WUTH Quality & Safety Strategy

"Insight" Staff Questionnaire Results

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Q&S	4	As you have indicated a score of 6 or below please can you identify what the barriers are to having an effective and efficient Clinical governance structure	10	
Q&S	5	Please provide any suggestions as to how the assurance process could be improved for measuring quality and safety indicators	17	
Q&S	6	Do you think clinical risks are clearly understood throughout the organisation?	18	Agree: 9; Impartial: 3; Disagree: 5; Strongly Disagree: 1
Q&S	7	Please explain why you have given this rating	14	
Q&S	8	How would you rate this statement? "Escalation lines provide support"	18	Strongly Agree: 1; Agree: 10; Impartial: 6; Disagree: 1
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Question 1 - In your Role/team how do you currently measure safety and quality?
Competencies sign off . staff and patient feedback . incidents or complaints. Education and ward audits. Recruitment and retention . MT compliance
We measure through all types of media including incident reporting, audit reporting, Tendable, dashboards
The patient safety learning panel (PSLP) review incidents that may have caused harm to the patient due to lapses in care or if after review every assessment and plan has been followed appropriately the incident or harm could not be avoided. Learning is shared across the divisions. Currently the panel reviews potential harm caused by a fall, pressure damage, MUST assessment and IPC incidents (excluding C.Difficile) and escalated to SI group. As future safety improvement is identified,these will be added to the panel. E.g deteriorating patient and NEWS 2.
Clinical governance meetings with terms of reference. Assurance of discussions. Dashboards discussed and actions followed up.
Through the use of information from the BI portal, Tenderble, staff audits and through monitoring of national guidelines and performance. We receive regular patient feedback via friends and family, verbal patient feedback, and local questionnaires
Through a range of divisional activities Directorate performance reviews (including safety and quality) Divisional performance reviews (including safety and quality) Divisional Quality Board Participation in PSQB Monthly patient safety forum with clinicians various ad hock communications to share relevent learning
Tendables Audits H&S folder - up to date and correct checks taking place, staff signature sheet, COSHH folder kept up to date and staff to sign, FFT, Feedback Friday, Incidents, Risk Register, SI/RCA, Rapid and local reviews, Governance boards, Compliments Complaints
I am currently leading QI focused Plan-Do-Study-Act (PDSA) tests of change with various ward and assessment teams under two quality improvement priorities (Deteriorating Patients and IPC/Clostridium Difficile). Marco improvements in these areas are collected and fedback to operational teams and senior managers from BI Portal e.g. NEWS2 Compliance and C.diff infection rates by location.
Within tissue viability safety and quality is based upon latest research and advancements in wound care, ensuring training is attended to and when possible external wound care events attended to, in order to improve the service, standards, and quality of care. It is also the tissue viability service role to help educate, support and raise awareness regarding wound care and management to ensure quality is achieved, first time ever time.
we do regular audits, and use these to review where key actions need to be taken, various meetings held, ie ipc, finance, falls pressure ulcer meetings, and again reviews taken and actions decided to prevent future harms.
'- Harm causing medicines management incidents. Ideal picture high reporting rates of medicines management incidents with low harm levels - KPIs for a variety of indicators across operational and clinical pharmacy
Via Tendible audit, visual observation, Ward accreditation. Triangulation of incidents/complaints & claims. Timely review of all clinical and non clinical incidents submitted, review themes and trends. Patient experience via FFT response rates. Incidents resulting in harm are investigated as rapid reviews/RCA's
Audits, reports, incidents, patient feedback
Pt feedback, Tendable audits, WISE accreditation, Staff feedback, Complaints, Sis, BI portal
We review Q&S metrics by dashboard and exception reporting at a monthly Divisional Quality Board where the Triumvirate meet with our Governance and Safety Lead. Reports from all specialities and operational teams are reviewed ahead of discussion in the Divisional Management Board scheduled for immediately after.
Tendable audit, friends and family feedback, staff survey
Collection of daily data for what matters most to the patient , we take part in NACEL audit which benchmarks the team across the NHS trusts to highlight areas of improvement and excellence. Specialist nurses within the team undertake competencies to ensure tey are upto date. We share learning across settings (community and hospice) within governance meeting to highlight any learning.

Question 2 - What sources of quality & safety insight are most used by your team?
Outputs from the measurements as described
Local Safety Standards Session utilisation Moderate Harms and above Pressure area care auditing Complaince to national standards
Documentation on Wirral Millennium, daily reports for MUST,TV, incident reports, BI portal, PSLP, SI, patient experience feedback, complaints, ward audits (tendable)
Patient feedback received verbally, via friends and family or via feedback Friday.
Divisional dashboard Risk Complaints & Concerns Incidents
Audit results outcomes of incidents/rapid reviews/complaints/compliments News letters unit meetings
Daily handovers, constructive feedback, swot analysis
'- Incident reports - Complaints - Mortality Reviews - Staff feedback - Audit results
FFT Tendible audit data CQC outcomes from inspection Ullyses safeguard system Risk register
Tendable & BI portal
Shared learning from rapid reviews and SI panel investigations. Local speciality feedback from CIF meetings. PALS feedback, GIRFT reviews, Speciality Network reports, safety dashboards from GSU and formatted reports to DMB, TMB, PSQB, DPR and Public Board.
Macro metrics from BI Portal. Micro metrics from PDSA tests of change.
Medicine saftey / governance meeting What matters most to the patient collated daily and hopefully achieved
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Dashboards, action trackers, web holding data, quality assurance report, outliers report (regional), NICE, audit, Policies tracker, NICE tracker.

How could the assurance process be improved for measuring Quality & Safety?
making indicators more visible
Easier production and documentaiton
Should be seen as improving quality and safety, rather than 'punitively' which sometimes comes across (blame culture) when an incident occurs which requires investigation within the divisions Need to align each incident and improve the feedback process.
We need to have more of a focus on working with our patients, carers and system partners to evaluate the work we undertake. we also need to improve the amount of co-design work that is undertaken in respect to pathway design, information leaflets and service improvement.
Improving the staffing resource in the team commensurate with the volume of work that is required
replicant process across the division - currently everyone does different things.
By providing a clear set of metrics via a dashboard.
Better reporting system from an IT process that isn't time consuming for all members of staff but accurate and relevant.
regular weekly time allowed for sisters matrons adn etc, to actually review the audits undertaken, and look at improving practice, lots of time is spent on action plans, that almost become meaningless, we look back to much and review rather than looking ahead. staffing is not allowed to be refelctive for increased harms to patients. although this is a direct correlation.
Medication safety indicators are monitored via MSOP. This needs greater senior nursing representation and needs medical representation.
Enhanced focus on shared learning, themes and trends. Complaints to be in the remit of the CG teams to ensure triangulation with incidents/claims and for shared learning.
More Bi developers to transfer data and information on to the BI portal to make everything more accessable.
use of SPC charts in all reports dashboards
robust governance - data collection - we collect data for several areas and this shows us areas of improvement Involvement in any national audits which would provide bench marking against other organisations
Robust feedback of learning from SI
Resource in the team. A job is going out for 15 hours per week.

Can you identify what barriers there are to having an effective and efficient clinical governance structure?
The formal process for reporting in particular a falls fracture is sporadic and varies across divisions. Incident reports are not being managed in a timely manner, i.e. an incident is initially reported as low harm where the patient has had a moderate/severe harm, this is not amended to reflect the severity. This score reflects the divisional governance structures.
Further resource is required to support clinical effectiveness - audit/policies/guidelines/ NICE
we are currently focused on targets and meeting guidance rather than on what our patients and cares need / want from out services. I would also like to see more integrated system working in relation to
The key barrier to improving this is a lack of staffing resource in the team to adequately deal with the volume of Q&S work generated which impairs the effectiveness and efficiency of the structure
We provide packs of information at various stages of reporting and escalation. Whilst we consider these representative, challenges can be raised regarding other areas where the Exec team feel assurance isn't complete. It would be most useful if these challenges could be forwarded to the Division ahead of meetings so we can produce the required information rather than be unable to research and provide an account within said meeting ie DPR.
Attendance at meetings Duplication - discussing at several forums leads to inertia
Poor compliance with the medial team to maintain or implement clinical guidance No one specific in governance for the area - job is currently pending advert Visibility of the team across the unit should be high and it currently isn't
time is a big factor, not having enough time to review agendas prior to the meetings. they turn into a reading meeting not an actions meeting.
CG structure works very well within pharmacy. I do not feel it works as well out in the divisions (this is due to inexperienced staff and lack of resources)

Do you think clinical risks are clearly understood?
Clinical risks are identified and discussed at every level

Staff may be aware of the risk to a patient/staff if a factor of the patient's care is not there, however may not be able to follow the escalation process apart from incident reporting, 'what happens next'.
I put this rating due to the quality of communication in MDT settings (PSQB, RMC, SI panel, etc)
I believe that we have a good reporting culture and risk recording process. we do however need to look more at how we capture the issues relating to quality rather than just staff/ financial / patient safety.
I believe clinical risk appreciation is the mainstay of WUTH's focus when considering patient care.
Inconsistent understanding.
poor sharing and understanding Risks are declined when submitted
All PDSA tests of change performed by the clinical teams on the DP & C.diff QI programmes aim to control and reduce clinical risk through their improvement efforts.
i dont think the grades below ward sisters fully understand or are aware.
There is no training for new managers on this. Staff are expected to just understand clinical risk with no training. There have been multiple 'leaders' in GSU over recent years and all have varied amount of input in to this and differing views. Staff are just confused.
Effective risk register monitoring in place. There does need to be additional training for divisional staff relating to clinical governance.
Operationally decisions appear to take priority over patient safety - non clinical managers making clinical decisions
I dont think this is understood at all levels of the organisation , not all levels aware of trust wide risks /strategic clinical risks
There is a robust system to identify and report clinical risks however i do feel outcomes could be communicated more clearly

How would you rate escalation lines?
I am supported when i escalate any concerns

i support staff if they escalate concerns to me
escalation processes in place Concern is that it may be seen as escalate and its not my problems where it should be escalate and seek support
I feel that there is a good escalation line within my division and with the exec.
When I escalate issues with the senior team they offer support, advice and or assistance to resolve
The process allows case and speciality scrutiny of care provided. Where harm has occurred or risk(s) identified, these incident reviews provide information of potential lapses in care with a good account of causation. These are then presented via escalation to encourage critical challenge, shared opportunities for learning across Divisions with outcomes reported to assurance committees and fed back to the team initially reporting.
Some escalation lines work really well. Others not so well - especially when accountability is unclear
new escalation lines in place and currently difficult to comment
Lack of evidence.
I feel if there is a clear structure for escalation this provides reassurance
In some ways escalation works and provides support but in others escalation falls on deaf ears becuase the leaders have so many competing priorities
Unsure as to the question, however if this relates to escalating safety concerns - yes this is very important to ensure senior support. Escalation of risks using risk matrix.
mixed feelings - dependant of who escalating to
I dont feel staff escalate for support , i personally feel they escalate to hand off the issue rather than seeking support and taking responsibility, Would be keen for staff to escalate to seek support to learn , develop and enhance accountability and ownership in teams
As above. Heard when asked a member of staff to complete an incident form; "what's the point, nothing ever changes"

What are the barriers to sustaining quality & safety in our organisation?
data is sometimes difficult to obtain
Time, Understanding, Compliance
Lack of staff training In some areas lack of support from Senior team (not my department)
Resource and staffing levels
Patient flow consistently pulling in resources from teams that are in place to support governance and quality improvement at times of high demand.
The current system is very process heavy rather than outcome focussed The Q&S team is under resourced The structures do not fully align with or fully reflect the delivery of clinical care
Over burdening of work. Staff absence. Fluidity of management and governance teams. perpetual revision of reporting templates and dashboard data requirements.
Too much effort on the counting than the doing - counting is important but investment in the process itself more important Accountability unclear and no real consequence to failure
no consistent approach lack of training and competence in the area
Poor investment in quality improvement specialist to support and provide education to all trust employees who have ideas for improvement.
Barriers lack of staff and the feeling unsupported at times. From a tissue viability perspective there is a lack of tissue viability staff to run a very busy demanding service that covers 2 hospital sites. This in return heaps pressure on the current staff for which there is only 2 tissue viability specialist nurses and 1 support worker to cover all daily needs, including triage, education, visiting patients, reviews and this can have an effect not only on quality and safety but also individuals own health. Further barriers is around education and staff nurses not being able to get released from a ward environment to undergo training around tissue viability and wound care. This has an immediate knock on effect as quality and assessment of assessing pressure ulcers is not documented right 1st time around and appropriate treatment regime implemented before referring to the tissue viability service.
I feel the biggest threat to this is staffing levels and the ability for staff to access/ attend training
reduced staffing and escalation areas constantly meaning staffing is stretched.
Lack of consistent leadership, lack of resource and time for clinical staff to focus on it, lack of engagement from

clinicians due to competing priorities
Lack of incident reporting. Extended length of stay and associated impact (IPC etc) Culture of staff to speak up. Poor leadership, Lack of staff training and resources, Lack of managerial support, Lack of buy in from clinicians, Poor communication, Sickness levels, Recruitment and retention, IPC (poor practice resulting in increased incidents of HAI's) Lack of data systems, Resistance to change
Resource - the organisation tends to have a focus - taking an eye of other things to focus on the hot topic then this changes and you go back to where you started - we don't allow time to embed before moving onto the next thing. therefore not monitoring the sustainability
flow, back door, too many non clinical decision makers
operational pressures, system pressures, repeating meetings - need streamlining, finance, limited staff awareness of Trusts risk appetite, knowledge / skills and staff re human factors, Just culture not embedded, some believe it is not their job or responsibility

Any other comments?
Thank you for the opportunity to complete this survey. It's refreshing and strengthens my perception that the Trust is heading in the right direction.