The Shrewsbury and Telford Hospital NHS

NHS Trust

Reporting to:	**TRUST BOARD - 27 JUNE 2013** **Enclosure 9**
Title	Quality Improvement Strategy- 2012-2017
Sponsoring Director	Vicky Morris - Director of Quality & Safety (Chief Nurse)
Author(s)	Chief Nurse
Previously considered by	N/A
Executive Summary	The Strategy approved by the Board in March 2012 provided a five year Strategy for Quality Improvement. The Quality Account provides an annual basis and opportunity from which to report on the progress being made from that Strategy. It is also an opportunity to review the Strategy and its objectives, which may need to be refreshed or renewed based on the context both nationally and locally. This updated strategy has therefore been reviewed by lead Executives, clinicians and staff to ensure it continues to be an iterative document supporting continuous Quality Improvement.
Strategic Priorities (please tick box) ☒ Quality and Safety ☒ Healthcare Standards ☒ People and Innovation ☒ Community and Partnership ☐ Financial Strength	**Strategic Objectives** (Please select strategic objectives from drop-down menu) Quality and Safety HS3 Deliver all key performance targets People and Innovation CP5 Deliver priority health+wellbeing initiatives Financial Strength
Board Assurance(BAF) Risks (please tick box)	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☐ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☒ Clear Clinical Service Vision or we may not deliver the best services to patients ☒ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 or we will not be authorised as a FT
Care Quality Commission (CQC) outcome	(Please select primary outcome from drop down box) Outcome 16 – Monitoring quality of service provisn
Action (Please tick box) ☐ **Receive** ☒ **Note**	**Recommendation** The Board is asked to NOTE the updated Strategy

| ☐ **Review** | |
| ☐ **Approve** | |

1.0 Introduction

The Trust Board approved a five year Quality Improvement Strategy in March 2012. The Intention for this Strategy was that each year the Strategy would be reviewed to ensure that any key national or local policies were reflected in the document to ensure that the strategy remains relevant to the organisation and the context which it finds itself.

2.0 Background and context

Significant consultation across the Trust with Internal stakeholders, patient representatives and external stakeholders influenced the original Strategy and its approval in March 2012.

The context of a new Chief Executive, a new organisational structure and clinical leadership model as well as national requirements through the Francis Inquiry and published reports(March 2013) were all stimulus for undertaking a review of the Strategy.

3.0 Trust wide ownership of the updated Quality Improvement Strategy

Following approval of the Strategy in March 2012, each Clinical Centre was asked to develop a Quality development plan (QDP), which identified their specific objectives for Patient Safety, Patient experience and Clinical effectiveness and described how they were going to progress the Quality Improvement objectives which were relevant for their clinical areas.

All Clinical Centres apart from Ophthalmology completed a QDP as well as developing their Governance arrangements within their Centres during 2012/13. The Quality and Safety Committee met with representatives from each of the Clinical Centres during 2012/13 to gain assurance about the Clinical Governance arrangements and also explore how they would achieve the Quality objectives.

In developing the Quality Account for 2012/13 (which is being presented in its final form to the June Board), there has been an opportunity to review the Quality Improvement outcomes for year 1 of the Strategy.

There have been some very positive examples of how individual Clinicians and their teams have driven the Quality improvements which they proposed for year 1 of the Strategy. Their passion and determination to make those improvements reflect their determination to put the patient first and at the heart of our improvement work. We need to find ways to celebrate these achievements and during 2013/14 the Executive team are determined to find effective ways to recognise these achievements.

4.0 Updating the Strategy

The Quality account will describe those outcomes and describe some of the priorities for the next year and these have informed the updating of the Strategy (Appendix 1).

- The wording of the Strategy has been updated to:
    - o Reflect the revised Strategic aims and objectives.
    - o Reflect the revised operational structure and leadership roles
    - o Reflect the essence of National reviews and Strategies which have emerged in the first year of the Strategy.
    - o Reflect senior Nurse and Clinicians views on additional objectives required for the Strategy or revised objectives where we have not achieved the improvement outlined in year 1.

5.0 Conclusions

The Quality Improvement Strategy has therefore been updated and will be circulated out to wards and Departments to inform team and care group discussions for 13/14.

The revised operational structure and the enhanced Governance Committee arrangements will monitor the Quality improvements closely and ensure that Board level Committee's are able to gain regular assurance on the progress of the Quality improvements required.

6.0 Recommendations

The Board are asked to **NOTE** the updated Quality Improvement Strategy and the outcomes reflected within the Quality account.

Chief Nurse/ Director of Quality and Safety

June 2013

The Shrewsbury and Telford Hospital **NHS**

NHS Trust

Quality Improvement Strategy

2012 – 2017

Updated version- June 2013ˌ

A National perspective on Quality Improvement

A forward to the Quality Improvement Strategy at The Shrewsbury and Telford Hospital NHS Trust

"The NHS belongs to the people. It is there to improve our health and well being, supporting us to keep mentally and physically well. To get better when we are ill and when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science- bringing the highest levels of human knowledge and skill to saving lives and improve health. It touches lives at times of basic need, when care and compassion are what matters most"

"The NHS Constitution"

National Key points for consideration prior to reviewing SaTH's Quality Improvement Strategy from the NHS Futures Forum following national consultation

- The declaration of "no decision about me, without me" must be hardwired into every part of the system- from the legislation through to each and every encounter between a patient and a healthcare professional.

- There has been too much focus on different parts of the system- GP's, hospitals, public health and insufficient attention to how they all join up to provide the Integrated care that patients need.

- Because the NHS "belongs to the people" there must be transparency about how public money is spent and how and why decisions are made and the outcomes being achieved at every level of the system

- The education and training of the healthcare workforce is the foundation on which the NHS is built and the single most important thing in raising standards of care.

- There will be rising demand as a result of an ageing population. Many of these people will live long, healthy and productive lives. But, increasingly numbers of them will suffer from conditions such as Arthritis, chronic heart and lung disease and dementia that will affect the quality of their lives and place significant demands on their families, carers' and health and social care system.

- A greater proportion of NHS funding will need to be targeted at the increasing numbers of frail older people. We must tackle unacceptable variations in Quality, keep pace with public expectations and raise these expectations where they are simply too low. Meeting all of these challenges requires constant evolution and adaptation by all healthcare professionals.

Contents

Putting Patients first – A Quality Improvement Strategy

Section 1

Introduction from the Board

During 2011/12 the Trust Board focused on the essential improvements required to provide a baseline for Quality Improvement. Following the original approval of this Strategy, the Trust has enhanced its Operational structure and approach to performance management with Clinicians remaining in key leadership roles. The Board therefore remains in a position where they can be confident that the Care Groups led by the senior Medical and Nurse lead can achieve the Quality Improvements that are needed.

Putting patients is our highest priority and will make us think what really matters, so that we can focus on how we use our resources more wisely and afford to do more. It is about:

- Putting the patient at the very centre of our work.
- Focusing on the outcomes of the care that we deliver in order to deliver the most effective and efficient care.
- Supporting the development of clinical leadership throughout the whole organisation so that people who are closest to the patient are able to make decisions in the best interests of the patient.

This Quality Improvement Strategy was approved by the Board in March 2012, and developed and owned by the whole organisation. It describes our priorities for the improvements in patient safety, the improvements in patient experience and the improvements in patient outcomes that we are seeking. It makes these improvements measurable so that we can track progress. The Trust is clearly committed to continuous Quality Improvement and has worked with staff and patients to outline the areas for Quality Improvement for 2012 and beyond. The Board and the Clinical leaders across the organisation will promote innovative ways to support clinical outcomes whilst focusing on promoting and maintaining health and well being as well as prevention.

The performance of Quality has been monitored closely by the Board. An Integrated Performance report is reviewed on a monthly basis at the Board giving an opportunity to review quality, operational and finance performance together to provide the Board with an opportunity to challenge any quality key performance indicators or the operational/finical performance which many impact on quality of care provision.

The ownership of quality improvements by the care groups and clinical leaders within specialist teams will significantly influence the successful delivery of this strategy and will be monitored operationally by the Chief Operating Officer through the Operational Performance Group and by the Medical Director and Chief Nurse through the Clinical Governance Executive Committee.

This Strategy document provides a five year framework from which the Trust can be held to account for the annual improvements it aspires to deliver. The annual improvement outcomes from this Strategy will be published through the Quality account each year. The Strategy document itself will need to be an evolving and iterative document being influenced by national policy and local requirements, however the core to this document are the improvements that staff and patients feel passionate about and we have a desire and an obligation to meet those improvements.

Bringing Clarity to Quality

The first step on the journey to improve quality is to be clear and explicit about the standard of care patients and service users can expect. Developing a confidence in caring is the essence of what this Quality Improvement Strategy sets out to achieve and intends to keep the patient focus at the heart of all areas of improvement.
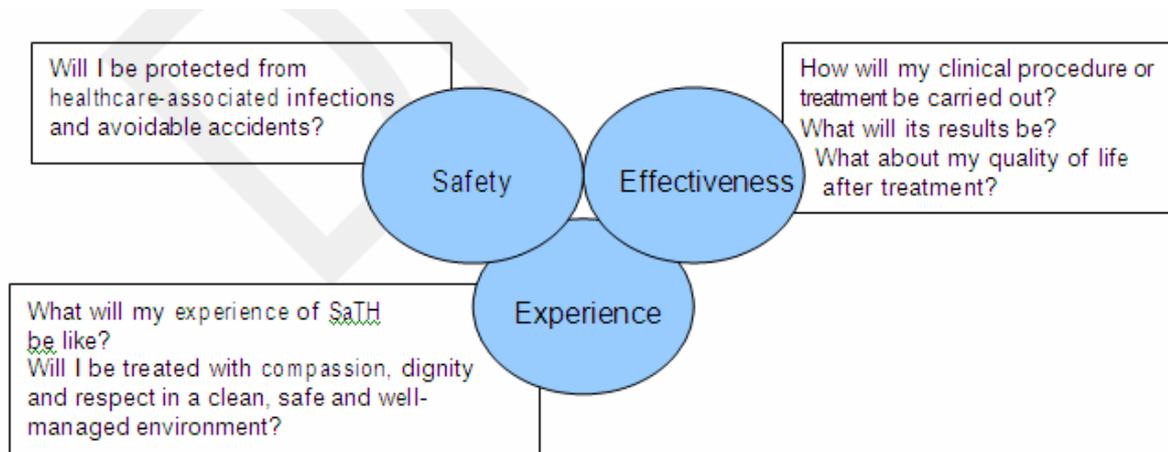
Our quality improvement strategy is a key business driver – we know that improving the quality of our service lies at the heart of being a sustainable and successful organization. In order for us to deliver our strategy we must improve all three dimensions of quality:

- The patient experience

- The safety of our services

- The quality of outcomes delivered through clinical excellence

Our quality improvement strategy (QIS) is supported by explicit year on year objectives across these 3 domains to ensure that quality is everyone's business in our organization (Appendix 1). We also know that being open with the public we serve is also essential if we are to build the confidence in our services.

Whilst we have seen some reductions in the number of falls we have not achieved a reduction in pressure ulcers and our ambitions will be to eradicate these over the period of this Strategy. To build confidence we need to address fundamental aspects of care and achieve the eradication of pressure ulcers and significantly reduce unavoidable falls. We have achieved England's best five-year mortality for colorectal cancer surgery and have a reputation for delivering the most patient friendly maternity service in the West Midlands, with the lowest intervention rates and a highly distributed service model.

Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivery at the Shrewsbury and Telford NHS Hospital Trust and we will monitor not only the clinical outcomes but a range of patient experience feedback methods developed as a framework of best practice in caring for patients. Patients and staff have identified clear priorities for inclusion within this Strategy and we will continue to work with them to ensure that the annual quality Improvement plan and Quality Accounts produced each year support us to become a leading national Trust on quality patient care with optimum outcomes.

We believe that by working together we can redefine the reputation we have for the provision of excellent, safe and high quality health care. We will define our brand in these terms and monitor and measure its validity and strength.

Section 2

Ensuring that Quality Drives our Agenda

2.1   Introduction

As an organisation we would like to be described in 3-5 years time as a Trust which operates according to our operating principles (values) with all our partners in care delivery.

- Putting patients first
- Honest and Integrity

- Being clinically led
- Working and collaborating together
- Encouraging individual ability and creativity
- Taking pride in our organization

2.1.1 Vision for the future: We are an organisation which actively promotes service integration

We have through a number of discussions across the Trust and with partners outlined that we want to provide service delivery which is patient focused, with patients at the centre of everything we do. In essence, care delivered in the right place at the right time by the right individuals. We will deliver care in a variety of settings with our partners, most notably primary care practitioners.

We are clear however, that Quality drives our agenda and in doing so have asked the following question:

"What would it take for all patients to say this about our hospital and recommend us to their friends and family?"

> "*My son, was admitted via SHROPDOC and then went to the Medical Assessment Unit and then for an operation for a burst appendix. During this time, each member of staff was unbelievably kind and nothing too much trouble, keeping us informed at all stages of what was going on. The Dr my son saw was quite wonderful and the nursing staff on MAU were simply brilliant. The surgical team carried on this unbelievable level of care with the outreach nurse who was simply the best- words fail me*"

The purpose of this Quality Improvement Strategy is to outline the transformational improvement that will be undertaken over the next five years to ensure that all patients experience the standards of care and treatment described above. From their first contact with us (as an Outpatient or Inpatient) ensuring that every contact with us creates confidence in the care provided so that each year increasing numbers of patients rate us among the best performing healthcare organisations.

2.2 Our Vision

> *To ensure the interests of our patients, and providing the best possible care to them, are at the heart of everything we do*

2.2.0 Put simply this means we aspire to ensuring that every patient and visitor contact with us at any time of the day or night is memorable for all the right reasons and not just meets but exceeds the individual's expectations and preferences.

2.2.1 Whether the contact is by telephone or in person, if someone is simply seeking advice, visiting a loved one, or attending one of our clinics or wards for care and treatment, they will experience the highest quality of care or service from every single member of staff and at every stage of their personal journey or contact.

2.2.2 The key building blocks to achieve this vision and the improvement goals set out below are for services to strive at all times for improvements in:

- Patient experience
- Clinical effectiveness
- High levels of patient safety

2.2.3 Each year, through our Quality Account, we will report our performance and progress in each of these domains and set out the improvement priorities agreed by the Trust Board for the forthcoming year.

2.3 How will we improve and how much by

2.3.0 We predict that through the development and implementation of the Quality Improvement Strategy, and by identifying ambitious annual Clinical Care Group Quality Development Plans, we will achieve further improvements in clinical quality and patient safety over the next five years. This Strategy does not however,

stand alone and fits with the Trust's overarching integrated business plan. The Integrated Business Plan will be supported by the following Strategies.

- Quality Improvement Strategy
- People Strategy/Workforce Strategy
- Organisational Development Strategy
- Information and technology Strategy
- Estates Strategy
- Risk Management Strategy

2.3.1   The Trust is confident that the five year Quality Improvement Strategy will deliver the following high-level improvement and performance goals by 2017

Achieving **ongoing improvements in patient experience** with the aim of

Getting it 'right first time, every time' for all out patients and Inpatients.

Underpinned and supported by:-

- Real time patient feedback being in top 80% performance with clear actions demonstrated on the 20% where experience is not optimal & to make those improvements whilst patients are still in our care.

- Excellent environment ratings for Patient-Led Assessments of the Care Environment (PLACE) inspections in all hospital wards and departments

- 95% of patients recommended our hospital to family or friends

- 90% of Outpatients rate their care as 'excellent' overall

- 95% of Inpatients rate their care as "excellent" overall

- Patient and Carer information leaflets provided for 100% planned procedures

- 100% Inpatient and Outpatient care delivery will be able to demonstrate carer and patient involvement in decisions and care delivery.

Being able to demonstrate **clinically effectiveness through improved patient outcomes by 2017**

Supported and underpinned by:-

- Achieve comparable national best practice clinical outcomes consistently across all services

- Ensure a 100% of all patients achieve their required constitutional rights on national waiting and access times

- Improve the effectiveness of patients requiring unscheduled care by

  o   Increase the number of elderly frail patients who can be effectively supported and discharged within 72 hrs to 80%.
  o   Reduce emergency surgical admissions by 5%.
  o   In A&E ,being reviewed by a specialist within 1 hr of request and
  o   If decision to admit then admission to a bed within 4hrs

- Increase % day case rates on elective basket of procedures to 80% by 2016.

- Reduction in Staff sickness to 3.5%

- Annual delivery of the Trusts CIP and LTFM

Achieving high levels of **patient safety by 2017 evidenced by a reduced in patient mortality rate and demonstrated by** :-

- o 25% reduction in crude death rate from baseline in June 2011.

- o In the top 10% of hospitals with the lowest Hospital Standardised Mortality rate being below 100.

Supported and underpinned by

- Elimination of "avoidable" hospital acquired pressure ulcers at grade 3&4 by 2013/14

- 80% reduction of inpatient falls resulting in harm by 2017

- Hospital acquired infections reduced year on year across 4 mandatory reporting criterion.

- 100% compliance of WHO safer surgery checklists (2012/13) and 100% compliance on procedural check lists (2013)

- 100% compliance to required medication systems and processes with outcomes in NRLS reporting in top 10% performance nationally.

- 95% reliable standardised care in high risk and volume conditions and clinical process

Section 3

An Integrated Framework for Quality and Service Transformation

3.1 The Quality Improvement Strategy will engage all services and staff in developing hospital care which is patient centred, safe and effective, while also ensuring that efficiency, equity and timeliness are embedded within the service improvement and changes we make.

3.2 The Board & Clinical Care Groups being sufficiently aware of potential risks to Quality

The focus on safety was initially supported in 2011/12 through the LIPs programme and LIA staff engagement process with some examples of quality improvement, however the Board priority for 2012/13 has been to address patient flow and to address the associated risk issues.

The joint working between the Executive team and revised Operational structure (Care Groups) through core committees (Hospital Executive Committee and Risk Management Committee) has enabled a high level view of any emerging risks. At all levels within the organisation there is a recognition that we want to build on this work to ensure that our performance monitoring of care provision is robust to ensure consistently safe and effective care.

3.3 Maintaining and measuring national minimum quality standards

While the primary focus of the strategy is a five year improvement agenda to identify, develop and deliver best practice and innovation, it is equally important that the Trust achieves and maintains excellent performance against minimum national standards such as Care Quality Commission (CQC) essential standards, national targets, NHSLA Risk Management Standards, Clinical Negligence schemes for Trust on Maternity standards and other external inspection or accreditation schemes such as CPA. The Health Assure system introduced into the Trust in late 2011 provides an ability to demonstrate compliance with CQC standards, involving clinical teams.

Delivery of national quality targets and standards (the "must do's") is reflected in the Quality and Safety Indicators Pyramid shown in Appendix 2

3.4 Building on our current Quality performance

We will focus on addressing the known issues that are a cause of concern for our patients as part of our commitment to continuous improvements in Quality as follows:-

- Getting it right first time/ first contact in patient pathways.
  Consistent and effective Communication- Care and compassion
- Providing information at each stage of the pathway
- Consistent clinical standards and practice- safe care
- Strong performance management of care that falls below the required standard
- Way finding (sign posts to wards and Departments)
- Access and booking
- Cancelled operations
- Patient transport

Staff and patient representatives contributing to this Strategy have outlined their concerns about the approach and communication from staff on the front line which they feel has led to a lack of consistency in care delivery. They have outlined that

- Verbal and written communication must be a priority for improvement so that the individual needs of the patient are core to how we professionally communicate as individuals and within clinical teams.
- They have emphasised the importance of the role of the ward manager and Matron in supervising care delivery but importantly to be a strong and visible leader with whom patients and carers can easily discuss any concerns and improvements made where required.
- However, they have identified a need for greater focus on all the interlinking dimensions to Quality as outlined in table 1 (page 11), through clinical leadership and performance management.

3.5   Building a Quality Framework

Recognising the national core questions that constitute a robust Quality Governance Framework will be key to the success of this Quality Improvement Strategy. The headings within this Strategy are taken from that Framework and have led the Trust Board and Clinical leaders to consider how they monitor the effectiveness of our Governance arrangements. Monitoring the evidence provided against that framework will form a key performance measure for the Board and for care groups. The Board have formally reviewed the Quality Governance Framework 2011/12 and in 2012/13 and this will continue to be monitored and managed prospectively. Operationally and strategically the following table provides some examples of how and where Quality performance is monitored.

Table 1

Dimension	Aspect of Care	Method and process for monitoring
safety	Avoiding injury from care that is intended to help; eg medication, surgery, medical equipment, falls, pressure sores, Infections. System and procedural safety checks Timely and effective response to patients who need our support.	Ward to board monitoring Clinical Care Group - Quality performance reports/ metrics Quality and Safety Committee Hospital Executive Committee Risk Management Committee Quality and Safety Committee Health Assure system LIPS,(use of Global trigger tool) Mortality reviews CQUIN'S Quality review meetings with Commissioners
Effective	Avoiding under use or over use of services eg unnecessary tests or investigations. Adherence to guidelines. Clinical audit and monitoring that clinical outcomes are maximised	Governance meetings Care Group Hospital Executive Committee (HEC) Risk Management Committee Workforce Committee Quality and safety committee Clinical audit Committee Research Committee
Patient centred	Providing respectful, responsive individualized care eg Partnership with staff and patients and commissioners to design and redesign care pathways, improve estate and lead changes in direct care. Meeting patients constitutional waiting times and written expectations	Patient experience and Involvement Panel (PEIP) Care Group- Governance meetings Hospital Executive Committee (HEC) Quality and Safety Committee (Q&S) Montgomeryshire CHC Health watch- Shropshire and Telford and Wrekin Balanced score card
Timely	Establishing clear expectations and information for Outpatient appointments. Providing reduce waiting times (Referral to treatment times) and meet clinical requirements for follow up appointments. Ensuring safe transition into and out of the hospital system.	Hospital Executive Committee Finance Committee Operational performance Group LHE- Commissioning groups Balanced score card Complaints Datix Centre performance meetings
Equitable	Providing equal care regardless of personal characteristics, gender, ethnicity, geographical location and socio-economic status	Care Group Governance meetings Real time patient feedback Complaints and patient experience reports to HEC/ Q&S and Board EDS reports to Q&S, HEC and the Board
Efficient	Providing care that best uses available resources for optimal benefit and focuses on eliminating waste such as unnecessary movements of patient &staff	QIPP Ward to Board indicators Finance and Performance Committee HEC, Q&S and the Board

3.6 Quality, Innovation, Productivity and Prevention

Nationally, it has been recognised that there is a potential gap between resources required and resources available of £15-20 billion cumulative by 2014/15 if the NHS carries on as it does now. The NHS has adopted a national strategy for responding to this challenge that combines:

- A recognition that at present there remain inexplicable variations in quality of care and health, and of the use of health services, with many opportunities to significantly improve quality by not carrying on doing what we do now but looking for ways to do it better
- A recognition that in many instances, improving quality can also reduce costs (for example, reducing rates of infection)
- A recognition that whilst the NHS often does a great job, it is better at responding to ill health when it becomes a serious problem than spotting problems earlier and heading them off at the pass before they get serious
- A recognition that with the assistance of new technologies , it is now perfectly feasible to support care at home or in the community that was previously the sole domain of high tech hospitals
- A recognition that there are still many examples where the NHS is simply not maximising productivity in how it works (e.g. duplication of treatment or diagnostic processes, high levels of temporary staff usage, or not achieving potential day case rates) or value in how it buys things in (procurement)
- A recognition that some of the opportunities for health and social care to work together to streamline care are not being maximised
- A recognition that some of what the NHS provides to patients is of low clinical benefit and that it is inappropriate in times of economic restraint for such activity to be allowed to crowd out other activity that offers greater clinical benefits
- A recognition that the management costs within the PCTs and Local Area teams will be reduced

This combination has been brought together under the banner of QIPP, Quality Innovation Productivity and Prevention, and all local organisations in the NHS have been developing plans for how to realise these opportunities locally including SaTH. The process is being led by the Clinical Commissioning Groups (CCG's) and we are working closely with our partners in health and social care to develop a QIPP plan which will provide a clinically and financially sustainable health service for Shropshire, Telford and Wrekin and mid Wales.

Our ambitions for quality improvements already evidence the focus from the Clinicians on putting the patient first and creating efficiencies in the patient pathway. The Trust has summarised its key Strategic aims in the table below which provide the key drivers to our objectives for Quality Improvements.

Trust wide Strategic aims

| **Quality and Safety** |
| Providing the best clinical outcomes, patient safety and patient experience |

| **Healthcare Standards** |
| Delivering consistently high performance in healthcare standards |

| **People and Innovation** |
| Striving for excellence through people and innovation |

| **Community and Partnership** |
| Improving the health and wellbeing of our community through partnership |

| **Financial Strength** |
| Building a sustainable future |

- Early intervention and timely support for our frail and complex patients which will allow them to be treated and sent home either on the same day or within 72hours so that they do not deteriorate through an extended admission where they could lose confidence in their independence and their mobility. The number treated within that time frame has already increased to 30% from December '11 to March '12.- **update**
- Surgical reconfiguration plans to support safe and sustainable services (2012)
- Achieving A&E trauma unit status to sustain effective A&E services at SaTH (2011).
- Increasing Consultant /senior decision making at weekends and out of hours to support effective and timely care for medical admission patients (2011)
- We have achieved England's best five-year mortality for colorectal cancer surgery (2010/11)
- Reputation for delivering the most patient friendly maternity service in the West Midlands, with the lowest intervention rates and a highly distributed service model (2010/11 & 2011/12).

As we move forward future service developments will be realised through the **Care Groups** clinical leadership model with Medical and Nurse leads for each Care group with clinicians identifying service developments alongside Local health economy partners. This visible leadership and strong workforce engagement will provide core and essential ingredients for delivering our ambition.

We are also aware that being safer is also likely to increase our productivity – as we encourage the adoption of evidence based pathways, and organise to make sure our patients are looked after well. We believe this focus is one of the keys to our future financial health.

By developing a widening base of small and large-scale safety improvement initiatives, we will progressively change the culture in our organization so that it is increasingly empowered to investigate and then implement safety improvement at every level.

Section 4

Ensuring the Board & Clinical teams have the necessary leadership, skills and knowledge to delivery of the Quality agenda

The Trust is committed to supporting staff to provide better services to our patients and to support all staff to bring to life the Trusts core values of:

- Working and collaborating together
- Encouraging individual ability and creativity

To support this approach the Trust has formed a Leadership Academy to act as a focus for our current leadership training programmes and to develop aspirant leaders. The different elements of the Leadership Academy are summarized in the diagram in fig 1.

Fig 1
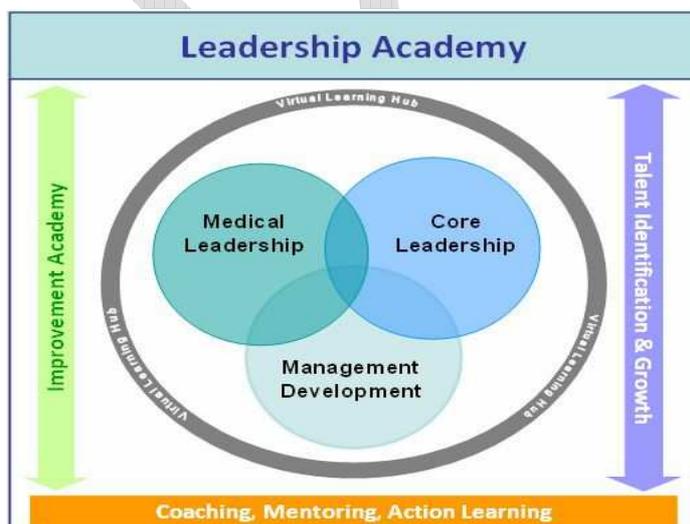
We are working in partnership with coaching specialists to deliver coaching skills training programme to a range of managers to support newly appointed managers and leaders. Coaching and mentoring are proven methods of development. Research shows that they have a positive impact not only with learners but also on the coach and mentor. This in turn will help us to deliver safe and affordable care for our patients.

4.1 The Contribution of the Workforce for Continuous Quality Improvement

The Quality Improvement Strategy recognises the significant contribution that a well-trained, motivated and supported workforce makes to delivering and achieving high quality care and services. It is well documented that changes and improvements which are owned and driven by an individual service or team are the ones which are most likely to be successful and sustained.

When asked, patients frequently cite that not only the skills but also the empathy and friendliness demonstrated by the people looking after them are important and are what contribute significantly to their overall experience of care. The Strategy will escalate action to ensure that all staff have and demonstrate highly-developed customer care and communication skills.

A longer-term strategy aim is to become a learning and quality driven organisation in which every member of staff understands their role in delivering clinical quality and works towards that goal every day.
In the Strategy consultation with staff and patients / carers, they identified the need for increased visibility of Matrons and senior nurses and the Executive team in clinical areas alongside the need to recognize these clinical leaders (clarity about uniforms). Over the period of this Strategy, further work will be undertaken on the image of nursing and midwifery to increase the confidence in care delivery and also the supervision of care delivery.

4.2 Ensuring clearly defined, well understood processes for escalating & resolving issues & managing performance

To support the Strategy principles, the NHS Constitution outlines the need for all clinical staff to re-state their commitment to the patient, public and service users in a pledge to deliver high quality and compassionate care. "Upholding this pledge, all professions can turn their disappointment at any poor practice into positive action". The Francis report (2013)and recommendations outline the importance of compassion and culture and the Dept of Health response to the Staffordshire Inquiry has been (amongst other recommendations) to suggest that all organisations sign up to a "Statement of common purpose" taken from the principles of the NHS Constitution. The Trust Board (May'13) and the Quality and Safety Committee (April '13) have already signed up to this pledge and discussions across all care teams will take place to engage staff in this pledge commitment.

Senior Nurses / Practitioners responsible for care delivery in Outpatients, wards and Departments will need (through this pledge) to re-state their full individual managerial and professional accountability for high quality care and champion quality from the point of care to the Board as well as managing poor performance where and if this arises. Truly compassionate care is skilled, competent & value-based that respects individual dignity. The Trust is committed to the provision of this standard of care and the Strategy recognises that:

- Delivery requires the highest levels of skill and professionalism.

- Tackling poor practice is the responsibility of individual practitioners but an essential component to the ward or Outpatient / Department manager's leadership role. Culturally the organisation needs to provide a confidence and support to tackle poor performance to ensure that performance is managed consistently across all teams.

- Boards and managers must play their full part in their responsibility for care and ensure that all practitioners are heard and heeded at every level, which would include response to the Trust's whistle blowing procedures and appropriate review of all risk registers within Centres and ability to escalate formal concerns about care delivery.

The Chief Nursing Officer in the Department of Health published a framework for best practice entitled "Confidence in caring" (2008). This identified how nurses could create an environment in which patients felt secure by identifying five "Confidence creators".
- A calm clean and safe environment

- A positive friendly culture
- Well managed care with efficient delivery
- Personalised care for and about every patient
- Good team- working and good relationships

This has been followed by a three year National Nursing Strategy "Compassion in Practice" which was published by the Department of Health in Dec 2012. The vision within that document is based around 6 key values.

Care, compassion, courage, communication, competence and commitment.

During the time of the Strategy, our vision will be to embed these values in all nursing, midwifery and care settings across the Trust. The Trust is developing a supporting programme for trained nurses/ midwives and Healthcare assistants to focus on the fundamentals of care and ensure that the range of competencies required are achieved by all members of the team. We have commenced a programme of values based recruitment, and aim to ensure that we appraise and train staff according to those same values.

The patient representative groups such as Montgomeryshire Community Health Council (CHC) and Shropshire "Healthwatch" and Telford and Wrekin statutory patient groups are keen to work with the Trust on improving the patient experience and ensuring consistent standards of care and will monitoring care provision with senior Nurses using these confidence creators and 6 C's.

This Strategy will be supported by the use of national frameworks for highlighting good practice which will enable both the spread of good practice and improve morale. References to the tools and approaches which can be used to improve care can be found on the Trust web site and in appendix 4 to this document. It highlights the good practice that exists and the contribution of nurses/ Allied Health professionals and Medical Clinicians to the challenge of reducing costs and the wider quality agenda.

Nationally it has been recognised that teams and Trusts need to identify and end the individual and system failures that underlie poor quality care. The need to collectively create cultures that welcome and embed innovation and excellence and value and care for the carers is key to this strategy.

Nationally the General Medical Council have developed a Consultation document that describes the accountability of Doctors for optimising care delivery for all inpatients and Outpatients. The proposals reaffirm their accountability for fundamental aspects of care such as Tissue viability (prevention of pressure ulcers) and improving the nutritional status of patients. In moving towards the requirements for revalidation, all registered Doctors will need to provide evidence on a range of patient outcomes to support effective care delivery.

These principles are already embedded within codes of practice for Allied Health professionals and nursing/ Operational Department practitioners and will equally progress into a wider revalidation process to uphold standards of care delivery.

Through these processes excellence in clinical leadership and mentorship for safety and quality improvement will be rewarded and effective leaders will be the role models for staff development and career progression.

Section 5

Shaping the Future

5.1   Promoting a Quality focused culture throughout the Trust

This Strategy will align closely with the development of the Trust's new People's Strategy (July 213) which will outline the transformational approach to supporting staff and recognising the impact on patient care. Emphasis will be placed on understanding our clinical systems and processes in greater detail, working towards excellence in those systems, engaging all staff in improvement activity, using small tests of change to build momentum, and learning from mistakes and poor quality to do better. The Quality Improvement Strategy has been shaped with input from staff, users and patients through a series of consultation events and by encouraging dialogue about what quality looks like and how quality of service can be ensured.

5.2   Actively engaging patients, staff and other key stakeholders on Quality

5.2.0   Public, patient and staff engagement commenced in 2011 with significant engagement and contribution to the development of this strategy. This included a "Listening into action" programme (LiA), LIPS (Leading Improvements in Patient safety) programme and Quality Improvement Workshops. In these engagement processes we asked patients and staff what was important to them in ensuring high quality services for all. Many of the aspects of their views have been integrated into this Strategy. A summary of the key themes that emerged from that engagement can be accessed on our web site under Quality Improvement.

5.2.1   This Quality Improvement Strategy makes a commitment and signals an even higher level of engagement and involvement with patients, community partners and stakeholders in supporting the redesign and transformation of services. This will be achieved by integration of quality improvements with ongoing development and implementation of the Trust's Patient experience and involvement Panel work programme (PEIP). The work programme will cover Outpatient areas, A&E, Theatres, Maternity and Inpatient areas.

5.2.2   Detailed Quality Improvement objectives for patient experience, clinically effective and efficient care, and patient safety will be further developed with input from the Trust's Clinical Care Groups, via the Lead Nurse and Medical Director within each group, clinical leads and audit and Outcomes team.

5.2.3   Our work in developing the Clinical Services Strategy is a key work stream that will ensure we plan for high quality, safe and sustainable services into the future. This work has begun (2013) and has to be done in partnership with our partner organisations in health and social care. Working with Clinical Commissioning groups and the Local health economy will be core to ensuring care is delivered in the best interests of the patients whether that is in their home or within the specialist clinical centre within the hospital. In essence providing the right care in the right place and by the right professional will be key to our success.

5.2.4   The Care Group Medical Directors/ Lead Nurses, Clinical Directors, clinical leads/ ward / Dept managers will work with the Trusts' Medical Director, Chief Nurse/ Director of Quality and Safety and Chief Operating Officer / Executive team to ensure a multidisciplinary focus on continuous quality improvement. Work within each Care Group and service area will lead to the development of an annual Quality Development Plan (QDP), with a focus on areas which improve quality while reducing costs. These QDP's will inform the annual updating of the Quality Improvement Strategy and will influence the top priorities reported through the Quality account

5.2.5   The Trust will continue to enhance the partnership work that it has built up over the last two year's with the Patients panel (PEIP) and with the Statutory Patient representative groups (Health watch in Shropshire and for Telford and Wrekin as well as Montgomeryshire Community Health Council; so that patients and patient and carer representatives are consistently involved in service redesign and are actively involved in the metrics approach to gaining patient experience from Outpatient areas, Departments and wards. The Trust will build on the methods of feedback and enhance the triangulation of themes and trends arising from those approaches.

5.2.5   As part of implementing the Quality Improvement Strategy we will investigate these themes further, using agreed patient feedback methodology including "Real Time" Monitoring to ask a high numbers of Outpatients and Inpatients about their immediate experience of care and services. If patients say they would recommend us to others we will ask why and for those who would not, we will also ask why and use

the information to give feedback to staff and target our improvement efforts. The use of the Net promoter will be key to measuring confidence in the care we provide.

5.2.6   We will also engage and consult with Commissioners about our improvement plans to ensure that they are consistent and contribute to the vision and quality framework set out in West Mercia Cluster and SHA Improvement programme. We will seek their support in implementation and in particular, we will do this through the Commissioning for Quality and Innovation (CQUIN) payment framework, contractual Quality improvement objectives, joint working and the continuation of collaborative improvement schemes across the sector, eg Safeguarding.

5.2.7   Quality improvements will also extend where appropriate to preventative and anticipatory care, in support of improving health gain, reducing health inequalities and keeping people out of hospital when it is clinically effective and appropriate to do.

5.3   Metrics approach to care delivery – The Trust approach to putting patients first

The Trust Board recognizes that Quality and Safety are core aspects of the Boards agenda and that at least 25% of the agenda at the Board is focused on those aspects of the Trusts business. In the principles of putting patients first (one of the organizing principles of the Trust) a patient story is read out at the Board at least Quarterly, and monthly at Quality and Safety Committee. The Care groups will be encouraged to do the same in their Governance Business meetings. This process ensures that the emotions of this story resonate whilst the core business continues. The following methods to reviewing care will provide a metrics approach for Departments/ wards/ centres and corporate Committee's to evaluate Quality care provision and performance.

5.3.1   **Observations of Care** – Observing care delivery in a ward and or Departments in teams of 2. Involves:- Board members, Corporate nursing team, senior managers/Matrons, members of the Patients panel and Commissioners. Direct feedback of positive aspects of care as well as any issues which may need to be addressed will be given to the ward manager or nurse in charge with written feedback to the relevant clinical centre as well as a high level summary to the Quality and Safety Committee.

5.3.2   **Patient Stories and Patient Diaries** - Recruiting patients at the beginning of their patient pathway either in Outpatients or as an inpatient to share their story with us or use a Diary to record all aspects of their care, will be a core part of our improvement programme. Both processes will be used to evaluate and improve care delivery. This involves :- Patient experience and involvement panel members (PEIP) who have received training on these principles; PAL's, Patient services team, Corporate Nursing team, Matrons, LiNKs, CHC and Commissioners. The themes from these stories will be triangulated with complaints and PALs/ real time patient feedback and fed back to wards/ Depts within each relevant clinical Care Group and corporately collated so that emerging trends and themes for improvement are clear.

5.3.3   **Themed patient panel reviews** – When trends or themes appear the Trust will establish comprehensive panel reviews into those issues resulting in an internal report for consideration by the Hospital Executive Committee, Quality and Safety Committee and Board consideration when required. This will involve:-Patient experience and involvement panel members (PEIP), Healthwatch, CHC, Corporate Nursing team, Clinical Matrons and Commissioners/ Education providers.

5.3.4   **Real time patient feedback** – Through an agreed template which has been designed to ask core open questions from patients during their Inpatient stay or in Outpatients/ A&E and Maternity. This will illicit real time feed back and enable prospective improvements to be made. Monthly this will reflect the progress being made on areas of improvement from the annual patient survey but also the top themes of concern from complaints and real time patient feedback as well as the "net promoter" questions on discharge. Ward managers, service area clinical matrons, PEIP members, Patient services team, corporate nursing team and Commissioners will be involved.

5.3.5   **Ward to Board review** – Core clinical (patient sensitive) Indicators have been agreed for ongoing review as indicators of the effectiveness of care delivery, this provides ward /Dept/ A&E/ Maternity level as well as care group and Board level information to identify trends and themes. The information will be gathered by ward managers/ Matrons/ Senior nurses and supported by PEIP members with the information gathered from this process being shared publically on each ward.

5.3.6   **Quality Performance reviews** – The Care Groups will all have a monthly Quality performance review of these Indicators as part of their core Governance performance meetings. To maintain an overview of the

overall and individual Care group Quality Performance the Deputy Chief Nurse is a member of the Operational performance Group chaired by the Chief Operating Officer.

5.3.7 **Patient-Led Assessments of the Care Environment (PLACE)**– A monthly review of Patient environments to ensure that cleanliness, estate and facility issues are picked up and improved. This involves:- Patient panel members, Corporate nursing team, facilities, Infection Control team and Estates.

The PLACE Assessment format is similar to that of PEAT in that it encompasses the same four broad categories as follows:

Cleanliness
Buildings and Facilities
Food and Hydration
Privacy, Dignity and Wellbeing

The key difference is that the assessment is led by the patient representatives rather than by the Trust staff as used to be the case with PEAT. There have been some changes to the recording documentation and the patient representatives now have the opportunity to complete their own assessment summary.

5.3.8 **Patient Safety First reviews** – The NPSA advocate "*Patient Safety first"* reviews of ward/ Dept areas. A tool is available which enables Executive Directors and Non Executive Directors meeting with staff teams to discuss care delivery, the concerns about care delivery and support to progress. These will always be announced and a summary of discussions and agreed actions will be fed back to the Departments, Executive team and Quality and Safety Committee.

5.3.9 **Unannounced ward and Department reviews** - Through our active monitoring and triangulation of key performance Indicators per ward and Department, we are now able to identify clinical areas which are cause for concern. In these circumstances we have over the last two years undertaken detailed reviews of wards, some resulting in formal investigations into the concerns, remedial action plans or assurance provided. This process now includes patient or carer representation and commissioners/ Education providers and will progress onto a planned annual programme of review which will encompass all clinical areas and highlight the positive progress being made by clinical areas as well as picking up areas for improvement where these have been evidenced through the review.

5.3.10 **Quality and Safety Committee** - is a formal committee established by the Board to review all quality and Safety issues in relation to performance. The Committee will identify trends and themes of issues with care delivery and raise any concerns with the Board. As part of this assurance process a 1 hour visit to a clinical area prior to the formal Committee business commencing is a formal part of the agenda with any issues from the visit being minuted.

5.3.11 **Executive Directors- Clinical profile and support roles** - The Executive Directors who are clinicians will be expected to undertake Clinical time with front line teams and ensure clear clinical leadership as well as clinical credibility. The Corporate nursing and Medical teams will also support this approach with all having 4 clinical sessions built into their job planning. Non Clinical Executive Directors will support a wider profile in clinical areas and also support a " Non Executive" Director style support to Care groups and their teams.

5.4 Key themes emerging from staff and patients

Using the information from staff and patient engagement in order to develop this Strategy and existing sources of patient user feedback, the following themes emerge as to what **Excellence in Quality** and service looks and feels like to patients, carers and staff:

- Caring, **compassionate** and **competent** staff

- Clear **communication** and **explanation** at all stages of care

- Effective **collaboration** and **team** work

- **Continuity** of care and service between different stages and organisations

- Clinical **Excellence** in care and treatment **outcomes**

- The need to feel **confident** and **safe** in our care

Section 6

Providing clarity of roles & accountabilities in relation to Quality Governance

6.1 Integrating Quality into the annual plans

Local markers relating to the three key areas of patient safety, effectiveness and experience will be developed within each Care group building on the previous Clinical centre work undertaken and service area /specialty in line with business and operating plans to ensure that these are embedded at a service line level and are consistent with future financial plans. Workforce measures will be developed at service line level to incorporate 'team' measures which will address staff- related quality issues, e.g improved management of poor performance.

The development of an annual Care group Quality Development Plan will set out clear objectives and milestones for delivery for each of the quality indicators. The plan will clarify governance arrangements and accountabilities for delivery of the plan.

Each year, through our Quality Account, we will report our performance and progress in each of these domains and set out the improvement priorities agreed by the Trust Board for the forthcoming year.

6.2 Identification and planning for Quality Innovation and Improvement through the Commissioning (CQUIN) framework

The Trust has been working with Commissioners to identify and align 2012/13 CQUIN improvements with Quality Improvement Strategy goals (Appendix 3). Careful consideration of future CQUIN measures will be undertaken to ensure that these are aligned to the annual Quality development plan.

6.3 Aligning the vision for quality with regional and national Quality tools.

The Trust's vision and goals for quality and safety improvement are intrinsically linked and integrated with the overall aims of the national and regional priorities (Appendix 2). Appendix 4 outlines the references to a number of national & regional tools, which will increasingly be used by the Trust (if not already) to measure and benchmark the quality of care provided by the Trust.

The regional Commissioning frameworks as well as the National Operating Framework will provide an ongoing Quality improvement programme with our commissioning colleagues. The work with our local Commissioners through the CQUIN measures will also use many of the patient related specific high impact measures recommended nationally and regionally. The Trust will develop these methodologies over the period of the Strategy to integrate and enhance our performance measurements. Using our current methods and a regional framework the aim will be to achieve desired productivity, efficiency and financial gains in tandem with increased patient and staff satisfaction and improved clinical quality.

6.4 Quality Alignment to Business and financial plans

The annual Quality Development Plans were developed in clinical Centres for 12/13 and will be developed alongside the business planning process each year. Discussions have commenced with Care groups in line with the development of 2013/14 business plans, with all of the Cost Improvement schemes, service developments and capital builds being assessed using the **Quality Impact assessment process** to ensure we are confident that any efficiency proposals are not to the detriment of quality of our services.

The following criteria are used to assess proposed CIP schemes.
- They will support the Strategic objectives of the Trust
- They will not be to the detriment of clinical Quality, more likely they will enhance the care we offer.
- They will not stifle innovation. More likely they will support our clinical teams in pushing the boundaries of excellent productive clinical care
- They will take into account key risks highlighted through the Trusts corporate risk register.

6.5 Aligning the vision for Quality with Audit, research and Innovation

Internationally, the highest quality of care and the best outcomes are found in hospitals that have developed a strong audit and research mission. The evidence shows that this is because patient care is improved by participation in clinical trials and the benefits accrued by the application of clinical innovation and the most advanced surgical and medical techniques.

The Trust has a clinical audit Committee chaired by the Deputy Medical Director. The Committee has a clinical audit forward work plan and the governance arrangements include tracking audit outcomes and action plans for improvement. Ensuring that action plans for improvement and repeating clinical audits once improvements have been made will be a key improvement process to underpin this Strategy and the Quality and Safety Committee will closely monitor the reports it receives from clinical audit.

The clinical Care Groups will all need to have a clinical lead represented at this committee to ensure that clinical audit programmes represent the improvements required within each centre and move to a Multidisciplinary focus for improvement rather than uni - professional audits. Each service area will need to develop its evidence base, audit capacity and research plans to drive translational research. Innovation to develop new care pathways and produce system change will be included in each service plan.

6.6 Aligning the vision for Quality with front line staff

6.6.1 Tackling poor care is everyone's responsibility. It is right that there should not be unacceptable variations in the standards of care. To achieve this we need confident nurses, midwives, Allied Health professionals and Medical staff as well as strong leaders. The General Medical Council the role of medical staff in upholding Quality standards (nutrition and tissue viability being two examples).

6.6.2 The Nursing and Midwifery Council Code enshrines the expectations of the profession to deliver high quality care. High quality standards of care are a feature of the NHS Constitution for all staff and are also expressed in the Principles of Nursing Practice launched by the Royal College of Nursing in November 2010. The Trust will work with Education providers to use the Principles of Nursing Practice as a pledge so that their nurses/ midwives and students understand what is expected of them. Our pledge to nurses and midwives is that we will give them much more autonomy.

6.6.3 Nursing, Midwifery, AHP and Medical leaders are responsible for ensuring compassionate, high quality, safe and effective care. The Trust expects there to be an increasing focus on improving outcomes and experiences for the people who use their services, particularly safeguarding vulnerable and frail elderly and to ensure "Dignity in care".

6.6.4 The atmosphere in which care is given must also be right. This will need better protection and a stronger voice for staff. We are resolute in protecting the right of staff to speak out about poor care or workplace bullying. There will be zero tolerance of direct threats to the physical safety of front line staff.

6.6.5 There is a clear corporate responsibility for care and the Trust will work with its Commissioners and staff to ensure that lines of accountability in SaTH are clear. It makes sense to identify a board member to be the champion of high quality care. This responsibility is currently with the Chief Nurse/ Director of Quality and Safety, but it should be clear that the quality of care is a corporate responsibility not just enshrined through one director.

6.6.6 The leadership exhibited by ward sisters, charge nurses, and other nurse leaders in SaTH is pivotal. The strength of that leadership has an unambiguous link to the quality of care and the reputation of the profession. But they must be given time to clinically lead their teams. Time consumed on bureaucratic tasks must be reduced so they have time to supervise staff and the delivery of care as well as provide a visible presence to patients and their families/ carers.

6.6.7 We need to get the best out of our staff. We want Drs, Allied Health Professionals, nurses and midwives to demonstrate their leadership skills and be more autonomous at every stage of their careers, suggesting ways of improving care and innovating to improve the delivery of services. SaTH has recognised the need for strong Clinical leaders and Operational managers through the development of the Clinical Care Groups.

Equally it recognizes leadership potential and will provide, in collaboration with universities and internal programmes, opportunities for leadership development.

6.6.8   To demonstrate this commitment we will be implementing a back to the floor programme for Matrons and senior nurses/ midwives to ensure a consistent focus on front line care alongside a development programme in which a junior nurse or midwife representative could sit with the Quality and Safety Committee or the Trust board on a rotational basis. This will give staff at a junior level the opportunity to express new ideas to decision makers and to gain an understanding of the wider operation of an NHS organisation.

Section 7

Implementing the Quality Improvement Strategy

7.1   The Quality Improvement Strategy framework aims to build on the organisation's strengths and previous successes in improving care and services and to complement the existing clinical governance infrastructure and quality initiatives already in place.

7.2   Quality improvement is a continuous process. Successful quality programmes require vision, creative thinking and ideas but also clear delivery plans with measurable goals and targets to ensure progress and success is tracked and celebrated. (Appendix 1)

7.3   In implementing the Strategy, the organisation will need to learn and adopt a range of quality improvement techniques and approaches, including measurement and the use of data for quality improvement. Clinicians and managers will need to work together and demonstrate drive and determination to develop the will and infrastructure required locally in each service to deliver and sustain the unprecedented scale of quality improvement we want to achieve.

7.4.1   The Quality Improvement Strategy quality driver diagram (Appendix 3) identifies four key interlinking and complementary organisational drivers, which when implemented will support achievement of the vision and the improvement goals set out in Section 2. These are driving development and implementation of

- Leadership and culture for quality improvement
- Measurement for quality improvement
- Evidence-based interventions and proven best practice
- Workforce capability and skill for quality improvement

7.5   Effective high-performing organisations recognise the significance of quality and continuous quality improvement to achieving their strategic and core business goals and are successful in engaging and communicating this to all staff and to service users.

7.6   The Trust Board will oversee implementation of the Quality Improvement Strategy. It will agree and articulate clear improvement goals, drive an improvement culture throughout the organisation, support effective clinical leadership and ensure and approve an infrastructure for strategy implementation.

7.7   The Board will use the principles from the national "Road map for Quality" (Appendix 4) to drive quality Improvements. In outline terms fig 2 outlines the key aspects to that virtuous Quality Improvement circle

7.8   The Board have authorised the Quality and Safety Committee to oversee the Quality and safety agenda and this committee will therefore monitor the development and implementation of the annual Quality Improvement plans arising from this Strategy. The Quality & Safety Committee is a formal sub committee of the Trust Board and as such will formally report on the progress of the implementation and also agree with the Board a programme of Quality presentations to be made each year which will best represent the progress or difficulties in the areas of safety, Clinical effectiveness and patient experience.

7.9   A five year plan outlined in Appendix 1 would be used to monitor the implementation of this strategy, whilst still leaving priority actions to be implemented through an annual Quality development plan (published with the Quality Account).

Fig 2 Quality driving the Trust agenda
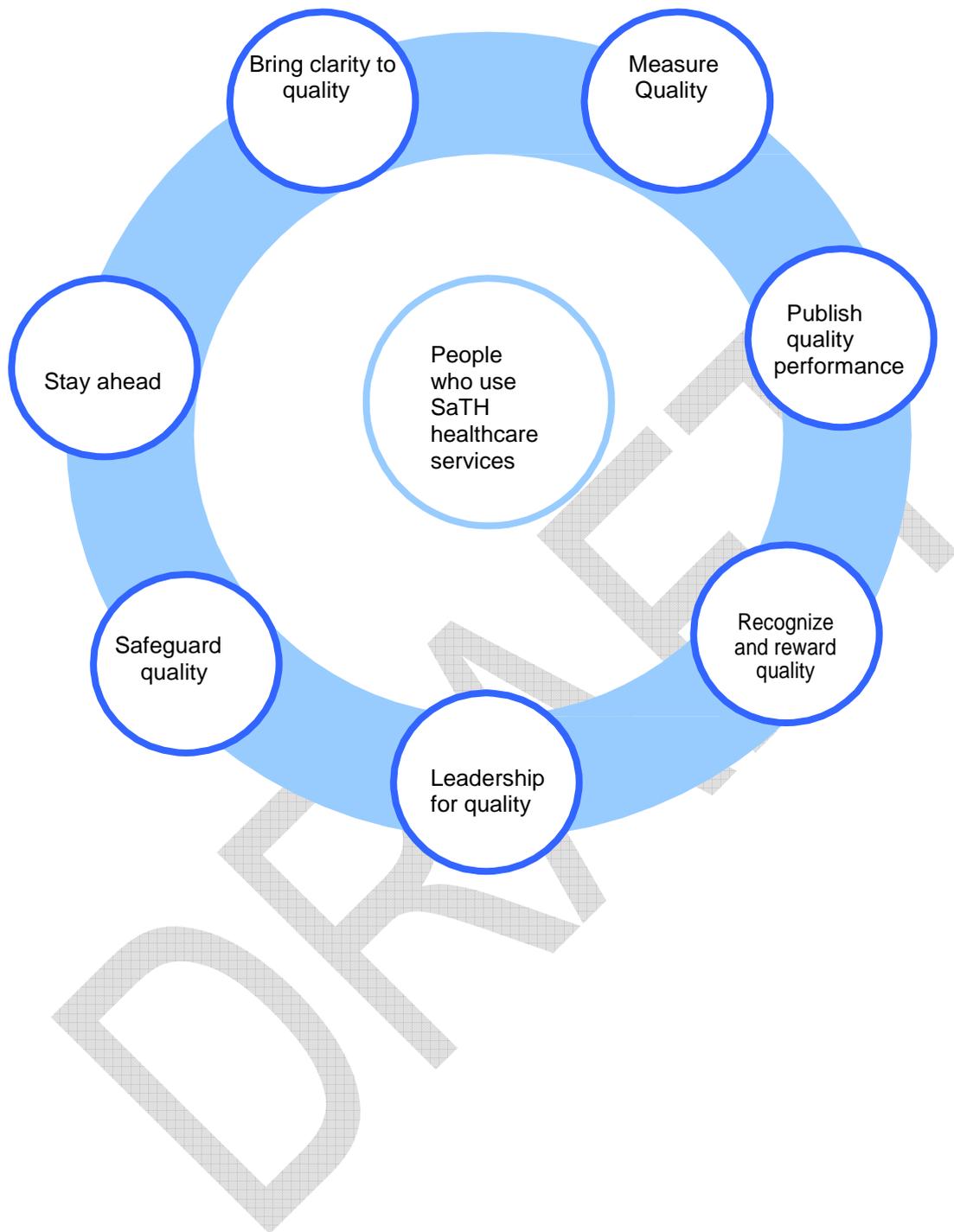
Section 8

Quality Information

8.1 Ensuring an appropriate review of quality Information

Measurement of Quality - The challenge set by "High Quality Care for All" was for healthcare organisations to be able to define, deliver and measure quality in the three dimensions of patient experience, safety and effectiveness and in all services and at every service level.

Ward to Board approach - Process and outcome metrics at Board, Care Group and ward/ Dept level will continue to be developed to enable progress towards the Strategy's goals and targets to be measured and reported for each implementation year. This is supported by a Peer review process and will be enhanced through the Metrics approach described earlier in the Strategy.

8.2 Developing Board assurance from Robust Quality Information

Meeting national quality standards and sharing that information provides assurance to patients, users and Commissioners that the Shrewsbury and Telford Hospitals NHS Trust is a safe and high-performing organisation with effective and robust clinical governance, including risk management, processes embedded in every Care Group, ward, service. All wards and Departments will develop an annual programme for updating patient information which is specific for their pathway and ensure that their customer care and approach is consistent to support the education and care required by all our patients. The clinical indicators used in the ward to Board metrics as well as the Health assure system will enhance the evidence provided against quality standards.

Robust Quality Information - Implementing the Quality Improvement Strategy across the Trust will require consideration of investment in expertise and resources to enhance existing data capture, improve coding and support frontline staff to acquire new skills and expertise in using data to support quality improvement at ward and service level. This will be supported through the workforce and OD strategy.

IT strategy supporting improved Quality Information - The support from the innovations outlined within our draft IT Strategy will release time to care for front line staff and improve Quality Information through a number of electronic methodologies to record and improve care information (Electronic patient record, patient observations).

QIPP programme -Quality Information being used effectively – Clinical teams will work with their service areas/ QIPP programmes to ensure that the Integrated patient pathway documents outlines and demonstrates best practice with educational and information leaflets being provided for all clinical and non-clinical services. Wards and departments will also identify and establish systems to define and monitor the quality of their services, including high quality customer service where appropriate and to demonstrate value for money and service efficiency. This will include a revised training and implementation plan for the QIPP work and benchmarking and ongoing development and use of visual management and 'Ward to Board' metrics.

The Quality and Safety Indicators Pyramid describes the Performance Dashboard and other indicators collected and reported currently, including the regional and locally developed CQUIN projects (Appendix 2).

If and where significant gaps or risks are identified in meeting minimum standards, national guidance or accreditation requirements; corrective action will be identified and if appropriate prioritised as part of that year's Quality Development Plan. The use of the ward/ Care Group risk registers to pick up the risks emerging from any clinical issues will need to be timely and effective to enable escalation to Risk Management Executive and Board if required.
These actions will ensure an integrated approach to continuous quality improvement and information, with equal priority given to maintaining minimum quality and safety standards, as well as working towards Excellence in quality and service delivery, and ensuring year-on-year advances in innovation.

Section 9

Evidence-based interventions and implementing best practice and innovation in Quality and safety

The Trust already has experience of implementing programmes such as the "Leading Improvements in Patient Safety" and "Listening into action". The Quality Improvement Strategy will require increased use of benchmarking and continued implementation of evidence-based safety interventions and recognised best practice to achieve excellent clinical outcomes for patients. Having robust care group driven clinical audit programmes which demonstrate year on year improvements will be key for the Trust's clinical audit forward work programmes and the evidence required by the Quality and Safety Committee to provide assurance that this Strategy is being implemented effectively.

The QIPP programme outlined earlier in the Strategy will enable all clinical teams and services to identify and define quality and best practice standards and markers for their services, including any nationally- agreed standards, guidelines for clinical effectiveness and quality indicators derived as a result of participation in national audits.

9.1   Continuous improvement requires commitment, an inclusive approach and continuous review.

The formal evaluation of this Strategy and the impact on quality improvements in care provision is essential to the organisation. We will work with staff and patients to ensure that the full range of patient specific measures of care and experience are robust to provide information for them as well as creating a clinical audit programme that underpins and demonstrate continuous quality improvement within the Trust.

The Care Groups will each need to develop a Quality development plan with clear Quality improvement goals to support the overall pace and drive outlined in this Strategy. The key performance measures will be monitored through the Operational performance meetings and reported through to Clinical Governance Executive, Quality and Safety Committee and the Board through the Integrated Performance Report.

The ongoing involvement of our Commissioners, staff, patients panel and Statutory patient representative groups is not only important in reviewing care and evaluating patient experience but in prioritising clinical areas for improvement in each annual Quality development Plan. The Trust will develop a programme of activity that enables this continuous involvement and the principles of this will be produced in the Annual Quality Accounts.

The Trust Board will encourage and promote innovation in quality and safety improvement at all levels and ensure achievements and successes (big and small) are recognised, rewarded and shared widely both internally and externally to the community, patients and partners.

Appendix 1

The Shrewsbury and Telford Hospital NHS Operational Objectives 2013/14		
	Objective	Exec Lead
Quality and Safety Providing the best clinical outcomes, patient safety and patient experience	QS1 Reduce avoidable deaths QS2 Improve the nutritional status of patients and hydration and fluid management QS3 Enhance communication and information for all patients and their carers QS4 Eradicate all avoidable grade 3 and 4 pressure ulcers QS5 Reduce the number of RIDDOR reportable falls QS6 Develop plans to extend 7 day working QS7 Achieve all CQUIN targets and PROMs to improve safety and patient experience QS8 Develop a long-term clinical services site strategy and wider health strategy for the optimal configuration of acute, community and primary care services QS9 Focus on improving clinical outcomes particularly for stroke and fractured neck of femur	• MD • DQ&S • DQ&S • DQ&S • DQ&S • DQ&S • DQ&S • DBE • MD
Healthcare Standards Delivering consistently high performance in healthcare standards	HS1 Ensure bed capacity meets demand supported through wider health partnership solutions HS2 Improving the timely flow of patients from admission to discharge HS3 Deliver all key performance targets HS4 Embed and enhance new booking and scheduling arrangements	• COO • COO • COO • COO
People and Innovation Striving for excellence through people and innovation	PI1 Implement a Staff Engagement Framework that improves employment experience and reduces absence to less than 4% PI2 Embed Employment Basics contract, pay and policy PI3 Increase workforce flexibility through new roles and working practices PI4 Build leadership and management capability PI5 Deliver benefits for patients from Academic Health Sciences Network, High Impact Interventions and Research and Development	• WD • WD • WD • WD • MD
Community and Partnership Improving the health and wellbeing of our community through partnership	CP1 Develop an integrated service strategy in conjunction with all health and social care partners CP2 Embed the Frail and Complex service CP3 Deliver the benefits for patients through the implementation of the RAID service (Rapid Assessment Integrated Discharge) and dementia practice CP4 Progress Telehealth initiatives in line with commissioners' strategies CP5 Deliver priority health and wellbeing initiatives CP6 Achieve sustained improvement in trust, confidence, reputation, customer service and public/community engagement	• COO • COO • COO/MD • DBE • CD • CD
Financial Strength Building a sustainable future	FS1 Deliver our milestones to achieve NHS Foundation Trust status FS2 Deliver our milestones within the Women and Children's services reconfiguration plan FS3 Deliver a Financial Surplus of £1.2m FS4 Deliver Trust 5% implied efficiency target and support delivery of joint QIPP FS5 Develop an investment strategy to secure funds to modernise the Trust estates and infrastructure FS6 Address liquidity issues FS7 Produce a strategy for integrated clinical and patient information systems and associated IT FS8 Complete Pathology reconfiguration and Central Sterile Services Department (CSSD) tender exercise FS9 Develop environmental and sustainability through Good Corporate Citizen progress	•DCG •DBE •FD •FD •FD •FD •FD • •DBE / FD •DCG

Quality Improvement Strategy Objectives in the 3 Domains of Quality

Domain 1 Safety   To reduce Mortality rate by 25% over the 5 years of the Strategy (2017).

Quality Improvement Strategy supporting objectives	2012/13	2013/14	2014/15	2015/16	2016/17	
Demonstrated by reduction in hospital HSMR to below 100. Also demonstrated by reduction in Crude death rates by 25% from 2011 baseline (June 2011)	10%	2%	2%	1%	maintain	
Reduce avoidable death, disability and chronic illness from VTE moving from 90% assessments in 12/13 to 95% by 2017 and then sustain level over 5 year period. Demonstration of required prescription for risk identified System for reporting DVT and PE's within the Trust Reduced pulmonary embolism demonstrated through Datix	91% 95% Not required Baseline not defined	92% 96% System in place tbd	93% 97% 90% recorded tbd	94% 98% 100% recorded tbd	95% 99% 100% recorded tbd	
Reduction and then Elimination of grade 4 hospital acquired (unavoidable) pressure ulcers (Baseline 2012)	Elimination by March 2013	0%	0%	0%	0%	
Reduction and then elimination of grade 3 hospital acquired (unavoidable)pressure ulcers	Elimination by December 2012	0%	0%	0%	0%	
100% compliance of assessment of skin integrity within 2hrs of admission and personalised care plan within 6hrs leading to improved tissue viability and reduction of grade 3&4 pressure ulcers as above	100% 95%	100% 98%	100% 99%	100% 100%	100% 100%	

Reduction of grade 2 hospital acquired pressure ulcers through improved assessment, reporting, care planning and management.	RCA on all grade 2's	25% reduction	25% reduction	25% reduction	25% to elimination	
Audit results demonstrating 100% of grade 1&2 pressure ulcers recorded in patient notes and on Datix reporting system.	Baseline year	100 % records	100% records	100% records	100% records	
Quality Improvement Strategy supporting objectives for SAFETY	2012/13	2013/14	2014/15	2015/16	2016/17	
Never Events	0%	0%	0%	0%	0%	
WHO safer surgery- 100% compliance	100%	100%	100%	100%	100%	
WHO safer Interventional procedure checks -	Policy in place	100% Care groups to implement policy	100% of agreed audits undertaken	100% compliance	100% compliance	
(i) The Trust has full clinical pathology accreditation for its laboratory services. We now wish to strengthen the regulation of points of care testing services delivered within the Trust to come under Clinical pathology services and the standards provided by achieving the accreditation – CPA (UK)Ltd- standards for medical Laboratories	To maintain To establish SOP's, required calibration processes and consistent kit	To maintain To achieve accreditation standard	To maintain To maintain	To maintain To maintain	To maintain To maintain	
Year on year reduction in MRSA Bacteraemia (in figures)	1	0	0	0	0	
Year on year reduction of post 72 hrs C-difficile (nationally determined)	45	27	24	20	15	
Year on year reduction in MSSA Bacteraemia figures (post 48hrs)	28	21	20	18	16	
Year on year reduction in E-Coli Bacteraemia figures (post 48hrs)	65	40	35	30	25	

Formally introduce the Safety Thermometer as an indicator across the agreed 4 national harm indicators and % patients where no harm has occurred.		tbd	tbd	tbd	tbd	
Reduction in central venous line infection rates on Neonatal unit demonstrated through improved compliance with care bundle (and reduction in infections)	90%	95%	100%	100%	100%	
Reducing Inpatient falls resulting in harm	20	15	12	10	8	
Implementation of PEWs (hard copy and then moving to Vital Pac)- % targets to be revised and confirmed by Clinical centre	90%	95%	100% on vitalPAC	100%	100%	
Reduction in stillbirth rate by 1) training all midwives in fundal height measurement and 2) implementation of detection of IUGR monitoring	1) 90% & 2) 85%	1)95% & 2) 90%	100% & 2) 95%	100% & 2) 100%	100% & 2) 100%	
Quality Improvement Strategy supporting objectives for Safety	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Safe and effective medicines management demonstrated through:-						
100% of patients have their drugs reviewed by Medical Practitioner within 12hrs of admission and within 24hr period by Pharmacy staff during week.	100%	100%	100%	100%	100%	
Audit programme on Safe and Secure handling of medicines and Controlled drug storage (including action plan for improvement and re-audit)	Not entered	100%	100%	100%	100%	100%
Drug related Never Events	Not entered	0%	0%	0%	0%	0%
Ensuring adherence to antibiotic guidelines and appropriate treatment with antibiotics	Not entered	90%	95%	95%	95%	95%
Effective prescription and administration of Insulin through completed diabetic training modules by staff (2 modules)with improving patient outcomes demonstrated from baseline audit and	90%	95%	98%	100%	100%	

Datix reports in 2012/13.						
Implementation of electronic prescribing in the Trust	Not entered	15%	15%	15%	75%	75%
Safe and effective discharge every time	Not Entered	90%	93%	95%	96%	97%
Improve response to patient deterioration evidenced by a range of key performance Indicators						
All EWS escalation levels and response defined and agreed within a Trust wide Policy. Care groups to define LTC impact into EWS and agree acute response	Not entered	Policy per specialty agreed				
Response to EWS within agreed timescales	90%	95%	98%	100%	100%	
Review by a senior decision maker on a daily basis for patients requiring review	95%	98%	100%	100%	100%	
Daily ward rounds/ Board rounds	100%	100%	100%	100%	100%	
Reduction in falls resulting in harm based on 2011/12	20%	20%	20%	20%	20%	

Domain 2 Clinical Effectiveness

Overall objective to provide optimum care provided at the right time, (every time) by the right professional and in the right place

Quality Improvement Strategy supporting objectives for Clinical Effectiveness	2012/13	2013/14	2014/15	2015/16	2016/17	
Improving patient access and waiting times through elective route- national Trust target achieved	100%	100%	100%	100%	100%	
Referral to treatment time for all cancer 2 week waits.	100%	100%	100%	100%	100%	

Define the required pathway to achieve required Diagnostic waiting times • within the cancer waiting times • Diagnostics within Emergency pathway in ED to sustain patient flow within required timescales	tbd	tbd				
Follow up appointment to agreed time requirement (set by clinician).	100%	100%	100%	100%	100%	
Exceptions to follow up patients (picked up by Datix or complaints) to have a full RCA to determine clinical impact on patient	100%	100%	100%	100%	100%	
Reduced delayed transfers of care monthly mean number of patients.	23	22	21	20	19	
Mean length of stay reduction (measured using – Trust information system) • Non elective length of stay • Elective length of stay	4.7 2.7	4.6 2.6	4.5 2.5	4.5 2.5	4.5 2.5	
Increasing % day case rates from 11/12 level to a sustained 80% by 2017	78%	79%	80%	80%	80%	
Increase the mean daily number of emergency patients who receive ambulatory assessment	Newly formed ambulatory assessment units – accurate baseline information will be available in Q1 2012	tbc	tbc	tbc	tbc	
Improve re-admission rates against national best practice (New objective for 13/14 -Subject to further discussion with Unscheduled care)	Not entered	tbc	tbc	tbc	tbc	

Quality Improvement Strategy supporting objectives for Clinical Effectiveness	2012/13	2013/14	2014/15	2015/16	2016/17	
Decrease the monthly number of elective surgical inpatients admitted before the day of surgery	80	50	50	40	40	
Reduction in the mean number of outlying patients (as defined by the patient being in the incorrect specialty bed at midnight)	110	80	60	50	50	
Patient centred clinical effectiveness targets:- measured by (1)SaTH 's own Energising for Excellence criteria	Baseline agreed with Centres	90%	92%	94%	96%	
(2)Improving the Nutritional status of patients i)based on nutritional assessments undertaken on all patients	100%	100%	100%	100%	100%	
ii)all medium and high risk patients having care plan in place	95%	100%	100%	100%	100%	
iii) ward audits providing evidence that care provided against care plan evidencing optimum care	95%	96%	97%	98%	100%	
iv) Protected meal times audits provide clear evidence of Red tray system and adequate support for patients	90%	92%	94%	96%	98%	
V) Nutritional steering group in place to achieve required best practice to support operative management and outcomes and emergency management/ outcomes	Not defined in 2012	tbc	tbc	tbc	tbc	
(3)High Impact Interventions compliance for Infection prevention and Control effectiveness i) audits undertaken	95%	100%	100%	100%	100%	
ii) compliance demonstrated with all requirements	90%	95%	98%	100%	100%	
(6) SSSI demonstrating compliance of one quarter in 2012/13 and moving to 2 quarters by all required sub specialties in 2013/14 and moving to monitoring every quarter by 2014/15 (Each centre will	100%	100%	100%	100%	100%	

drive year on year improvements for their specialty patient outcomes)						
(7) PROMs systems and processes in place to effectively monitor outcomes across all specialties required at national level	100%	100%	100%	100%	100%	
Effectiveness of clinical outcomes demonstrated by Clinical Audit programmes demonstrating full audit cycle 100% (including action plan for improvement and re-audit)	95%	98%	100%	100%	100%	
Effective end of life pathway in place to support effective care and discharge to preferred place of care provision with optimum management.(gold standard framework / Liverpool pathway). Measurable outcome based on patient and family experience	Baseline to be agreed	90%	95%	100%	100%	
Implementation of NICE Jaundice guidelines (2012/12)- -% key performance Indicators to be defined by Centre in 2012/ 13.	tbd	tbd	tbd	tbd	tbd	
Implement scanning hips of breach babies (NICE) guidelines--% key performance Indicators to be defined by Centre in Q1 2012/13.	tbd	tbd	tbd	tbd	tbd	
To raise the standards of prosthetic rehabilitation offered to the Head and Neck patients ie implants, custom made plates- KPI's to be defined by the Centre in Quarter 1 2012/13	tbd	tbd	tbd	tbd	tbd	
All cancer patients to be seen by the Clinical nurse specialist at the start of their pathway as a point of contact to co-ordinate and optimise care	100%	100%	100%	100%	100%	
All Haematology and oncology patients requiring urgent assessment and treatment are admitted to the right specialty bed within the hour from phone call to admit to optimise treatment	100%	100%	100%	100%	100%	
Patients admitted, for at least 24hrs between midday Sunday and mid day Friday, have their drugs reviewed by Pharmacy staff within 24hrs	60%	80%	90%	90%	90%	
Medicines reconciliation complete within 48hrs of first review by	60%	80%	90%	90%	90%	

pharmacy.						
Ensuring Trust formulary is maintained and up to date with national guidelines eg. NICE within 1 month of guidance issued	Not entered	100%	100%	100%	100%	100%
Inpatient prescription monitoring performed by a pharmacist at least every 72hours	Not entered	80%	85%	85%	90%	90%
100% compliance on safe Blood transfusion key performance Indicators leading to improved patient safety outcomes and improved efficiency of Blood transfusion	95% Failed	90% readjusted	100%	100%	100%	

Domain 3   Patient experience   Getting it right first time, every time.

Overall objective to be the provider of choice for the local population reflected by achieving 95% in the Inpatient survey by year 5 of the Strategy and 90% in the Outpatient survey by year 5 of the Strategy.

Quality Improvement Strategy supporting objectives for Patient experience	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
The net promoter question to be used in 2012/13 as baseline for improvement for year on year improvement (at least 30% of Inpatient discharges)	100%	tbd	tbd	tbd	tbd	
Real time patient feedback to be gathered in each clinical area based on 10 patients at least in 2012/13 and then 20 pts in 13/14 and then 40 patients in 14/15 leading to increased confidence in care	100%	100%	100%	100%	100%	
Patient experience metrics to be implemented in full across all outpatient clinical areas to achieve a year on year improvement in monthly metrics- evaluated through % improvement in OPD Bi -annual survey	100% of metrics utilised by Centres	75%	80%	85%	90%	
Patient experience metrics to be implemented in all ward areas to achieve monthly improvements- evaluated by year on year	75%	80%	85%	90%	95%	

improvements in In -patient survey						
Implementation of Care Group specific PEIP panels to develop and embed patient and carer involvement in specific pathways : • Scheduled care group • Unscheduled care group	Corporate PEIP workplan	50% Centres with PEIP	75% of centres with PEIP	85% of centres with PEIP	90% Centres with PEIP	
Include a wider range of carers and family representation in the PEIP programme with specialty specific carer information to support the care around the patient	Not outlined	tbc with PEIP	Tbc with PEIP	Tbc with PEIP	Tbc with PEIP	
Improve the patient experience in Outpatient clinics in Otology clinic by how much over the period to be agreed through baseline (RTPF)	Baseline by RTPF	TBC	TBC	TBC	TBC	
Changes to the Induction of labour pathway leading to an improved patient experience using real time patient feedback and complaints as indicators for improvement in satisfaction levels	100% of changes made	85%	90%	95%	98%	
Communication /customer services workshops held to improve communication and approach- Real time patient feedback and complaints to be used as baseline for improvements in satisfaction levels	100% of staff trained	85%	90%	95%	98%	
Priorities across the 5 years are the experiences of patients with Dementia/ cognitive impairment Frail elder patient Learning Disability and Dementia Demonstrated through:- Real time patient feedback improving % satisfaction % improvement in carer involvement in plan of care and overall experience Reduction in complaints relating to patients in above criteria	 80% 70% baseline	 85% 75% tbd	 90% 80% tbd	 95% 85% tbd	 98% 90% tbd	

Demonstrating improved % of staff with training and awareness in Dementia to degree required	100% Band 7 and Matrons	40% of Applicable staff	60%	80%	100%	
Training and awareness in DOLS/ MCA assessments	100% of Consultants and Band 7	40% of applicable staff	60%	80%	100%	
Completion of Dementia risk assessment	70%	90%	95%	100%	100%	
Referral onto specialist assessment where required	100%	100%	100%	100%	100%	
Supported by information for family and Carers through "This is me" Passport and other information leaflets over the 5 year strategy. Evidenced through RTPF and carer feedback satisfaction levels	60%	70%	80%	90%	95%	
Documentation within the care plan demonstrates involvement of the family in the care of their loved one (in documentation and care plans)	75%	80%	85%	90%	95%	
'Managing your medicines' patient information leaflet provided to inpatients when first seen by pharmacy- measured by the Trust patient satisfaction survey	Entered in 2013	40%	50%	60%	75%	75%
Real time patient feedback to be gathered through Outpatient dispensary satisfaction survey -10 patients each site each month	Entered in 2013	100%	100%	100%	100%	100%
Medication compliance chart provided to patient on discharge	Entered in 2013	40%	60%	70%	80%	90%

Quality and Safety Indicators Framework

	Indicators & Measures	Outcomes
NATIONAL	• National choice & access targets • HAI MRSA < 0 C Diff < • VTE • CQC Registration Criteria Never Events <0 per year Medication Omissions	Improved access Reduced infection Reduced avoidable harm Unconditional CQC Registration Reduced serious harm Improved patient safety & experience
REGIONAL	•Real time patient feedback CQUIN milestones and contractual objectives •Pressure Sore reduction and eradication •Nutrition •Falls •Smoking cessation	Patient Experience improvements Improvements in Quality Indicators improvements in patient safety & LOS Improved healing and recovery Improved patient safety Improved patient outcomes
LOCAL	• Patient Experience RTM 100% of wards • VTE Risk Assessment > 95% • Surgical Site Surveillance Quality Account • WHO Surgical Checklist > 100% CQUIN • Mortality Reduction 25% • NHSLA Level 2 – 3	Improved patient care and experience Improved safety Improving infection rates and outcomes Public transparency Improved patient safety Improved patient outcomes Reduction in Harm Events Improved safety and outcomes
CENTRES	• NHSLA Level 2 – 3 • SSI/ PROMS • National Audit Participation • NICE Guidelines • National Service Frameworks • Clinical benchmarking • LEAN Rapid Redesign future state	CQUIN's Clinical Audit and Outcome Clinical outcome improvements -Team Service areas performance and Quality Dashboards improvements Ward to Board Indicators

Alignment and collaboration at all levels

Local clinical ownership of Indicators

Quality Improvement Framework

Quality Drivers

Key enablers & deliverables

95% of patients recommend us

Patient Centred

Effective Safe

Mortality lowest 10% in NHS

Top 10% for patient & staff satisfaction

Leadership & Culture

Measurement

Quality & Safety Interventions & Initiatives

Workforce skill & capability

• Board direction and leadership
• Executive Walkabouts
• Outstanding clinical leaders
• Patient involvement at every level
• Stakeholder involvement at every level
• Evidence based optimal care
• Promote a fair and just culture
• Promote a learning & improvement culture
• Optimize & reward teamwork behaviour
• Continue to build IT infrastructure for electronic record
• Quality & Safety Improvement Board metrics

• Mortality
• LIPS
   Adverse events – global trigger tool, VTE
• Infection – SSI, UTI, MRSA, C diff
• Acutely unwell – managing deteriorating pt
• Nurse indicators – Falls, TVs, Nutrition
• CQUIN outcome measures
• Patient experience and staff satisfaction scores
• PROMS
• Efficiency indicators – LEAN benefits
• Productivity indicators

• Rapid Redesign - LEAN
• Productive Ward
• Essence of Care, back to basics
• Patient Safety First Campaign
• Reliable care for high volume & risk conditions & processes
• Care bundles (Saving Lives, Critical Care) Bed Bundle

• OD & workforce Strategy
• Patients participate in all improvement teams
• Benchmark staff improvement capability
• Build infrastructure and capability for Quality improvement in service areas
• Build a culture of continuous quality improvement
• Develop leaders & mentors for QI
• Reward and celebrate successes and spread them quickly
• Recruitment & Retention

Putting Patients First

The Road Map to Quality
The seven elements to improve quality

1. Bring clarity to quality

| Bringing clarity to quality | Measure Quality | Publish quality performance | Recognise & reward quality | Leadership for Quality | Safeguard quality | Stay ahead |

In practice
Quality Standards and NHS Evidence
Clinical teams can use quality standards to deliver, commissioners can use them as an aid to commissioning, and patients can use them as a guide to best practice. NICE host NHS Evidence, a website giving access to kite-marked evidence and guidance.

Resources
- NHS Evidence:
  www.evidence.nhs.uk
- NICE Clinical Guidance:
  www.nice.org.uk/guidance
- RCN Clinical Guidelines:
  Httip://tinyurl.com/rcn-org-uk
- Confidence in Caring:
  http://tinyur.com/5nwy4d
- High Impact Actions for Nursing:
  www.institute.nhs.uk/hia
- Saving Lives – High Impact Interventions (HII) care bundles:
  www.clean-safe-care.nhs.uk
- Standards for adult inpatient learning disability units:
  http://tinyur.com/rcpsych
- National Mental Health Development Unit:
  http://tinyur.com/ygk8a2c
- The Health and Social Care Act 2008:
  Code of Practice for health and adult social care on the prevention and control of infections and related guidance (December 2009): http:/tinyur.com/y9zsjng
- National evidence based guidelines for preventing healthcare associated infections in NHS hospitals in England:
  Journal of Hospital Infections (2007) 65 (Supplement)
- National Institute for Health and Clinical Excellence (2003) Infection Control: Prevention of healthcare-associated infections in primary and community care:
  http://tinyur.com/yfagns8

2. Measures Quality

Bringing clarity to quality → **Measure Quality** → Publish quality performance → Recognise & reward quality → Leadership for Quality → Safeguard quality → Stay ahead

Essence of Care

A nationally developed self-assessment benchmarking and audit tool, Essence of Care covers 12 areas and enables frontline teams to appraise how they deliver care, against a set of best-practice indicators that have been developed by patients, other service users and professionals.

Energise for Excellence

Quality framework for nursing and Midwifery that aims to support the delivery of safe and effective care creating positive staff and patient experiences that build in momentum and sustainability this is underpinned by "social movement thinking" principles.

Further tools to measure quality improvement

- The transforming guides for best practice, supporting community services and covering six areas.

Resources

- Indicators for Quality Improvement:
  http://tinyurl.com/lesm89
- Essence of Care
  http://tinyurl.com/yls48of
- NHS Surveys co-ordination centre:
  www.nhssurverys.org
- NHS Choices
  www.nhs.uk
- Quality Framework For Community Services:
  http://tinyurl.com/ybphkrl
- NHS Institute Productive Services:
  http://tinyurl.com/ku5mcd
- Transformational reference guides for best practice:
  http://tinyurl.com/yv4bu56
- Care Quality Commission Patient Information Surveys:
  http://tinyurl.com/yfetqss
- DH Surveys information:
  http://tinyurl.com/ppwzs4
- Understanding What Matters: A guide to using patient feedback to transform care:
  http://tinyurl.com/ppwzs4
- Getting in Right for Children and Families:
  http://tinyurl.com/ygtsmss

3. Publish quality performance

| Bringing clarity to quality | Measure Quality | **Publish quality performance** | Recognise & reward quality | Leadership for Quality | Safeguard quality | Stay ahead |

Resources
- o Quality Accounts:
  http://tinyurl.com/dcjnxw

4. Recognise and reward quality

| Bringing clarity to quality | Measure Quality | Publish quality performance | **Recognise & reward quality** | Leadership for Quality | Safeguard quality | Stay ahead |

In practice
One way of doing this is through the use of Commissioning for Quality and Innovation (CQUIN) payment framework. CQUIN makes a proportion of provider income conditional on locally agreed goals around quality improvement and innovation.

CQUIN goals are agreed locally between the commissioners and the NHS provider and will include at least one goal in each of four areas: safety, effectiveness, patient experience and innovation. The CQUIN framework ensures that both commissioners and NHS providers pay as much attention to delivery of high quality care for patients as they around activity performance.

Resources
- o Commissioning for Quality and Innovation:
  http://tinyurl.com/ylld5v9
- o The Quality and Outcomes Framework (QOF):
  http://tinyurl.com/6f382t

5. Leadership for Quality

| Bringing clarity to quality | Measure Quality | Publish quality performance | Recognise & reward quality | **Leadership for Quality** | Safeguard quality | Stay ahead |

In practice
The National Quality Board (NQB) has been established which provides strategic oversight and leadership on quality. It brings together key organisations and individuals from the NHS and social care, ensuring that the whole health system is pulling in the same direction to provide high quality care for patients. The Chief Nursing Officer is a member of this group. Building on existing local clinical leadership, strategic health authorities (SHAs) have appointed medical directors and formed clinical advisory groups which work alongside existing nurse directors.

Resources
- National Quality Board:
  http://tinyurl.com/yhmkagf
- Releasing Time to Care Series:
  http://tinyurl.com/ybaqt6z

6. Safeguard quality

| Bringing clarity to quality | Measure Quality | Publish quality performance | Recognise & reward quality | Leadership for Quality | Safeguard quality | Stay ahead |

Seven Steps to Patient Safety
A series of publications for different healthcare sectors, setting out the steps that local organisation can take to improve patient safety.
LIPS- web site links to programme outline
Root Cause Analysis (RCA) toolkit and supporting documents
Helps you to apply a robust methodology to analyse patient safety incidents and issues

Resources
- Care Quality Commission: www.cqc.org
- NHS National Patient Safety Agency: www.nrls.npsa.nhs.uk
- Patient Safety First: www.patientsafetyfirst.nhs.uk
- Seven Steps to Patient Safety: http://tinyurl.com/ylg5f7n
- RCA toolkit and supporting documents:
- http://tinyurl.com/ycym7tt
- Manchester Patient Safety Framework: http://tinyurl.com/y9dgewg
- Foresight Training: http://tinyurl.com/yhwyn7k
- Being Open: http://tinyurl.com/ydxjo58
- NRLS Resources: www.nrls.npsa.nhs.uk/resources
- Patient Safety First 'How to' Guides: http://tinyurl.com/ybtvlqe

7 Stay Ahead

| Bringing clarity to quality | Measure Quality | Publish quality performance | Recognise & reward quality | Leadership for Quality | Safeguard quality | Stay ahead |

Preceptorship
A national framework and funding have been developed to promote nurses as confident, autonomous practitioners, and to ensure that preceptorship is available for all new registrants.

Leadership
The National Leadership Council (NLC) is developing initiatives that embrace nursing, including clinical leadership fellowships and a multi disciplinary leadership competency framework, with an associated accreditation system.

Healthcare Support Workers
Nurses are increasingly leading care and delegating to healthcare support workers. DH is exploring how to strengthen and standardise education and training frameworks for support workers in Bands 1 – 4.