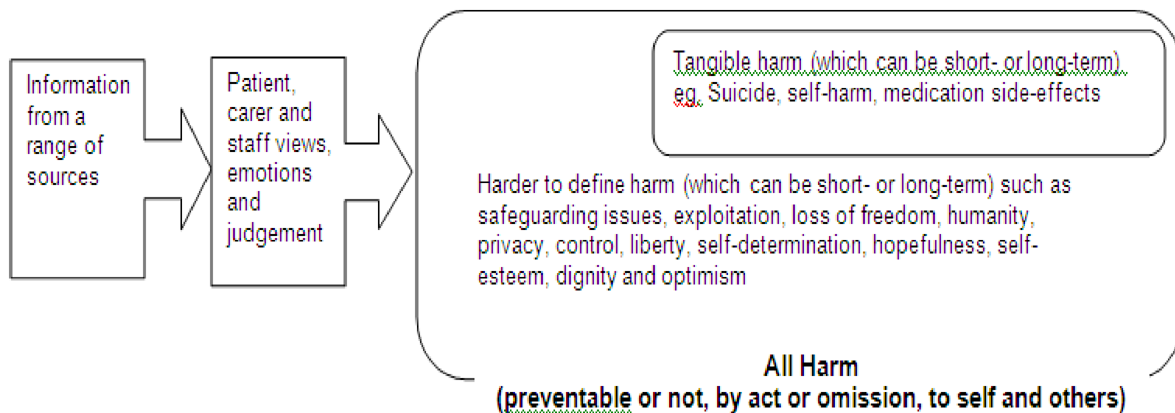
TEWV's definition of harm

We recognise that in supporting patients to make decisions about potential harm and how those harms should be managed, it is necessary to see harms in the broadest sense to include:

- Tangible harm – such as suicide, self-harm, falls, physical health deterioration, mediation adverse reactions, neglect and vulnerability

- Harder to define harm may include safeguarding, exploitation, or loss of: freedom, humanity, privacy, control, liberty, self-determination, hopefulness, self-esteem, dignity, optimism (This list is not exhaustive)
- Short term harm (that might require physical healthcare or lead to an inability to pursue one's interests) and long term harm, such as loss of confidence, independence or inspiration
- Harm as a result of an act and/or of omission
- Harm to self and others.

A diagram to conceptualise the definition of harm:



What will we do to deliver harm reduction and improve safety?

To improve safety and reduce harm we will:

- Strengthen our methods and systems to prevent harm
- Support recovery and well being
- Be open and supportive when harm occurs
- Learn lessons and share learning
- Enhance a safety culture

How will we implement the Framework?

We will:

- Develop and monitor the implementation plan to ensure delivery of the Framework
- Establish the Patient Safety Group as a Trust wide governance group reporting to the Quality and Assurance Committee
- Gather patient safety incident information on a periodic and real time basis, tracking risks and trends
- Manage local and national incident reporting and investigation by an effective and timely process

- Use national patient safety information for benchmarking the performance and position of the Trust
- Have systems to identify lessons learned from the review of incidents and alerts for dissemination and take appropriate action
- Implement processes to publish patient safety information
- Have data management processes to ensure all patient safety information is collated and reported to services in a timely manner
- Have processes to review and learn from reflection upon information and take action
- Use systems to monitor that feedback is acted upon in a timely manner
- Follow up the implementation of actions taken to address lessons learned
- Monitor the use of patient safety information and learning in service and practice improvement activity.

Patient safety systems

Quality Strategy Scorecard Metrics for Patient Safety

No	Metric	Baseline 2013/14	Target 14/15	Target 15/16	Target 16/17	Target 17/18	Target 18/19
Patient Safety							
22	Percentage of practice change demonstrated following action taken as evidenced via audit	Not known	To collect baseline	TBD once baseline known	TBD once baseline known	TBD once baseline known	TBD once baseline known
23	Number of Level 3 and above patient related incidents (excluding self harm) expressed as a rate per 10,000 open caseload	81.32	73.19	65.87	59.28	53.35	48.02
24	Number of Level 3 and above self harm incidents expressed as a rate per 10,000 open caseload	63.95	57.56	51.8	46.62	41.96	37.76

How will we know we are delivering our Framework?

The Patient Safety Group will monitor the delivery of this Framework by:

- Developing and monitoring the progress of the Framework Implementation Plan to achieve the objectives
- Collating and monitoring the scorecard metrics for the relevant Quality Strategy Goals and Objectives
- Reviewing the trends, risks and key issues from the patient safety information that is monitored by the Directorate Quality and Assurance Groups and Locality Management and Governance Boards
- Monitoring information and managing the performance of the patient safety improvement projects and standing working groups
- Monitoring the key performance indicators for the corporate systems that will support delivery of this Framework
- Producing reports for the Quality and Assurance Committee to demonstrate progress and performance
- Producing reports for the Council of Governors and it’s relevant working groups to demonstrate progress as required.

Clinical Effectiveness Framework: 2014-2019

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- What is the framework for?
- Why do we have a Clinical Effectiveness Framework?
- Aim of the Clinical Effectiveness Framework
- Quality strategy goal and objectives
- TEWV Service Users and Carers description of Effectiveness
- How will we implement the framework?
- Clinical Effectiveness Systems
- Quality Strategy Scorecard Metrics for Clinical Effectiveness
- How will we know we are delivering our framework?
- National Context and references

What is the Framework for?

- To enable the delivery of the Quality Strategy, that will ensure what we do delivers the outcomes that make a positive difference to people's lives
- To ensure continuous improvement of services is based on information on the effectiveness and outcomes of our services
- To describe how we measure the effectiveness of services, treatments and pathways
- To set out how we assure ourselves – that we have quality services driven by ensuring that the people who can then demonstrate positive outcomes and improvement, following care and treatment.

Why do we have a Clinical Effectiveness Framework?

- To ensure that clinical practice is explicitly evidence based with the goal of ensuring the best possible outcomes for the people who use our services.
- To have systems to regularly review clinical service and practice delivery to ensure practice is based on well founded and contemporary information and in line with national and local guidance and policy.
- To have information available about the effectiveness of our services to give assurance that treatment and care is safe, is evidence based and is relevant to the needs of the individuals who use them.
- To ensure we assess and monitor clinical service and practice delivery to identify change required for improvement and to demonstrate whether changes made have improved the quality and clinical cost effectiveness of the practices.

Aim of the framework

Goal 3: We will deliver excellent outcomes as reported by patients and clinicians.

To deliver this we will ensure:

- Every team demonstrates a year on year improvement in patient reported outcomes
- Every team demonstrates a year on year improvement in clinician reported outcomes
- That all the services and treatment we deliver are evidence based.
- We have the right number of appropriately skilled staff to support the delivery of the improved outcomes

TEWV Service Users and Carers describe effectiveness as:

- Happy contented patients
- Safe
- Quality of life
- Purposeful and meaningful
- Effective care
- Good outcomes for the patient
- Involved patients
- Dignity
- Being listened to
- Identifying service user and carer needs
- Staff care and have empathy
- Staff being aware of and working with peoples needs in a compassionate respectful and dignified manner
- Regular medication reviews
- Identifying when medication is not working
- Owned by patients as well as staff
- Consistent, high quality and effectively managed
- Being aware of risks
- Acute and MH teams working in tandem where patients have physical and MH problems
- Families and carers are important and involved
- Carers being involved in the patient's recovery
- Being aware of carers issues
- Having a regular care review
- Advocacy
- Measureable
- Appropriate signposting and support

How will we implement the Framework?

To deliver this we will :

- Develop and monitor the implementation plan to ensure delivery of the Framework
- Establish the Clinical Effectiveness Group as a Trustwide governance group reporting to the Quality and Assurance Committee
- Gather clinical effectiveness information on a periodic and real time basis, collecting data using a range of methodologies for example inspection and audit findings
- Manage the development and delivery of the annual clinical audit programme by an effective and timely process, involving the Speciality Development Groups
- Have systems to identify lessons learned from the review of audit and inspection findings for dissemination and to take appropriate action
- Implement the relevant NICE guidelines
- Develop and implement evidence based patient pathways that incorporate NICE guidelines
- Implement processes to publish clinical effectiveness information
- Have data management processes to ensure all clinical effectiveness information, including Clinician Reported and Patient Reported Outcome Measure (CROM and PROM) data is collated and reported to services in a timely manner
- Use systems to monitor that findings of audits, surveys and reviews are acted upon in a timely manner
- Follow up the implementation of actions taken to address lessons learned
- Monitor the use of clinical effectiveness findings in service and practice improvement activity
- Provide fora for involvement of people who use services in the monitoring of clinical effectiveness.

Clinical Effectiveness systems

Quality Strategy Scorecard Metrics for Clinical Effectiveness

No	Metric	Baseline 2013/14	Target 14/15	Target 15/16	Target 16/17	Target 17/18	Target 18/19
Clinical Effectiveness							
9	Percentage of AMH inscope teams that achieve an improvement in the patient reported outcomes (SWEMWBS) for their patients	54%	60%	65%	69%	71%	75%
10	Percentage of MHSOP inscope teams that achieve an improvement in the patient reported outcomes (SWEMWBS) for their patients	38%	42%	46%	50%	55%	60%
11	Percentage of AMH inscope teams that achieve an improvement in the clinical reported outcomes (HoNOS) for their patients	50.60%	60%	70%	80%	83%	85%
12	Percentage of MHSOP inscope teams that achieve an improvement in the clinical reported outcomes (HoNOS) for their patients	15.79%	18%	21%	24%	27%	30%
13	Mean level of improvement in SWEMWBS (AMH)	5.69	5.97	6.27	6.58	6.91	7.26
14	Mean level of improvement in SWEMWBS (MHSOP)	3.35	3.52	3.67	3.88	4.07	4.28
15	Percentage of HoNOS ratings that have improved in the non-psychotic and psychosis superclass (AMH & MHSOP)	38%	43%	48%	53%	58%	63%
16	Percentage of HoNOS ratings that have improved in the organic superclass (MHSOP)	25%	30%	35%	40%	45%	50%
17	Number of actions within NICE implementation plans showing as red	3	0	0	0	0	0
18	Percentage of audits of practice that demonstrate full compliance with NICE guidelines	54%	85%	85%	85%	85%	85%
19	Percentage of teams whose staffing levels are 20% or 2 WTE (which ever is highest) lower than plan	6.89%	6.0%	5.5%	5.0%	5.0%	5.0%
20	Percentage compliance with mandatory and statutory training (all not just core)	86.5%	90%	95%	95%	95%	95%
21	Percentage of staff in post more than 12 months with a current appraisal (snapshot)	89%	95%	95%	95%	95%	95%

How will we know we are delivering our framework?

The Clinical Effectiveness Group will monitor the delivery of this framework by

- Developing and monitoring the progress of the Framework Implementation Plan to achieve the objectives.
- Collating and monitoring the scorecard metrics for the relevant Quality Strategy Goals and objectives
- Reviewing the tends, risks and key issues from the clinical effectiveness information that is monitored by the Directorate Quality and Assurance Groups and the Locality Management and Governance Boards
- Providing information to the Speciality Development Groups to support them in developing and monitoring practice standards and implementation plans for NICE guidance
- Monitoring the key performance indicators for the corporate systems that support delivery of this framework
- Monitoring information and managing the performance of the clinical effectiveness improvement projects and standing working groups.
- Producing monthly reports for the Quality and Assurance Committee to demonstrate progress and performance
- Producing reports for the Council of Governors and its relevant working groups to demonstrate progress.

National Context and References

The Clinical Effectiveness Framework of the Trust is based on the National Strategy for Improving Quality in the NHS: The three key elements to the NHS Executive's model for achieving clinical effectiveness (NHSE, 1996) which supports this are:

Inform: Identifying evidence based information regarding clinically and cost effective practice and making it available to clinicians, managers and patients

Change: Reviewing routine clinical and managerial practice and changing practice and services where necessary to ensure they are based on well-founded information

Monitor: Assessing and monitoring practice to demonstrate how changes have improved the quality, clinical and cost effectiveness of patient care and treatment. This relies on a range of tools to evidence best practice including: clinical audit, outcome measurement and benchmarking.

Clinical Assurance Framework: 2014-2019

Content

- What is the Clinical Assurance Framework for?
- What is a Clinical Assurance Framework?
- What are our principal risks?
- What are our controls in the framework?
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- Trust wide governance groups
- Assurance Information
- What does the framework look like?
- Clinical Assurance reporting
- Implementing the framework
- How will we know we are delivering the framework?

What is the clinical assurance framework for?

- To enable the Board of Directors to monitor the quality of and risks to the delivery of our services.
- To enable our Directors of Operations and their managers to manage the quality of and risks to the delivery of our services.
- To outline the systems and processes that we use to monitor and measure quality.
- To support the delivery of the Quality Strategy.

What is a clinical assurance framework ?

- **Clinical Assurance Framework:** A structure within which the Board of Directors identifies the **principal risks** to the Trust meeting its objectives of delivery of services and through which we map out both the **key controls** to manage those risks and how the Board have gained sufficient **assurance** about the effectiveness of those controls.
- **Assurance:** Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved.
- **Assurance Data:** Information used to evidence that the internal controls are operating and that objectives are being achieved.
- **Controls:** The many different things that are in place to mitigate risk and assist in securing the delivery of objectives. They should make a risk less likely to happen, or reduce its effect if it does happen.

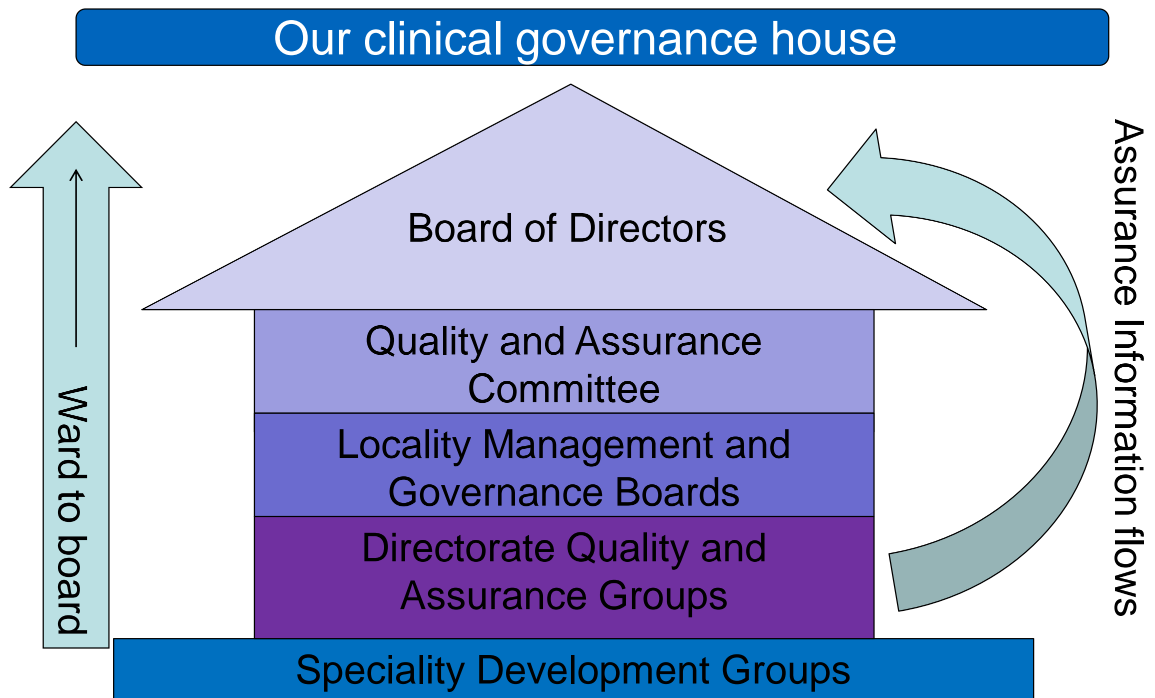
What are our principal risks?

- Poor quality care.
- Harm to patients.
- Bad patient experience.
- Ineffective treatment leading to poor outcomes.
- Non compliance with quality standards.
- Non compliance with requirements that could impact on our ability to maintain registration/licensing with our regulators and fulfil our contracts with commissioners.

What are our controls in the framework?

The **clinical governance structures** ensure there is engagement and ownership throughout the Trust in the quality and assurance agenda for services.

- The clear lines of accountability -from the teams to their Directorate Quality and Assurance Groups, to their Locality Management and Governance Boards to the Quality and Assurance Committee and to the Board of Directors – give a direct line of governance from ‘ward to board’ to act as controls and a system for escalation in managing risk.
- The Speciality Development Groups lead the development of clinical standards, through the design of clinical pathways based on NICE guidelines and other evidence. This facilitates the learning and adoption of best practice from and between different parts of the Trust. This helps mitigate and control the risks of ineffective or inappropriate care through geographical variation.



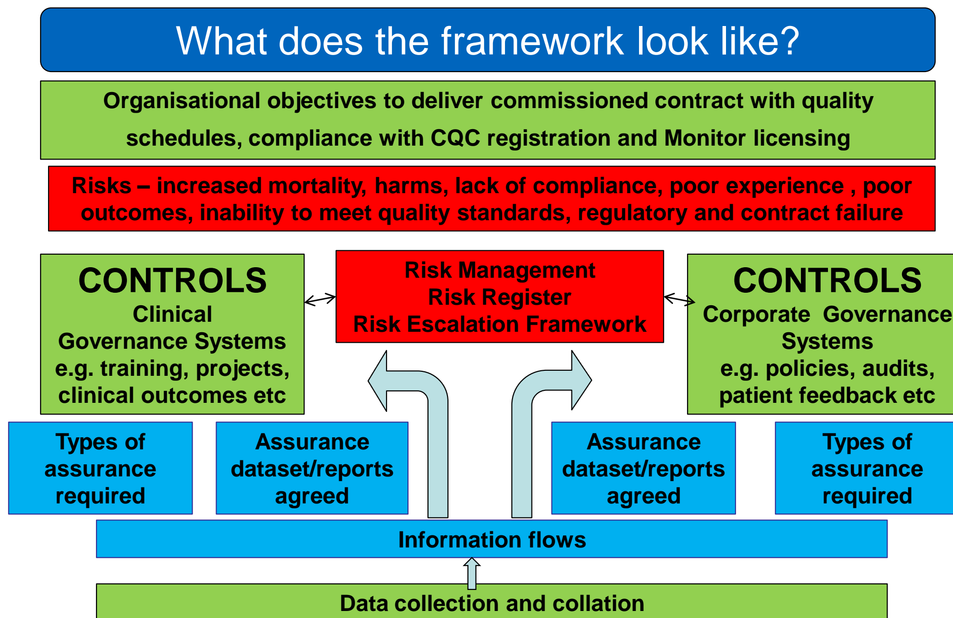
What are our controls in the framework?

The Trust governance groups and corporate teams provide controls by the management of the policies, procedures and work programmes they are responsible for. The data they collate and information they produce, for feedback to the clinical services, acts as a further control enabling services to reflect on their performance, highlight and manage potential risks and secure improvement.

- Controls to risks are also Trust policies, procedures and standard work, supported by training, to enable the workforce to deliver the agreed standards of care and treatment. Training and education, staffing profiles, clear job roles , data systems, the project framework and improvement plans all mitigate against risk and prevent risks impacting on delivery of direct care and Trust business.
- The Trust governance groups and corporate teams have key performance indicators through which systems can be monitored. Compliance with policy is checked by audit programmes.
- The Assurance and Escalation Framework outlines the steps required to set controls, develop mitigation plans and what is to be done if risks change, or controls and mitigation fails.

Assurance Information

- **Assurance information** is not just descriptive 'reassurance' or the absence of risk –it is hard figures or information representing some form of activity.
- Assurance information can be performance data for activity or compliance, it can be outcome or survey data or can be inspection or audit data. Controls used for mitigation will also produce assurance data- e.g. training information.
- Information may be collected about negative issues –e.g. Incidents or complaints – here it is the monitoring of the quantity and themes that is important to ensure there are no system or individual practitioner failings that are presenting risks to delivery of quality care.
- Performance data from systems, monitoring data from key performance indicators and progress outputs from projects can all be used as assurance information.
- The types of assurance information will be defined for the clinical assurance framework. Standard agendas for Directorate QuAGs, LMGBs and QuAC as well as predesigned governance datasets demonstrate the assurance information that can and should be monitored. Targets and thresholds will be adjusted to identify where risks and performance have changed and where escalation is required.



Clinical Assurance information reporting

- The monitoring data on clinical services is collated monthly by corporate teams into standard monthly reports to the Directorate Quality and Assurance Groups (QuAGs)
- Assurance reports are produced from that data, by QuAGs for the Locality Management and Governance Boards who, by further analysis, produce a standard exception assurance report on the quality of and risks to service provision for the Quality and Assurance Committee (QuAC)
- A monthly Governance Report to the QuAC summarises the locality and Trust position on an agreed range of quality and safety indicators , demonstrating potential trends and outliers
- A monthly progress report on the Quality Strategy Scorecard Metrics is reviewed by the appropriate governance sub-groups to the QuAC, with a quarterly update reported to the QuAC and the Board of Directors
- The QuAC receives regular standard assurance reports from the other sub-groups as well as progress reports on the Workforce Strategy Scorecard and information reports from other corporate Trust committees and groups on issues related to quality, eg the Mental Health Legislation Committee
- Corporate governance teams produce information for the QuAC governance sub-groups who will report to the QuAC against a number of key performance indicators for corporate governance systems and on the progress of Quality Strategy Framework Implementation Plans

- Many of the QuAC governance sub-groups have standing work streams and improvement projects – information on progress and the assurance that provides is also reported to the QuAC
- Any of the governance groups can request additional assurance reports
- The QuAC reports monthly to the Board of Directors, covering the clinical governance assurance reports and information from the Trust governance groups
- The Council of Governors receives a number of assurance reports that have been discussed at the QuAC
- The governance information flows have been summarised in a standard document.

Implementing the framework

We will ensure:

- Agreed information flows through the operational and governance systems.
- Standard datasets available to clinical governance groups and committees
- Thresholds and standards set in key performance areas with clear agreement on exception levels for reporting
- Standard terms of reference and agendas for key governance groups and templates for minutes and regular reports
- Clear roles and expectations of individuals and teams with regard to management and governance accountability
- Clarity of risk management and escalation frameworks
- Systems of induction and advice for staff to ensure understanding of the framework and governance systems.

How will we know we are delivering our framework?

- Ability to demonstrate the monitoring of the quality of care, the outcomes and the experience received by patients
- Effective controls are mitigating against the risks – as demonstrated by the ongoing delivery of services
- Monitoring of the information flows and assurance reporting
- Risk registers and the escalation framework implementation
- Regular reports and information availability.

Quality Improvement System

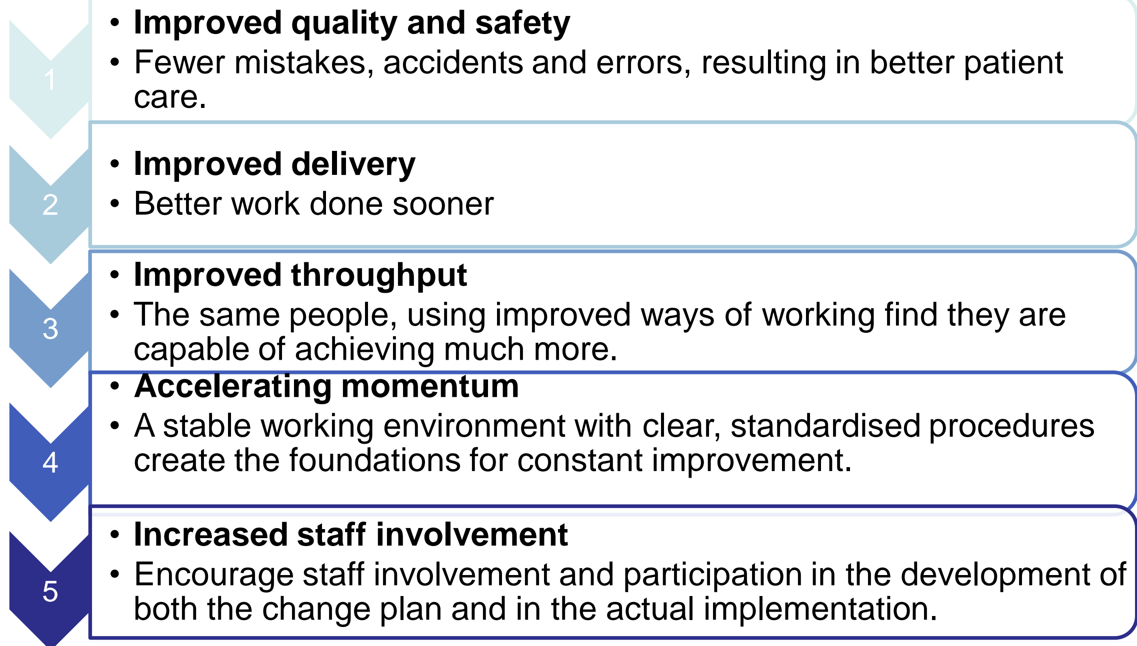
TEWV Quality Improvement System

Our Quality Improvement System (QIS) is not just a set of tools, it’s the way we do things at TEWV to eliminate waste and improve quality

- In 2007, we committed, as part of a ten year strategy, to drive up quality and patient safety. We created the Kaizen Promotion Office (KPO) and worked closely with a United States healthcare provider, who had successfully translated methodologies derived from Toyota, to improve the quality of care provided to patients
- Since 2007 we have consistently strived to embed a culture of quality improvement in our Trust, in order to continuously improve the quality of care we provide to our patients
- Using a simple philosophy incorporating vision, compact and method and by putting the patient at the heart of everything we do, the Trust has continued to utilise this methodology at scale and pace since 2007

What is QIS?

- TEWV QIS is about improving the ways we do things within the Trust by identifying and removing wasteful activities and focusing on those that add value to our ‘customers’, especially those who use our services and their carers
- A significant number of TEVW staff are trained as leaders in the methodology and nearly two thousand have taken part in improvement activities and events
- It is based on the belief that the staff know what to improve, how to eliminate waste and reduce non value adding activity. We believe it is the job of management to make the time and improvement methods available to staff to enable them to make those improvements.



QIS and the Quality Strategy

- An annual programme of quality improvement activity, that is supported by the KPO is developed each year based on the key priorities of the Board of Directors in the business planning
- In addition Directorates identify and carry out their own improvement events to address areas of quality and performance. Each Directorate has a number of trained and accredited QIS leaders to make this possible
- QIS methodology is therefore an important enabler of realising the ambition of the Quality Strategy –

To ensure safe, patient centred and effective high quality care and treatment, delivered by valued individuals and teams