Livewell Southwest

**Quality Governance Strategy
2016 – 2017**

Version No 2.3
Review: June 2017

Notice to staff using a paper copy of this guidance.

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Asset Number: **816**

Reader Information

Title	Quality Governance Strategy 2016-17. V.2.3
Asset Number	816
Rights of Access	Public
Type of Formal Paper	Strategy
Category	Corporate
Format	Microsoft Word 2003 and PDF
Language	English
Subject	Quality
Document Purpose and Description	This strategy sets out our approach to continuous quality service improvement incorporating what our priorities are and how they will be delivered.
Author	Governance/Safety & Quality & Performance Committee
Ratification Date and Group	LSW Board – August 2013
Publication Date	21st June 2016
Review Date and Frequency of Review	One year after publication, or earlier if there is a change in evidence.
Disposal Date	The PRG secretary will retain an e-signed copy for the database in accordance with the Retention and Disposal Schedule; all previous copies will be destroyed.
Job Title of Person Responsible for Review	Governance Manager
Target Audience	All staff employed by Livewell Southwest CIC, people who use our services, carers and the public.
Circulation List	Electronic: Plymouth Intranet and LSW website

Written: Upon request to the Policy Ratification Secretary on ☐ 01752 435104.

Please note if this document is needed in other formats or languages please ask the document author to arrange this. |
| Consultation Process | Safety, Quality & Performance Committee
Executive Team |
| Equality Analysis Checklist completed | Yes |
| References/Source | Equity and Excellence: Liberating the NHS (2010) |

	Putting Quality First in the Boardroom – Improving the Business of Caring' (2010) High Quality Care for All (2008) LSW Quality Account 2015/16
Supersedes Document	All previous frameworks

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Document Review History

Version No.	Type of Change	Date	Originator of Change	Description of Change
0.1	New document	22.3.12	Governance Manager	
1	Ratified	June 2012	Governance/Safety & Quality & Performance Committee	
1.1	Extended	June 2013	Deputy Director of Governance.	Extended, no changes.
2	Reviewed	November 2015	Deputy Director of Governance.	Reviewed
2.1	Extended	June 2015	Director of Professional Practice, Safety and Quality	Extended, no changes.
2.2	Extended	June 2016	Director of Professional Practice, Safety and Quality	Formatted to LSW
2.3	Reviewed	June 2016	Director of Professional Practice Safety and Quality	Updated to include 2016 five aims, Quality Objectives and sub committee structure

Contents

Contents		Page
1.	Quality Governance	5
2.	Context of the Strategy	5
3.	Regulation and Assurance	5
4.	Risk Management	6
5.	Patient Experience and Engagement	6
6.	Patient Safety	7
7.	Clinical Effectiveness	7
8.	Quality assurance framework and Risk register	7
9.	Objectives 2016/2017	8
10.	Monitoring and review of the strategy	8
11.	Groups Reporting to LSW Sub-Committees	10

Quality Governance Strategy 2013 – 2015

1.   Quality Governance

Regulation and Assurance	Patient Safety	Patient Experience	Clinical Outcome / Effectiveness	Risk
This Quality Governance Strategy is an overarching strategy which outlines the plan for continued development of Governance for Livewell Southwest. The strategy identifies what Governance means for Livewell Southwest and gives clear direction and a shared vision for how we ensure this is a priority at all levels in the organisation. It outlines as part of a whole system approach the improving of standards and the protections of the public from unacceptable standards of care. The strategy draws together the five key components of Governance.				

2.   Context of the Strategy

The vision for Livewell Southwest is to ensure people who use services receive the highest standards of care and are supported to be safe, well and at home.

To support this vision Livewell Southwest has five key aims;

- To be a recognised employee led organisation;
- Based around local people and communities;
- To provide seamless system leadership;
- Sustainable successful and admired;
- Where experience exceeds expectation.

The key aim 'Where Experience Exceeds Expectation' is overseen by the Safety, Quality and Performance Committee of the Board.

Governance is at the heart of our vision, ensuring that systems and processes are in place to assist staff to deliver quality care. This includes:-

- Ensuring required standards are achieved.
- Investigating and taking action on sub-standard performance.
- Planning and driving continuous improvement.
- Identifying, sharing and ensuring delivery of best practice.
- Identifying and managing risks to quality of care.

3.   Regulation and Assurance

- Deliver continual compliance with the Care Quality Commission.
- Maintain and improve on the LSW's assessment in relation to the NHSLA risk management standards.

- Ensure the governance and risk management framework continues to be fit for purpose.
- Ensures there are explicit and robust accountability arrangements in place.
- Monitor improvements through the further development of outcome based indicators.
- Ensure that intelligent information and regular reports are available to support decision making and effective operation.
- Reviewing and adapting systems and practices to meet the needs of regulatory and legislative changes and development .

4. Risk Management

- Maintain a safe environment for users of the service, employees and visitors.
- Ensure risks are continuously identified, assessed, reported and minimised.
- Develop activity to support the Board assurance framework through on-going review of local and corporate risk registers.
- To use risk assessments and intelligent risk information, gathered from a variety of sources to inform the overall business plan as well as other components of governance.
- Ensure a provision of a robust system for reporting and analysis of incidents with timely learning for all staff and openness and transparency for people and their families.

5. Patient Experience and Engagement

- To develop and maintain key performance indicators for users of the service experience.
- Demonstrate leadership and organisational commitment to understanding service user experience to improve services and designing improvements in collaboration with service users.
- Dedicate resources to capture, understand and utilise users of the service experience through narrative and numerical data.
- Ensure the board receives regular and meaningful reports on service user experience.
- Make the focus on understanding and delivering a positive user of the service experience an integral part of staff induction, development and appraisal.
- Develop a framework which enables the triangulation of a range of sources of service user feedback, including complaints. This will

provide a single, joined-up view of users of the service experience that provides feedback from a range of sources.

- Work in partnership with the communication team to deliver and share outcomes with the public in accordance with a policy of condor.
- To publish an annual user of the service experience report and a quality report to the Board.
- Develop and expand qualitative user of the service experience into focus groups and growth of volunteers.
- Develop relationships with external stakeholders including Health Watch.

6.   Patient Safety

- To ensure systems and processes are in place to provide reports, audit trails, scrutiny and assurance of governance practices to the Board and its sub-committees.
- To ensure gaps in assurance are supported by action plans which are implemented and monitored.
- To reduce avoidable errors and transform the safety culture, to ensure quality and safety is everyone's top priority.
- To ensure monthly reporting to the safety and quality committee and to the Board.

7.   Clinical Effectiveness

- To ensure that NICE guidance informs and influences practice and that compliance is monitored.
- To provide a clinical audit programme that is effective, informed by our priorities and addresses the contractual requirements.
- Develop appropriate outcome measures for all clinical areas and that these help monitor and improve the quality of care.
- To influence the education and training strategy and policy development and monitoring.

8.   Strategy Implementation

Board

The Board has overall responsibility for the activity, integrity and strategy of LSW and has a statutory duty of quality as part of its role, to ensure high standards of quality governance.

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

Safety, Quality and Performance Committee

- To provide a clear vision for quality governance within LSW to assist in working towards clinical excellence as identified.
- To set clear quality targets and hold localities to account for the delivery of the governance agenda.
- To escalate any areas of concern to the Board.
- To provide a level of security regarding governance including compliance with regulatory requirements set by the Care Quality commission and compliance against NHSLA Risk Management standards.

9. Objectives 2016- 2017

Our priorities for quality and safety for 2016 – 2017 include:

- ✓ The reduction of avoidable harm for patients, for example Pressure Ulcers, Catheter Acquired Urinary Tract Infections and Falls

- ✓ The maintenance of safe staffing levels

- ✓ Mental health – to reduce the number of suicides for people receiving care within Livewell

- ✓ Ensuring that Infection prevention and control is embedded in all areas of our activities

- ✓ Taking steps to become recognised as a research active organisation, supporting the development of innovation and new treatments.

- ✓ Continuing an "open culture" for incident reporting and investigation so that we learn from the occasions when we do not meet high standards of care

- ✓ A comprehensive Risk Management approach will underpin our service delivery approach, recognising that positive risk taking plays a significant part in many service delivery areas.

- Specific plans relating to strengthening safe services include :

Quality Governance Strategy 2016 – 2017. V.2.3

- ✓ The effective transition for Children and Younger people to Adult Mental Health Services

- ✓ The Establishment of a "triangle of care " in our services which includes Service Users, Carers and Professionals

- ✓ Effective leadership within Adult Safeguarding arrangements and an active contributor to Children's Safeguarding arrangements.

- ✓ Implementing a quality and effectiveness trigger tool to provide early warning across services.

- ✓ A positive and proactive care strategy to reduce the need for restrictive interventions.

- ✓ Strengthened professional leadership for all professions; medical staff, nurse revalidation and scholarship programme, allied health professionals and social workers.

- ✓ A programme for staff competencies including a care certificate programme for staff without professional qualifications.

- ✓ Collaboration with national leaders in best practice to constantly improve experiences for people and families who use our services.

In addition to our quality priorities stated above, the development of our Quality Accounts reporting on progress within 2015/16 will identify further areas for action. Once published this will include a further quality priority for 2016/17 that will fall under the aim of 'where experience exceeds expectation.

10. Monitoring and review of the strategy

This overarching strategy supports the following strategies:-

- Clinical Audit and Effectiveness Strategy.
- Education and Training Strategy.
- Service User and Engagement Strategy.
- Risk Management Strategy.
- Information Governance Strategy.

Assurance of these strategies and associated work and action plans is monitored via the Safety and Quality Committee, Audit Committee, Executive Team and the Board.

11. Livewell Southwest Safety Quality and Performance Committee Sub committees
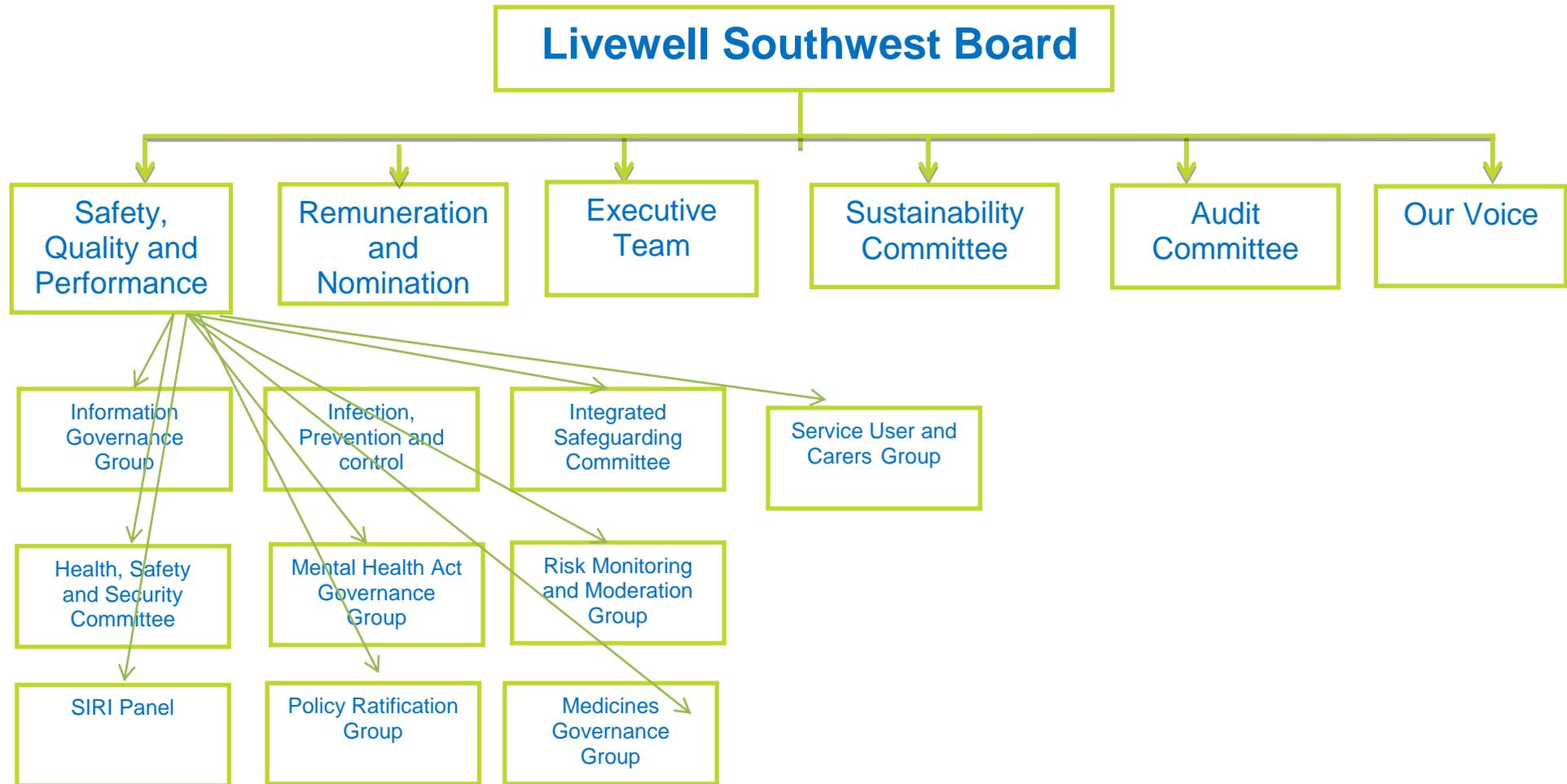
Summary of Livewell Southwest Committee and Safety Quality and Performance sub committee roles:

Board
The Board is the full Board of the organisation responsible for the overall governance and operation of the organisation as a Community Interest Company. The Board consists of a Non-Executive Chairman, three Non-Executive Directors a Chief Executive, Deputy Chief Executive and three Executive Board Directors.

Executive Team
The Executive team is a subcommittee of the board, is Chaired by the Chief Executive and is attended by Executive Board Members. The purpose of the Executive Committee is to assist in; development and implementation of strategy, business plans and budgets for approval by the Board, development and implementation of operational plans, policies and procedures, monitoring of operating and financial performance, assessment and control of quality and risk and in keeping the Board up to date and fully informed about strategic issues and commercial changes affecting the Company and the market in which it operates.

Sustainability Committee
The Sustainability Committee is chaired by a Non Executive Director and has a role to ensure that LSW achieves a sustainable financial position on a recurrent basis. The Committee oversees the delivery of the Board approved savings programme and any in year additional recovery programmes, identifies and validates any future income streams for the organisation, reviews the annual organisational workforce and estates plans and approves new business opportunities.

Service User and Carer Group
The service user and carer group is chaired by a Non-Executive Director and has members who represent local service user and carer groups. The purpose of the Service User & Carer Group is to enable users and carers to influence the future direction of the organisation and debate current issues that affect the business it is engaged in.

Safety Quality and Performance Committee
The function of the Safety Quality and performance Committee is to ensure that robust assurance, governance and performance mechanisms are in place and monitored to provide assurances to the Board that essential standards of safety and quality are being met including areas of

Quality Governance Strategy 2016 – 2017. V.2.3

quality, safety, safeguarding, the Mental Health Act, patient experience and complaints. The Committee is Chaired by a Non-Executive Director and receives monthly routine information, additional information by exception, plus a range of scheduled quarterly or annual reports from various workgroups and sub committees listed in the diagram.

Integrated Safeguarding Committee
The Integrated Safeguarding Committee is a subcommittee of the Safety a, Quality and Performance Committee, is chaired by a Non-Executive Director and meets monthly. The committee provides a focus for all developments and actions related to child and adult safeguarding including Prevent and Deprivation of Liberty safeguards across the organisation.

The information Governance committee
The Information Governance committee is chaired by the Senior Information Risk Owner who is also an Executive Director and coordinates activity relating to the Information Governance Tool Kit in order to provide a high level of information governance across the organisation.

Medicines Governance Group
The Medicines Governance Group is a sub group of the Safety Quality and Performance committee whose purpose is to provide governance arrangements for medicines management. This includes providing a forum for clinician engagement in the formulation and implementation of medicine related policies, Patient group Directive procedures, guidelines; develop adequate responses to safety alerts and ensure these are implemented; review medicine management action plans and to monitor and respond to medication related incident reports.

Infection Control Committee
The Infection Control Committee is a subcommittee of the Board chaired by the Director for Infection Prevention and Control. The committee directs all infection prevention control action within the organization; providing the Chief Executive with relevant information and advice and monitors progress of the annual Infection prevention and control programme, infection control policies, procedures, guidance and Service Lead Agreements and reports infection surveillance data, monitor performance and, makes recommendations for improving patient safety.

Serious Incidents Requiring Investigation Panel
The Serious Incidents Requiring Investigation Panel is chaired by the Deputy Director of Professional Practice Quality and Safety and is a subgroup of the Safety Quality and Performance Committee. The role of the Panel is to review reports and investigations in detail and to produce a report summarising serious incidents requiring investigation, together with comments, recommendations, identifying any trends or learning and disseminating this across the organisation.

Health Safety and Security Committee

The Health Safety and Security Committee is chaired by the Senior Risk Manager and the purpose is to consult on and keep under review the measures taken to ensure and protect the health, safety and security at work of all employees and others. The committee supports the organisation to remain informed of, and alerted to, relevant health, safety and security risk management issues facilitating development and implementation of organisation wide health, safety and security policies and to promote development of local safety rules to ensure safe systems of working.

Risk Monitoring & Moderation Group (RMMG)

The Risk Monitoring and Moderation Group is chaired by the senior risk manager is attended by senior operational managers and heads of service.

The role of the group is to review and moderate all new risk assessments with the use of the risk register, determine whether new risks should be escalated to local, locality or corporate level, agree the risk score for new risks to ensure consistency across the organisation and to Identify trends.

Policy Ratification Group

The Policy Ratification Group is chaired by the Deputy Director of Professional Practice Quality and Safety and is a subgroup of the Safety Quality and Performance Committee. This provides a systematic process for the dissemination and review of 'approved documents' including policies, protocols, procedures, guidance prior to publication and dissemination to all staff.

Mental Health Act Governance Group

The Mental health Act Governance Group is chaired by a Non-Executive Director and has a role to ensure that the statutory duties under the MHA'83 of the Hospital Managers (Board) are exercised lawfully, reasonably and fairly, in particular, those relating to the treatment and care of all detained patients and the provision of information relating to statutory rights.

The group receive and review reports on incidents and review the Mental Health Act Manager quarterly reports on the activity of detentions under the Mental Health Act, including but not limited to Hospital Manager's hearings and Mental Health Tribunals.