Foundation Trust Programme Update

Agenda Item:	15	**Reference:**	WCT14/15-138
Meeting Name:	Trust Board	**Meeting Date:**	3 September 2014
Lead Director:	Alison Hughes		
Job Title:	Trust Board Secretary		

Link to Business Plan:					
Has an Equality Impact Assessment (EQIA) been undertaken & attached?	**Yes** ☐	**No** ☑	**N/A** ☐		
Have the Public & Stakeholders been consulted?	**Yes** ☐	**No** ☑	**N/A** ☐		
To Approve ☐	**To Note** ☐	**To Assure** ☑			

Financial Implications:
E.g. What is the Impact on the Trust? Does it provide Value for Money?
All costs should be clearly explained in the section below.

Dependant on achieving Foundation Trust status.

Overall Cost / Pressure:	**n/a**	**Overall Income:**	**n/a**
Additional Funding Required:	**n/a**	**Funding Already Ring Fenced:**	**n/a**

Identified Risks:

Ability to deliver the organisational change to meet NHS policy within the financial envelope and timescales set by Department of Health.

Assurance to Board:

Programme management arrangements, overall timetable and risks to achieving FT status determined, as set out in this paper.

Publish on Website: Yes ☑ No ☐	**Private Business:** Yes ☐ No ☑

Report History		
Submitted to	**Date**	**Brief Summary of Outcome**
Regular report submitted each month		

Wirral Community NHS Trust

Foundation Trust Programme - Update

Purpose

1. The purpose of this paper is to provide an update with regard to the trust's progress with its application for Foundation Trust status.

General Programme Update

2. The programme plan and associated actions are on track to support continued delivery to the anticipated timetable.

3. The trust submitted its five year Integrated Business Plan, long term financial model and associated strategies to the TDA in line with the national deadline of 20 June 2014.

4. The CQC Chief inspector of Hospitals visit commenced on 1 September 2014.

5. The trust continues to work with Monitor to undertake a Quality Governance Assurance Framework (QGAF) review under the new approach to QGAF. This involves the external review during the TDA phase of an FT application being undertaken by Monitor rather than an independent body. This ensures consistency with the review when entering the Monitor phase of an FT application.

Work stream updates

Business planning work stream

6. The Trust has submitted is five year business plans to the TDA in line with the national deadline of 20 June.

7. Plans were submitted in the form of an updated Integrated Business Plan (IBP) and Long Term Financial Model (LTFM). These are the seventh version of the trust's documents and set out plans and financial expectation for 2014-2019.

8. The formal submission comprised the following documents

    i) Integrated Business Plan 2014 – 2019
    ii) Base Case Long Term Financial Model (LTFM)
    iii) Downside LTFM
    iv) Mitigated Downside LTFM
    v) Summary of five year plans
    vi) Activity plans
    vii) Five year Workforce Plans

9. The submissions show the clear alignment of trust plans with the wider health and social care economy and demonstrate the delivery of high quality, safe, effective and responsive services which are financially sustainable.

10. The submitted documents demonstrate the case for foundation trust status.

11. Initial feedback from the TDA suggests there are no identified concerns with the plans submitted.

12. The next key milestone involves the submission of a development support plan associated with the IBP. This will be submitted to the TDA by 30 September.

Quality work stream

13. There has been significant progress in the quality work stream with developments in two key areas.

14. The trust's inspection under the CQC Chief Inspector of Hospitals inspection regime commenced on 1 September 2014.

15. This is a highly significant event in its own right and something we welcome as an opportunity to demonstrate the high quality care we provide. It is also a significant part of the foundation trust application process as both the TDA and Monitor will not approve FT applications at either of their final approval stages without satisfactory sign off as good or outstanding by the CQC under the new regime.

16. The programme of planned inspections will continue up to 6 September but it is possible for the CQC team to complete unannounced inspections as a follow up during the 10 working days post-inspection. The inspection also includes a new element which is specifically focused on GP OOHs services.

17. The inspection includes a variety of visits to services and clinics, including home visits, and four staff focus groups with Health Visitors, Community Nurses, Allied Health Professionals and Specialist Nurses.

18. The draft report from the CQC will be provided to the trust in mid-late October, providing an opportunity for the trust to respond ahead of the Quality Summit which will take place on 11 November 2014.

19. A thorough programme of work to prepare for the inspection has been completed reviewing the trust's services against the five CQC domains of Safe, Effective, Caring, Responsive and Well-led.

20. In addition to the preparation for the Chief Inspector of Hospitals inspection the trust has been has engaged with Monitor on a review of our Quality Governance Assurance Framework (QGAF). This work has been on-going since mid-July and has included a thorough review of information, a series of interviews with teams across the trust, staff focus groups and board and committee observations. The programme of work will continue until 8 September when a board confirm and challenge session will be held with Monitor to review their findings.

21. At the end of the review Monitor will submit their overall assessment of the trust's QGAF score, which will ensure consistency as we move from the TDA phase of our FT application to the Monitor phase.

22. We will continue to keep the Board updated on developments with both the CQC inspection and the Monitor QGAF review.

Finance and performance work stream

23. As described above the trust's five year financial plans have been submitted to the TDA. These consist of base case financial plans, the testing of the sensitivity of those plans and associated assumptions to risks, and the plans to mitigate risks.

24. These plans show, subject to the delivery of challenging CIP savings each year of 4% - 5%, the Trust maintains a financial surplus of more than 1%, a healthy case position and a continuity of services risk rating of four for each of the five years of the planning period.

25. The plans are sensitive to assumptions on the delivery of CIP, the annual NHS tariff deflator and pay inflation, however the assumption made in the plans are robust and prudent.

26. Under a so called "downside" scenario the trust would be able to maintain its surplus, cash balance and risk rating through the delivery of identified mitigating actions.

TDA reporting

27. The Trust has submitted its fourth set of monthly TDA monitoring returns for 2014/15. These were agreed at the August Finance and Performance Committee and relate to the month of July.

28. The Trust has undertaken to recover its slower than planned in-year delivery of CIP savings and to be back on profile by the end of December.

29. The Finance and Performance Committee reviewed the relevant elements of the self-certification statements and recorded assurance on the submitted position of compliance with all indicators.

Board action

30. The trust Board is asked to note and to be assured on the progress made by the trust in its FT application process and assure itself that the actions identified are consistent with existing timeframes.

Alison Hughes
Trust Board Secretary

30 July 2014

Patient Safety Strategy 2014 - 2017

Agenda Item:	16	**Reference:**	WCT14/15-139
Meeting Name:	Trust Board	**Meeting Date:**	3 September 2014
Lead Director:	Sandra Christie Ewen Sim		
Job Title:	Director of Quality and Nursing Medical Director		

Link to Business Plan:	Ensures essential levels of quality and safety are met and drives forward continuous improvement for: • Patient, Community and Commissioners • Care Delivery • People and Resources • Enabling Functions
Has an Equality Impact Assessment (EQIA) been undertaken & attached?	**Yes** ☑ **No** ☐ **N/A** ☐
Has the Public & Stakeholders been consulted?	**Yes** ☑ **No** ☐ **N/A** ☐

To Approve ☑	**To Note** ☐	**To Assure** ☐

Financial Implications:
E.g. What is the Impact on the Trust? Does it provide Value for Money?
All costs should be clearly explained in the section below.

None

Overall Cost / Pressure:	**£**	**Overall Income:**	**£**
Additional Funding Required:	**£**	**Funding Already Ring Fenced:**	**£**

Identified Risks:

None identified.

Assurance to Board:

The Patient Safety Strategy provides assurance to the board that the organisation is committed to developing a strong patient safety culture throughout the organisation and signing up to the Sign up to Safety pledge.

Publish on Website:Yes ☐ No ☑	**Private Business:** Yes ☐ No ☐

Report History

Submitted to	Date	Brief Summary of Outcome
Quality and Governance Committee	18 August 2014	Comments received and incorporated into final strategy

Wirral Community NHS Trust

Patient Safety Strategy

Purpose

1. The purpose of this paper is to ask the board to approve the Wirral Community NHS Trust Patient Safety Strategy 2014-2019 (**Appendix 1**).

Executive Summary

2. The trust has a strong track record of patient safety, harm free care and patient safety incident reporting.

3. This strategy builds on that and is a key part of Wirral Community NHS Trust's Business Plan 2014/202019 and will be implemented alongside the Quality Strategy and the Patient Experience Strategy.

4. The patient safety strategy sets out our vision for patient safety, supported by clear goals to provide safer community services for patients.

Rationale and Implications

5. The trust has developed this patient safety strategy which:

    - Is based on the trusts strategic objectives
    - Links clearly with the quality strategy and the quality goals
    - Incorporates the national Sign Up to Safety Campaign
    - Incorporates the trusts Harm Free Care programme and Open and Honest Reporting

6. Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

7. Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

8. As part of approving the Patient Safety Strategy the trust board is also asked to sign up to the national patient safety campaign Sign Up To Safety; committing to actions in the strategy they will undertake in response to the following five pledges:

    - **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
    - **Continually learn**. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.
    - **Honesty**. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

9. The Sign Up To Safety sign up pack is included at **Appendix 2**. The pack describes the actions the trust will undertake in response to the five Sign up to Safety pledges.

10. The Sign Up to Safety action plan will be presented to and monitored at the Quality and Governance Committee.

Conclusion

11. Wirral Community NHS Trust is committed to safeguarding patients and service users and to putting patient safety at the heart of everything we do.

Board Action

12. The board is asked to:

- Approve the Patient Safety Strategy.
- Approve the Sign Up to Safety pledges.
- Agree to publish the Sign Up to Safety on the trusts website for staff, patients and the public to see.

Sandra Christie
Director of Quality and Nursing
Ewen Sim
Medical Director

Contributors:
Paula Simpson, Head of Quality and Nursing
Claire Wedge, Governance Manager

Wirral Community NHS
NHS Trust

Patient Safety Strategy 2014 - 2017

POSITIVE ABOUT DISABLED PEOPLE

MINDFUL EMPLOYER

for you, with you

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Review and Amendment Log

Version Number	Type of Change	Date	Description of Change
1	New		Developed to outline the trust's priorities in relation to the Trust's commitment to delivering high quality safe clinical services ensuring patients are free from harm

1. Foreword

Wirral Community NHS Trust is committed to safeguarding patients and service users, ensuring that patient safety is placed at the heart of everything we do. The trust already has an excellent reputation for patient safety, being identified as the safest community trust by the NHS Benchmarking Network in 2013, based on monthly Safety Thermometer submissions.

The patient safety strategy sets out our vision for patient safety, supported by specific annual quality goals reported monthly in the Quality Report, with the aim of providing safer community services for patients.

Staff Safety is also very important to the Trust but is not within the scope of this Strategy. Staff safety is covered within various Health and Safety policies and Guidelines for Dealing with Physical and Non-Physical Assaults Against Staff (Zero Tolerance), which are accessible via staffzone on the trust's intranet website.

The trust's patient safety strategy is based on the five principles outlined in the Sign up to Safety Campaign, supported by NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA).

The campaign aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign, Wirral Community NHS Trust demonstrates commitment to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

It has been widely established from the many reports which have followed recent failings in healthcare that one among them – safety – emerges repeatedly as the most expected priority for patients, families and the public. ''First do no harm'' is not just a slogan in health care; it is a central aim.

Patient safety should therefore be the ever-present concern of every person working in or affecting the services we deliver.

The quality of patient care comes before all other considerations in the leadership and conduct of the organisation, and patient safety is the keystone dimension of quality. Implementation of the patient safety strategy will require shared ownership of this vision, clear leadership, openness to change and innovation.

This Patient Safety Strategy has been developed for the period 2014 – 2017 to promote a safety culture that encourages, shares and supports this vision and the commitment that as an organisation, we will place the quality of patient care, especially patient safety, above all other aims.

Simon Gilby,

Chief Executive

2. Strategic Principles for Patient Safety

Wirral Community Trust is committed to delivering high quality, safe patient care, free from harm.

The trust's objectives to achieve patient safety are based on the five priorities outlined by the Sign up to Safety Campaign – Listen Learn Act.

1. **Priority One**: Put safety first

2. **Priority Two**: Continually learn

3. **Priority Three**: Honesty

4. **Priority Four**: Collaborate

5. **Priority Five:** Support

These principles support the trust's strategic objective to deliver safe and effective patient care

3. Introduction

Patient Safety is recognised as a top priority for the NHS. At its core, the NHS remains a world-leading example of commitment to health and health care as a human right – the endeavour of a whole society to ensure that all people in their time of need are supported, cared for, and healed. It is a fine institution. But the events at Mid Staffordshire have triggered a need to re-examine what the NHS does and determine how it can improve further.

The various accounts of Mid Staffordshire, as well as the recommendations of Robert Francis and others, have highlighted the following problems:

- Patient safety problems exist throughout the NHS as with every other health care system in the world.
- NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems.
- Incorrect priorities do damage: other goals are important, but the central focus must always be on patients.
- In some instances, including Mid Staffordshire, clear warning signals abounded and were not heeded, especially the voices of patients and carers.
- When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.

- Improvement requires a system of support: the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement.
- Fear is toxic to both safety and improvement.

To address these issues the organisation must:

- Recognise with clarity and courage the need for wide systemic change.
- Abandon blame as a tool and trust the goodwill and good intentions of the staff.
- Reassert the primacy of working with patients and carers to achieve health care goals.
- Use quantitative targets with caution. Such goals do have an important role en route to progress, but should never displace the primary goal of better care.

This strategy addresses how we are going to achieve this, and reflects what Wirral Community NHS Trust is recognised for:

Putting People First

We take the time to listen and respond to the needs of our patients, our community and our colleagues.

Trusted to deliver

We take pride in the excellence of our work, our friendly and caring people and the reliability and professionalism of our service.

Passionate about health

We use our knowledge and skills in innovative ways. We care about having a positive and supportive effect on the lives of our population.

4. Trust Vision and Values

The trust vision is to be the outstanding provider of high quality, integrated community care to Wirral and the communities we serve.

Our values show what we stand for, believe in and are passionate about:

- **H**ealth is our passion, with patients at the heart of everything we do
- **E**xceptional care as standard
- **A**ctively supporting each other to do our jobs
- **R**esponsive, professional and innovative
- **T**rusted to deliver

5. National drivers

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. The purpose of the CQC is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care; they also encourage care services to improve.

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety; findings are published including performance ratings to help people to choose care.

The principles of the CQC are:

- To put people who use services at the centre of their work
- To be independent, rigorous, fair and consistent
- To have an open and accessible culture
- To work in partnership across the health and social care system
- To be committed to being a high performing organisation, applying the same standards of continuous improvement internally
- To promote equality, diversity and human rights.

NICE

The National Institute for Health and Care Excellence (NICE) sets the nationally agreed standards for quality safe healthcare. Guidance is evidence based and cost effectiveness is considered.

Patient Safety Collaboratives

Patient Safety collaboratives are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods.

Patient Safety Fellows

Patient Safety Fellows consist of a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety.

New National Reporting and Learning System (NRLS)

The NRLS is currently being reviewed and will be re-commissioned. The system is already the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team

A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care.

Speak Out Safely

The Speak out Safely campaign led by the Nursing Times aims to encourage NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, to actively encourage staff to raise the alarm when they see poor practice, and to protect them when they do so.

Human Factors

Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work.

Clinical Human Factors are defined as: ‘enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings’. (K.Catchpole, www.chfg.org.uk).

Open and Honest

Open and honest care: driving improvements is a central part of NHS England’s ambition to ensure every patient gets high-quality care, and to build improved services for the future.

The publication of monthly Open and Honest reports demonstrate a continued journey of openness and transparency across the NHS. There are clear links between excellent healthcare and an excellent reporting culture where issues are raised early and discussed openly, so lessons can be learnt and improvements put in place. The reports develop this principle further, by enabling members of the public to access key information about their local health service.

The information included in the trusts ‘Open and Honest’ reports include:

- NHS Safety Thermometer
- Information on healthcare associated infection (MRSA and C Diff)
- Pressure Ulcers
- Falls causing moderate or greater harm
- Information on staff experience
- Information on patient experience including Friends and Family Test
- A patient story
- An improvement story describing what the trust has learnt and what improvement they are making

Duty of Candour

The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour will place a requirement on providers of health and social care to be open with patient when things go wrong.

Providers should establish the duty throughout their organisations, ensuring that honesty and transparency is the expected standard in every organisation registered by the CQC.

Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care.

The tool provide a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time.

Central Alerting System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other, including independent providers of health and social care.

Alerts available on the CAS website include safety alerts, CMO messages, drug alerts, Dear Doctor letters and Medical Device Alerts.

Serious Untoward Incidents

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, IT failure or incidents in population programmes like screening and immunisation where harm potentially extend to a large population;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of never events.

NHS England (2013) Serious Incident Framework

Never Events

Never Events are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by the healthcare provider.

6. Roles and Responsibilities

Trust Board

The Board of Directors has overall responsibility for ensuring that the trust delivers high quality services that are efficient, effective and safe. The Board is made up of the Chairman, Chief Executive, Executive Directors, Director of Quality and Nursing, Medical Director and Non-Executive Directors. The Board demonstrates commitment to patient safety by the endorsement of this strategy.

Chief Executive

The Chief Executive is accountable for the quality and compliance with safe and effective clinical governance systems for all aspects of patient safety within the trust.

Quality and Governance Committee

The Quality and Governance Committee oversees, with delegated responsibility from Board all aspects of quality governance. The Quality, Patient Experience & Risk Group (QPER) monitors operational performance and reports to Quality and Governance Committee. The Pressure Ulcer Multi-Disciplinary Review Meeting and the Harm Free Care Collaborative, report to the Quality, Patient Experience & Risk Group.

Pressure Ulcer Multi-Disciplinary Review Group

The pressure ulcer multi-disciplinary review group is responsible for reviewing clinical patient records for those individuals who develop a community acquired grade 3 or 4 (EPUAP) pressure ulcer. From a review of the available evidence, and in partnership with all clinical services involved, the group are responsible for determining if the developed pressure ulcer was avoidable or unavoidable, in accordance with the Department of Health Definition.

All grade 3 and 4 community acquired avoidable pressure ulcers will be subjected to a root cause analysis investigation.

Evidence to support decision making in respect of unavoidable pressure ulcers will be submitted to the Commissioning Support Unit for review at the Clinical Commissioning Group's Quality Committee / Serious Untoward Incident meeting.

Reporting of community acquired grade 3 and 4 pressure ulcers via the Strategic Executive Information System (StEIS) and root cause analysis investigation is conducted in accordance with the trust's incident reporting policy.

Harm Free Care Collaborative

The harm free care collaborative supports collaborative working with Wirral University Teaching Hospital NHS Foundation Trust, supporting patient safety and learning from health economy incidents with the aim of delivering harm free care to patients.

Divisional Managers

The divisional manager is responsible for monitoring that service leads have appropriate systems in place to promote patient safety, and for disseminating lessons learned from incidents, complaints and concerns to continuously improve patient safety.

Service Leads

The service lead is responsible for ensuring that all relevant staff are conversant with this strategy and are appropriately trained and qualified to fulfil their specific duties.

Individual Employees

Individual employees are responsible for maintaining patient safety, reporting incidents and prevented patient safety incidents to facilitate the identification of learning from experience.

7. Wirral Community Trust Strategic Objectives

The principles of patient safety are in line with the trust's strategic objectives which are grouped into four themes as outlined below:

Our Patients and Community: Putting our patients and communities at the centre

- We will deliver safe and effective patient care
- We will deliver a positive experience of our services
- We will engage effectively with the patients and communities we serve
- Reducing inequalities will be integral to all service development and delivery

Our Services: Leading, developing and delivering high quality services

- We will effectively manage and develop our relationships with our current and new commissioners and stakeholders
- We will defend and grow our core business
- We will lead the delivery of out of hospital integrated care
- We will deliver to expectations of our commissioners and demonstrate quality and value

Our People: Valuing the individual, the team and the organisation

- We will further develop and maintain a competent, caring and flexible workforce
- We will develop leadership at every level of the organisation
- We will continuously develop the organisation and its governance framework

Our Sustainability: Supporting sustainable delivery

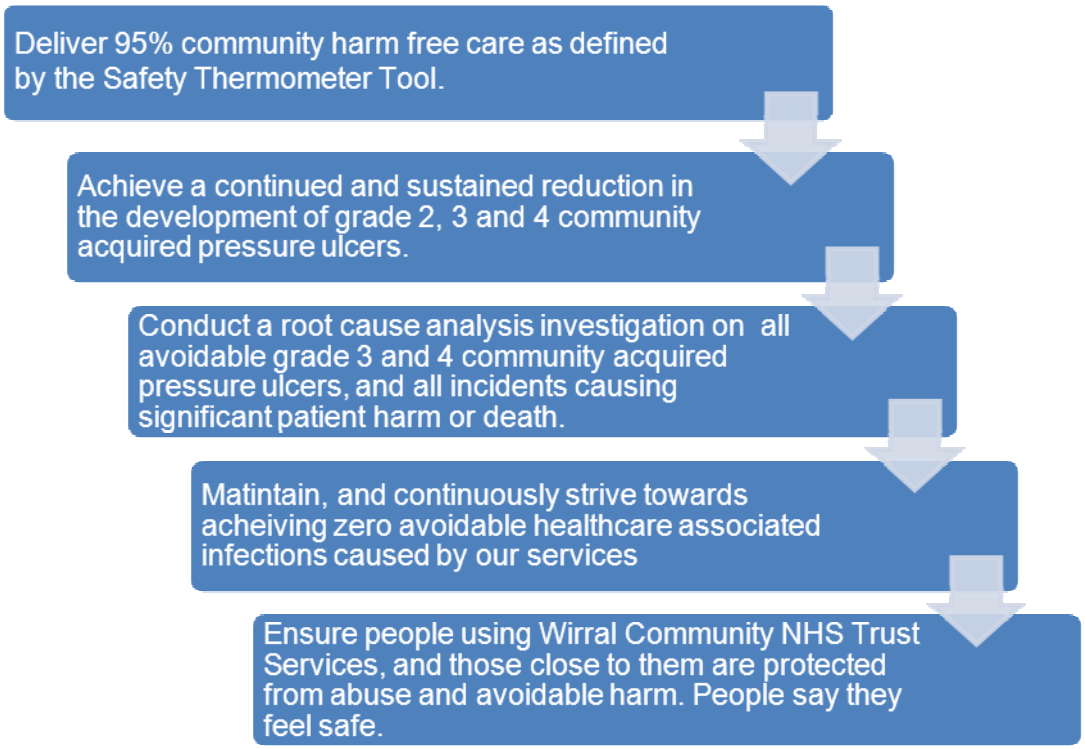
- We will optimise the use of our resources
- Our support and infrastructure services will operate to enhance the delivery of our services and secure future sustainability
- We will develop our information and business intelligence to make informed decisions about what we do
- We will effectively manage our finances and fully deliver our efficiency programmes
- We will deliver transformation supported by innovation and research

8. Patient Safety priorities

8.1 Priority One: Put Safety First.

Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

To achieve this we will:



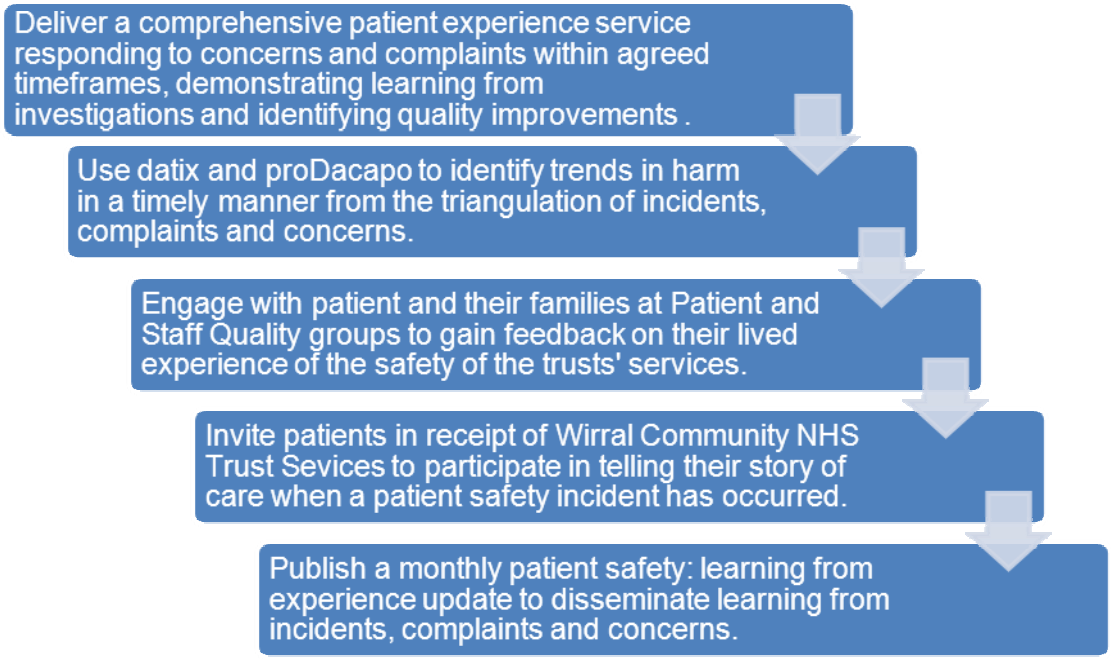
To measure improvement we will monitor:

- Monthly rates of harm as defined by the safety thermometer tool, and reported via the trust's monthly Quality Report.
- The Trust's monthly Quality Dashboard for current month and year to date trends.
- The incidence of community trust acquired pressure ulcers and successful completion of action plans reported to the Quality, Patient Experience and Risk Group, and Quality and Governance Committee.
- And thoroughly investigate all reported healthcare associated infections caused by our services to determine whether they are avoidable.
- And cross-reference referrals to the trust's Safeguarding service with incidents involving safeguarding concerns, to ensure people using the trust's services are protected from abuse and avoidable harm.

8.2 Priority Two: Continually Learn

Develop a resilient risk culture at all levels of Wirral Community NHS Trust, by acting on the feedback from patients, and by constantly measuring and monitoring safety of services.

To achieve this we will:-



To measure improvement we will monitor:

- Responses to reported concerns and complaints, and the number of quality of improvements resulting from investigations.
- Trends analysis of information reported via Datix, ensuring appropriate escalation to the trust's risk register as required.
- Feedback obtained from patient and their families.
- The number of patients engaging with the trust to tell their story of care when a patient safety incident has occurred.
- The quality of the trust's patient safety: learning from experience update, and monitor subsequent reporting of incidents, complaints and concerns relating to the on-going dissemination of lessons learned.

8.3 Priority Three: Honesty

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

To achieve this we will:

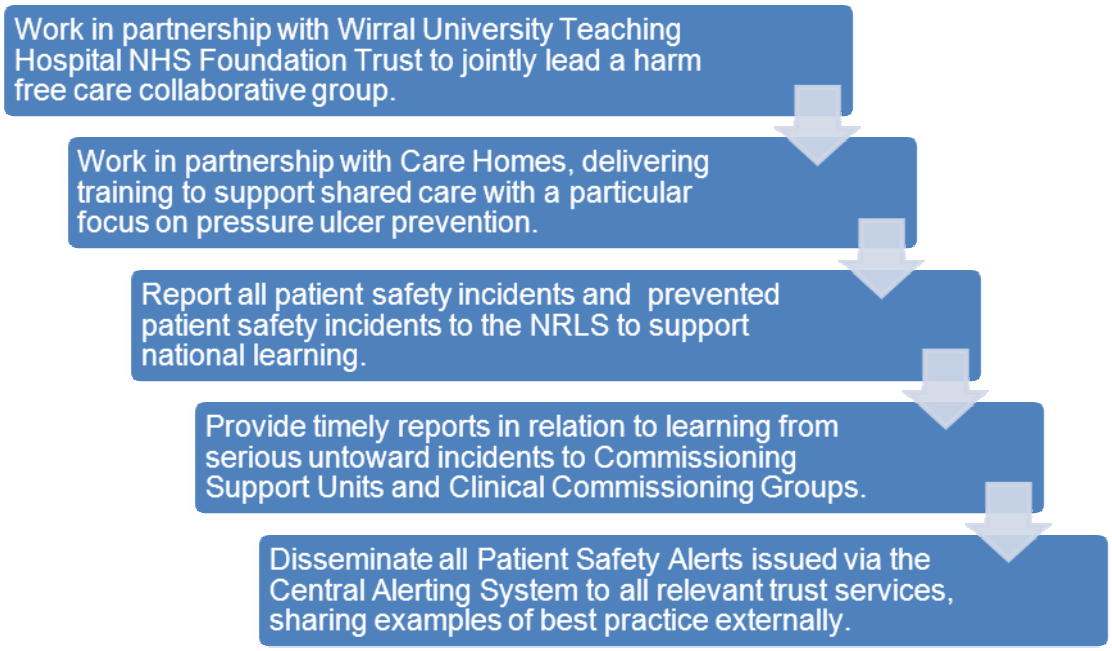
To measure improvement we will monitor:

- Timeframes for responses to concerns and complaints.
- Outcomes from Open and Honest reports, and public feedback in response to the reports.
- Outcomes from involving patients, families and their carers in root cause analysis investigations.
- The trust's monthly friends and family test score, by service, division and trust wide.
- Feedback from the publication of the trust's annual Quality Account.

8.4 Priority Four: Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

To achieve this we will:



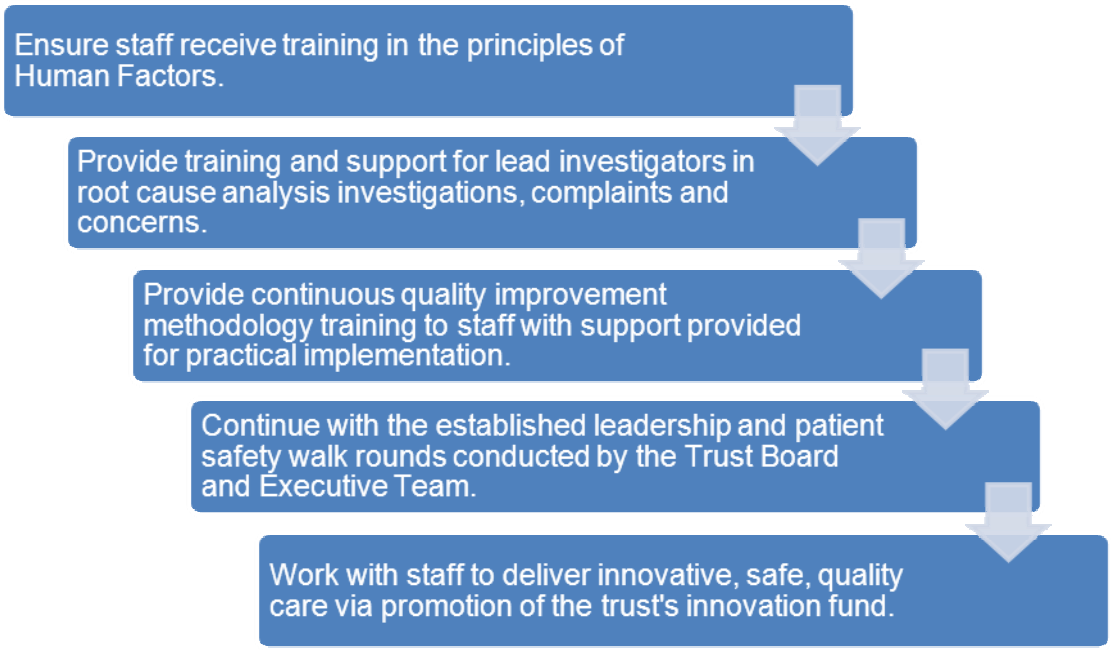
To measure improvement we will monitor:

- Outcomes, learning and quality improvements resulting from the Harm Free Care Collaborative group, aim monitor rates of clinical patient harm.
- Feedback from Care Homes in receipt of training from Wirral Community NHS trust.
- The quality of shared pressure ulcer prevention care plans, and the incidence and prevalence of pressure ulcers in Care Homes.
- Reporting timescales to the Commissioning Support Units and Clinical Commissioning Groups.
- The dissemination of patient safety alerts, and any action plans developed and implemented in response to an alert.

8.5 Priority Five: Support

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

To achieve this we will:



To measure improvement we will monitor:

- Attendance rates at trust training.
- The quality and impact of RCA action plans.
- Learning resulting from complaints and concerns as reported monthly to Trust Board, identifying any repeated trends.
- The number and impact of quality improvements delivered throughout the trust.
- Outcomes resulting from patient safety walk rounds.
- Innovations implemented throughout the trust.

9. Equality Impact Assessment

During the development of this strategy the trust has considered the needs of each protected characteristic as outlined in the Equality Act (2010) with the aim of minimising and if possible removing any disproportionate impact on patients for each of the protected characteristics, age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

If staff become aware of any clinical evidence of exclusion impacting on the delivery of care, a trust incident form must be completed and an appropriate action plan developed.

Safeguarding

In any situation where staff may consider a patient to be a vulnerable adult/child or the feedback relates to a safeguarding issue, staff need to follow the trust safeguarding policies and discuss the situation with their line manager and document outcomes. The Director of Quality and Nursing must also be informed.

10. Delivery and Monitoring

The Director of Quality and Nursing is responsible for the delivery of the trust's patient safety priorities as detailed within the patient safety strategy.

The strategy will be delivered through the Quality and Governance Division, working with partners both within the Trust and externally.

Progress will be monitored through a combination of:

- Progress against patient safety quality goals will be reported monthly to the Quality and Governance Committee via the Quality Report.
- Risks to patient safety will initially be reviewed by the Quality, Patient Experience and Risk Group, with escalation to the Quality and Governance Committee for risks rated as 15 and above, potentially impacting on the trust's strategic patient safety objectives.
- Monthly reporting of the quality dashboard to Trust Board.

11. Cross references with key trust documents

The Patient Safety Strategy cannot work in isolation developed a range of strategies to outline its strategic objectives and vision for the future, these include:

- Quality Strategy
- Medicines Optimisation Strategy
- Risk Strategy
- Engagement and Experience Strategy
- Research and Innovation Strategy

- Equality and Diversity Strategy
- Human Resources Strategy
- Nursing Strategy
- Clinical Strategy
- Concerns and Complaints Policy
- Incident Reporting Policy
- Being Open Policy
- Safeguarding Policies
- Infection Prevention and Control Policies

This list of documents is not exhaustive; documents should be accessed via the trust's staff zone to ensure they are the most up-to-date version.

12. Conclusion

Wirral Community NHS Trust is committed to the delivery of harm free, safe patient care. Implementation of the Patient Safety strategy will ensure that the trust is a leading patient safety organisation, **listening** to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

13. References

Care Quality Commission, (2014) Provider Handbook: Consultation – Community Services.

The Francis Report (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary

The Berwick report (2013) A promise to learn– a commitment to act Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England

NHS England (2013) Serious Incident Framework

14. Consultation

Staff Council	Communication Team	Directors
Quality and Governance Committee	Quality and Governance Team	Non Executives
Director of Quality and Nursing	Medical Director	

15. Strategic Review

This strategy will be reviewed annually by the Quality, Patient Experience and Risk Group.

SIGN UP PACK

Welcome to Sign up to Safety

Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to strengthen patient safety by

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 and 4) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a safety improvement plan which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your safety improvement plan you will be asked to identify the patient safety improvement areas you will focus on. You will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from your own local priorities.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net or post to Sign up to Safety, Skipton House, Area 2B, 80 London Road, London SE1 6LH

Sign up to SAFETY
LISTEN LEARN ACT

SIGN UP FORM

Organisation name:

Wirral Community NHS Trust

In signing up, we commit to strengthening our patient safety by:

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
- Make public our plan and update regularly on our progress against it.

Chief Executive Sponsor:

Simon Gilby		3-Sep-2014
Name	Signature	Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Mrs	First name:	Sandra	Last name:	Christie
Email:	sandra.christie@wirralct.nhs.uk			Job title:	Director of Quality and Nursing

The five Sign up to Safety pledges

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

We will

Deliver 95% community harm free care as defined by the Safety Thermometer Tool.

Achieve a continued and sustain reduction in the development of grade 2, 3 and 4 community acquired pressure ulcers.

Conduct a root cause analysis investigation on all avoidable grade 3 and 4 community acquired pressure ulcers and all incidents causing significant patient harm or death.

Maintain and continuously strive towards achieving zero avoidable healthcare associated infections caused by our services.

Ensure people using Wirral Community NHS Trust Services, and those close to them are protected from abuse and avoidable harm. People say they feel safe.

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

We will

Deliver a comprehensive patient experience service responding to concerns and complaints within agreed time frames, demonstrating learning from investigations and identifying quality improvements.

Use datix and proDacapo to identify trends in harm in a timely manner from the triangulation of incidents, complaints and concerns.

Engage with patients and their families at Patient and Staff Quality groups to gain feedback on their lived experience of the safety of the trusts' services.

Invite patients in receipt of Wirral Community NHS Trust Services to participate in telling their story of care when a patient safety incident has occurred.

Publish a monthly patient safety learning from experience update to disseminate learning from incidents, complaints and concerns.

Sign up to SAFETY
LISTEN LEARN ACT

3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will

Respond to concerns and complaints about care in an open, responsive and timely way.

Fully adhere to the Duty of Candour throughout all services within the organisation.

Publish monthly Open and Honest reports on the Trust external website.

Involve patients, families and their carers in root cause analysis investigations, providing evidence of organisational learning at every opportunity.

Publish the number and theme of all Serious Untoward incidents and Never Events in the trust's annual Quality Account.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will

Work in partnership with Wirral University Teaching Hospital NHS Foundation Trust to jointly lead a harm free care collaborative group.

Work in partnership with Care Homes, delivering training to support shared care with a particular focus on pressure ulcer prevention.

Report all patient safety incidents and prevented patient safety incidents to the NRLS to support national learning.

Provide timely reports in relation to learning from serious untoward incidents to Commissioning Support Units and Clinical Commissioning Groups.

Disseminate all Patient Safety Alerts issued via the Central Alerting System to all relevant trust services, sharing examples of best practice externally.

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will

Ensure staff receive training in the principles of Human Factors.

Provide training and support for lead investigators in root cause analysis investigations, complaints and concerns.

Provide continuous quality improvement methodology training to staff with support provided for practical implementation.

Continues with the established leadership and patient safety walk round conducted by the Trust Board and Executive Team.

Work with staff to deliver innovative, safe, quality care via promotion of the trust's innovation fund.

Sign up to SAFETY
LISTEN LEARN ACT

FREQUENTLY ASKED QUESTIONS

1. **What is Sign up to Safety?**

   Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

2. **What does Sign up to Safety mean?**

   This campaign and its mission are bigger and much more important than any individual's or organisations' programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that organisations currently own and aligning them with this single common purpose.

3. **What is different about Sign up to Safety from previous campaigns?**

   What is unique and fundamentally different is that this campaign is for everyone. It transcends organisational boundaries and will align the whole system to achieving our shared ambition. There will be no targets or 'performance management' from the centre – the energy, ideas and expertise will be found deep inside the NHS and within your organisation. The Chief Executives of NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA) have all signed up to align their work with this campaign.

   The idea is to harness the talent and enthusiasm within organisations and connect this to others in our National Health Service.

4. **Who can sign up to the campaign?**

   Sign up to Safety is for everyone, everywhere. Whether you work in primary, secondary, or tertiary care; whether you work in acute, mental health, learning disabilities, ambulance, or community care settings;

whether you work in a national body or a general practice, Sign up to Safety applies to you.

5. **How is the campaign being organised and supported?**

A National Co-ordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organisations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.
- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

6. **What support is available to organisations who sign up to the campaign?**

The National partners will work together with improvement experts to establish what a good improvement plan looks like and to support organisations to learn from each other in drawing up and delivering theirs. It is crucial that the leadership of the campaign is exercised locally but equally that this work is completely aligned with and mutually supportive of the work that is already underway or planned in relation to patient safety improvement.

In this first phase, an 'Alliance of Improvement Experts' will be asked to come together and offer provider organisations who sign up the opportunity to have improvement support and advice. The Improvement Alliance will also combine their sign up coaching with supporting the local patient safety collaborative to help enhance and align the activities of both. The level of advice and support will depend on what local organisations ask for, but the Improvement Alliance will act to bolster the development of these linked initiatives where they can, transferring skills to collaboratives and provider organisations, as well as supporting the development of the Patient Safety Fellows Programme.

Over time we expect that the Campaign will be self-supporting as capacity is created locally to harness enthusiasm and develop capability, not least through the developing patient safety collaboratives.

At the outset of the campaign a National Co-ordinating and Support Group will be established chaired by Sir David Dalton, with NHS England leadership provided by Dr Mike Durkin. The CQC, Monitor, the NHS LA and TDA will be part of the Group alongside representation from professional bodies, patient groups and improvement experts. The Group will encourage organisations to commit to the campaign and will listen to what they need for support. The Group will also work to ensure the alignment with and support the establishment of related system activities including the patient safety collaborative programme, the Patient Safety Fellows Programme and the core development and support activity of the Trust development Authority and Monitor already in place. It is crucial that this campaign is seen as bringing the activity of the whole system together with a common and urgent single purpose.

7. How should organisations get patients, families and carers involved in Sign up to Safety

We strongly encourage organisations that sign up to be actively engaging with patients in a meaningful and productive way. Patients, their families and carers have a vital role in patient safety and their perception of safety and opinions on where improvement can be made should form part of the development of the improvement plans. Their opinions are one of the most powerful influencers of other people and their choices and their voice a powerful force for change if listened to and learned from. This could be through a patient suggestion scheme, inviting patient representatives to be part of committees or forums to develop the plans, holding consultation events etc. More suggestions on including patients in the campaign are available on the website and case studies will be added as more and more organisations sign up to the campaign.

8. **How does Sign up to Safety align with other patient safety programmes and initiatives?**

The following linked initiatives to improve patient safety will be aligned with the campaign so that the whole system supports involvement.

Patient Safety collaboratives – These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. They will begin their work later in the year. Organisations that sign up to safety can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Patient safety Fellows – work is underway to create a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety. The group will launch later this year and organisations who participate in Sign up to Safety are involved in the collaboratives will benefit from the expertise of the fellows and can also support their own staff to become fellows.

New National Reporting and Learning System (NRLS) – work is underway to review and re-commission the NRLS. We already have the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team – A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care. SAFE will be piloted later this year and could help support signed up organisations, and others, who

require additional help.

Safety website – A new set of hospital patient safety data is now available on NHS Choices enabling trusts to be compared against each indicator. Putting key safety information into the public domain supporting transparency and helping patients to make informed choices about their care and exercise their right to challenge their local healthcare providers on safety issues. Organisations that have signed up to safety can use this public data to inform their plans and conversations with their local communities.