The Shrewsbury and Telford Hospital NHS Trust

Paper 13

Recommendation ☐ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** **Receive and Approve** the final draft of the Trust Quality Strategy – Safest & Kindest Every Day
Reporting to:	**Trust Board**
Date	30 November 2017
Paper Title	Trust Quality Strategy – Safest and Kindest Every Day
Brief Description	This Quality Improvement Strategy will demonstrate how we have already begun our journey to be the safest and kindest in the NHS and what further developments we need to undertake to ensure that our organisation is acknowledged as one that is open, honest, safe, effective and compassionate. This document is for 2017-2018 and the measurement of how we have improved will be reported through regular reports to the Q&S Committee as well as our annual Quality Account The Strategy document is an overarching one – it is supported by a number of key documents particularly the Trust Quality Improvement Plan. **The Board is asked to note that the document is in text form only at this stage – following final Board approval the document will be formatted before publication**
Sponsoring Director	Deidre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety
Recommended / escalated by	None
Previously considered by	Quality & Safety Committee
Link to strategic objectives	PATIENT AND FAMILY - Deliver a transformed system of care (VMI) and partnership working that consistently delivers operational performance objectives SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce

Link to Board Assurance Framework	If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204) If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186) If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)
Equality Impact Assessment	○ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Paper 13

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Safest and Kindest Every Day

Quality Improvement Strategy 2017-2018

Index

Foreword by Director of Nursing, Midwifery and Quality

To be finalised

Our Vision and Values

Our Vision:

To be the Safest and Kindest in the NHS

Our Values:

- Proud To Care
- Make It Happen
- We Value Respect
- Together we Achieve

Our Organisational Strategy was developed with staff, patients and their families with the aim to build on our achievements to deliver a transformation in our own organisation.

Without this clear foundation of our values, our journey towards the safest and kindest would not be possible.

The values that we have chosen will underpin our behaviours, support the empowerment of our staff and result in the development of our culture.

Introduction

Our vision is to provide the safest and kindest care in the NHS. We need to make sure that our Trust listens to patients, their families and their carers as well as the wider community, and act on what we hear in order to achieve our vision. We also need to train and support our staff to provide the highest quality care, to be open and honest with people when things sometimes go wrong and to live the values every day and importantly we need to learn to get things right every time.

An accepted definition of what is meant by "quality care" in the NHS was set out in 2008 (DH, 2008). That is, quality care is when:

- Patients and staff are kept safe by working together to reduce avoidable harm
- We measure the effectiveness of care and how we can continue to improve
- Care that ensures that patients, their families and the staff that provide it have a positive experience

Quality care is not achieved by focusing on one or two aspects of this definition - high quality care encompasses all three aspects with equal importance being placed on each. As a Trust we are committed to ensure that we achieve all three elements of quality as defined above.

Continuous improvement means that what is considered to be high quality care changes as developments in healthcare move forward. The world of healthcare is ever more complex and the need to support our staff to continue to provide high quality care to our patients is paramount to ensure that our care continues to be safe and effective and our patients and their families have a positive experience.

Supporting our staff has many aspects. We will ensure that our staff have the highest standards of training, have safe working environments and that the equipment they are provided with is that which they need to carry out their roles. We will support them through the development of our culture which will encourage sharing of learning and understanding of what are the factors that affect how we, as humans, behave and what we can do to change those behaviours when they are not how they should be.

Registered professionals work within a framework of professional regulation that requires them to be personally accountable for the quality and safety of the care that they provide to patients. The Board of Directors and senior leaders of organisations such as Shrewsbury and Telford Hospital NHS Trust (SaTH) have the ultimate responsibility to enable them to do so by ensuring that the processes in place to support them are robust, that we learn from success as well as when things do not go right (and share that learning) and we develop our workforce to ensure that our services continue to move forward.

The Board cannot do this unless the information provided to them is accurate, timely, reliable and verified. This will provide them with the assurance that they need to make decisions to develop the Trust appropriately for the people that use our services. This is what is known as quality governance and, like other forms of governance, depends on robust structures and a strong culture to enable clinicians to work at their best and measure and monitor services accurately.

One of the supporting documents of this strategy provides detail on how we implement our governance structures and measure their effectiveness at providing this robust assurance that the Board requires.

This Quality Improvement Strategy will demonstrate how we have already begun our journey to be the safest and kindest in the NHS and what further developments we need to undertake to ensure that our organisation is acknowledged as one that is open, honest, safe, effective and compassionate.

We will be clear of the milestones that we need to achieve along the way towards our vision – including a good or above rating from the Care Quality Commission, excellent outcomes in the national reports of our services such as the National Confidential Enquiries into our services including Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE), achievement of the standards in National Audit including the Sentinel Stroke National Audit Programme (SSNAP) and, more locally, positive reports from our commissioners and other groups including Healthwatch.

The Strategy will use the domains of culture and leadership, quality governance, improving safety and a positive experience as a framework and will demonstrate actions we have already undertaken as well as our plans for the remainder of 2017-2018 and beyond.

Culture and Leadership

In the world of healthcare we all want to get it right first time for our patients so when a mistake is made we want to learn how to do things differently to stop it happening again. Where our care falls below our standards of safest and kindest, we need to learn and change as a result. We know that many problems in healthcare are system rather than individual failings so a culture where our staff have the confidence to raise issues is vital.

This involves supporting staff so that they feel safe to raise issues – creating a 'just culture' where, by supporting those who care we are putting safety first by putting our staff first.

A 'just culture' is one where people are supported when things go wrong and which looks to understand why mistakes happen at the same time ensuring that we take responsibility and are accountable for our actions. A just culture is where:

- People who make an error are cared for and supported to learn and develop
- People who don't adhere to rules and policies are asked to explain why they took an action first before being judged
- People who intentionally put their patients or themselves at risk are held accountable for their actions

(Woodward, 2017)

The Trust has already acknowledged the importance of developing our staff to be strong, visible and approachable leaders, particularly those in clinical roles who have a direct impact on patient safety and the development of our culture.

A number of actions have already taken place including the development of the Trust Leadership Academy to underpin the importance that we place on strong leadership, a crucial part of our organisational strategy. The aims of the Academy are to:

- Support all leaders to deliver the safest and kindest care.
- Develop all leaders to be innovative and inspirational.
- Ensure all leaders have the tool kit to do the job.
- Support a consistency in leadership behaviour aligned to our values.

The Leadership Conference in October 2017 focussed on "Leading a Safety Culture" reflecting Human Factors (anything that can affect the way a person behaves including

distractions, environment, fatigue which then impacts on a system), learning and the importance of a culture where people feel “safe to speak out”.

We know that we need to demonstrate how we are developing the learning culture within the Trust. The work of the Virginia Mason Institute (see more below) helps us to do this by the use of very specific methodology that not only demonstrates how we learn and change through the use of Plan Do Study Act (PDSA) cycles but also how we share and embed this learning thereby ensuring sustainability of change.

Other key events and actions in place that are part of our developing culture:

Away days for staff to help them identify and develop the skills they need in their roles	
The development of core competencies for nursing and midwifery staff groups which reflect the leadership elements of their roles	
Additional leadership training opportunities including Lean for Leaders, part of the work of the Transforming Care Institute (TCI)	
Nursing and Midwifery Forum – held monthly to provide a forum for nursing leaders to discuss challenges and identify solutions	
Doctors Essential Educational Programme (DEEP) – thematic sessions that ensure that senior medical staff are sighted on clinical priorities for the Trust	
Allied Health Professionals (AHP) - head therapist for each profession who provides clinical and professional leadership. Themed away days to review issues such as teamwork and patient pathways as well as quarterly professional meetings.	
Values Guardians in place and working with staff to raise awareness of issues and identify solutions	

The Exemplar Programme is a method of assessment that enables clinical areas to be measured against specific standards to achieve one of three levels of award. Not only is this a way of learning from excellence but it enables leaders to celebrate with their staff.

The programme represents our vision and aspirations for the Trust and reflects our vision to be the safest and kindest. The core standards within the programme build upon our previous achievements and ambitions for Nursing and Midwifery. The standards, which are based on a positive patient experience, are:

- Environment
- Infection Prevention and Control
- Documentation
- Tissue Viability
- Falls Prevention
- Nutrition and Hydration
- Leadership
- Professional Standards
- Communication
- Care and Compassion
- Medicines Management

We have had one ward go through the Exemplar Programme so far leading to a Gold Award being achieved. Over the next months we will support and encourage other clinical areas to apply for the programme to demonstrate continuous improvement across the Trust.

The table below shows the Exemplar Programme targets for achievement until the end of financial year 2018 – 2019:

Genba Walks across the Trust	At least one area a week
Executive Genba Walks	One clinical area every other month
Mock Assessment	One clinical area per month
Assessment by end 2017/18	10% (4 clinical areas)
Assessment by end 2018/19	15% (7 clinical areas)

Our annual Values in Practice (VIP) Award ceremony thanks our staff who have earned a Long Service Award for their service in the NHS and presents awards to teams and individuals who live the Trust Values in everything they do and who have been nominated for an award by their colleagues.

We have a Workforce Strategy which lays out in detail how we will develop and support our staff to be the safest and the kindest – for example through the provision of annual appraisal and training plans for the coming year, support with revalidation and the provision of mandatory and statutory training.

We work with Health Education England to support the development of our staff and to look at better ways of working to address the shortfalls we experience in our nursing workforce particularly.

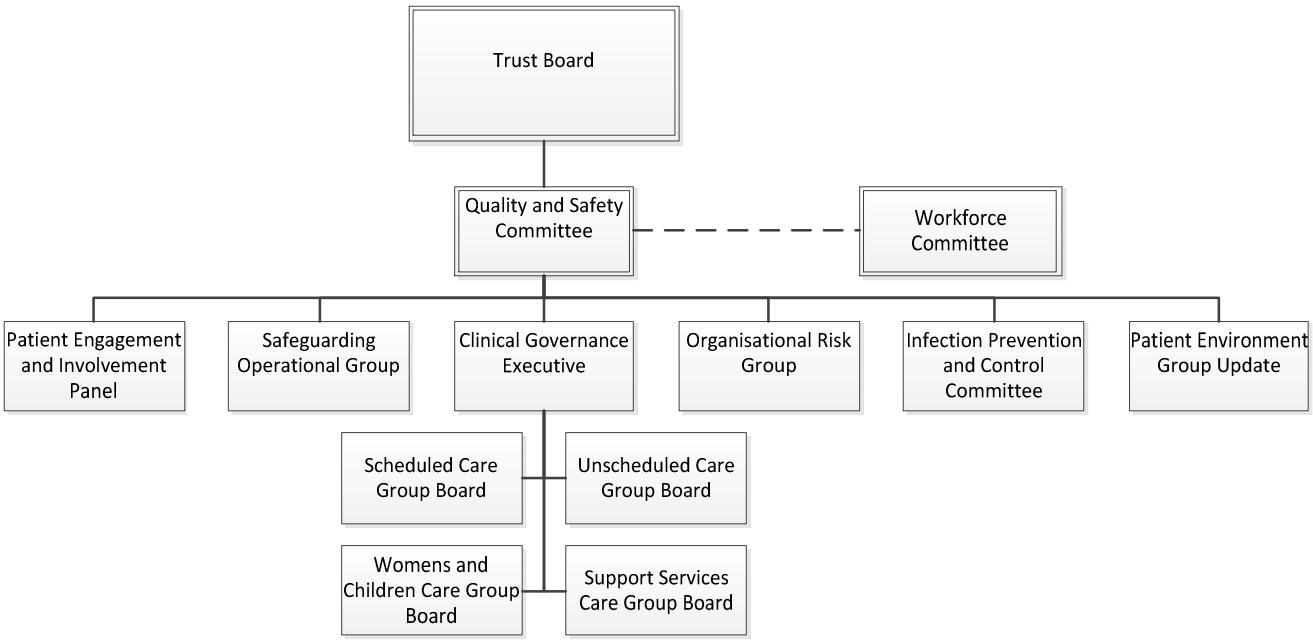
Quality Governance

In their guidance document "Developmental Reviews of Leadership and Governance using the Well Led Framework (June 2017), NHS Improvement state that "robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services". Confidence is gained by the provision of assurance.

Additionally Professor Sir Ian Kennedy (Solihull Hospital Kennedy Breast Care Review, 2017) is clear on the responsibilities of the Board in relation to the safety of patients and the quality of care that they provide. Sir Ian states "The Board must agree with the Executive a range of information about the safety and quality of care which must be reported to it and which will inform the Board about the Trust's performance" (page 139).

We know that the Trust Board and our other senior leaders as well as our regulators and other key partners need to gain assurance that the information that they are being provided with is current, accurate and reliable and has been validated to ensure that it is robust. That information should not be seen in isolation. Triangulation provides a picture of the organisation as a whole and can validate feedback from patients and staff and enables appropriate actions and decisions to be taken.

Information that fulfils all these criteria not only enables senior leaders to make strategic decisions but also clinicians to develop their services and provide continuous quality improvements. To ensure that the Board receives the information it requires a combination of structures and processes is required as shown below.



Trust Board:
The Trust Board is responsible for the overall delivery of services and is accountable for operational and financial performance as well as quality and safety.

Quality and Safety Committee:
The Quality and Safety Committee provides assurance to the Trust Board in relation to clinical quality through robust reporting relating to patient safety and experience and effectiveness of our services. The Committee has a comprehensive workplan to ensure that all aspects of quality governance are managed in a methodical and effective way whilst enabling it to consider issues in a dynamic fashion as they arise.

Clinical Governance Executive:
The Clinical Governance Executive provides assurance to the Quality and Safety Committee in relation to quality performance in the four Care Groups as well as from areas such as Clinical Audit, Research and the Complaints and Patient Advise and Liaison Service (PALS).

Patient Engagement and Involvement Panel:
The Patient Engagement and Involvement Panel provides feedback to the Quality and Safety Committee from the volunteers that support our quality governance.

Safeguarding Operational Group:
The Safeguarding Operational Group provides the Committee with assurance relating to the Safeguarding of adults, young people and children within the Trust.

Organisational Risk Group:
The Organisational Risk Group provides assurance to the Committee that risks within the organisation are managed through the risk management process and that suitable controls are in place and monitored robustly.

Patient Environment Group:
The Patient Environment Group provides feedback to the Committee that issues that have been raised in relation to the patient environment are being addressed in a timely and effective way and if not, suitable controls are put in place to ensure that patient safety is maintained.

Infection Prevention and Control Committee:
The Infection Prevention and Control Committee provides feedback and assurance to the Committee that risks associated with Infection Prevention and Control are managed correctly, staff receive appropriate training and controls and plans are in place to manage situations such as outbreaks.

What we are doing to improve our Quality Governance:

We have developed our quality reporting to ensure that the Quality and Safety Committee and the Board receive accurate and robust information in a timely manner. They receive a monthly report outlining quality metrics and on a quarterly basis they receive a detailed report that provides trends across a number of quality related metrics.	✓
Care Groups Directors have a process in place by which their Boards gain assurance and can then escalate successes and concerns through our established Quality Governance Process to the Board	✓
We have identified learning opportunities such as feeding back from incidents that have common learning themes to promote wider dissemination of learning from incidents and patient feedback across all Care Groups.	✓
We have ensured that Care Groups have a regular opportunity to engage with the Quality and Safety Committee to provide assurance and escalate concerns to them	✓
We are developing a Trust Assurance Strategy to bring together governance and risk management processes to provide a framework by which assurance is gained that quality of care is managed effectively given any risks that the organisation faces.	✓
We undertake targeted Quality and Safety Assurance visits to clinical areas and report back on achievements and risks identified	✓

Improving Safety

In order to continue the process of providing assurance to external organisations we are subject to a number of external reviews of our services. We welcome such reviews as they enable us to identify where we may not be doing so well and to plan what we need to do to address these gaps, as well as celebrating success where we are providing quality care.

Examples of external reviews include reviews by our regulators the Care Quality Commission (CQC) and NHS Improvement, regular visits from our commissioners and those from specialists such as the national lead for Stroke Services and the Office for Standards in Education, Children's Services and Skills (Ofsted) in conjunction with CQC as part of their joint review of health and social care services for children and young people. We also contribute to an annual programme agreed, through our commissioners, with the West Midlands Quality Review Service (WMQRS).

The CQC last visited the Trust as part of their comprehensive inspection programme in December 2016 and we received the report into their findings in August 2017. We were pleased to see that in some areas we had provided assurance that we had improved since their previous visit in 2014 although there were some improvement opportunities identified.

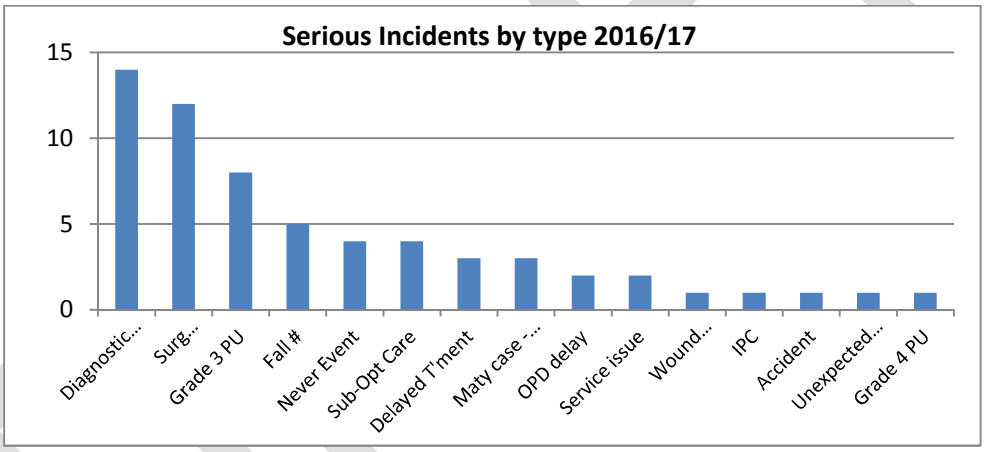
One major action that we have taken since then is the development of our Quality Improvement Action Plan – a way of bringing together all the action plans from such external visits into one, to provide clarity across all areas in relation to progress and to provide

regular updates to the Quality and Safety Committee that actions are complete and compliance measured, therefore providing assurance that actions are being taken and learning embedded in practice.

In order to provide the safest care we need to ensure that we have the right numbers of staff in our services. This is not only nursing staff but medical and associated healthcare professionals such as therapists and specialist staff who work in areas like our operating theatres. We have short, medium and long term plans in place to strengthen our workforce, which, in common with other Trusts in the NHS is affected by demographical challenges. We are working with our colleagues in higher education and Health Education England to put into place long term actions as well as carrying out local initiatives for recruitment and, very importantly, retention.

In relation to safety and particularly learning, the CQC noted that openness and transparency about safety was encouraged and that there were clearly embedded systems, processes and standard operating procedures to keep people safe. However, they also noted that there is a need to continue to drive improvement in the way we report and investigate incidents and share the learning that results. This is one of the quality priorities for us during 2017-2018.

In 2016-2017 we reported 63 Serious Incidents as shown below:



The highest number of Serious Incidents were in the delayed diagnosis category – 14 (22% of the total number), followed by surgical procedures/complications (12) and avoidable grade three pressure ulcers (8). Investigations showed some system and process errors which failed and some linked to human factors. Scheduled Care has identified several actions within theatres to address human factors issues particularly around staff education and awareness of processes.

Monitoring and learning from mortality can provide valuable insights into areas for areas for improvement. To support that, the governance around mortality is well developed, both in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

We have seen an improvement in our performance regarding mortality over the last five years that was maintained during 2016. This is demonstrated over the four mortality parameters and we now are consistently lower than our peer comparators.

The four mortality parameters are:

- **The Hospital Standardised Mortality Ratio (HSMR).**
  This is a national measure and an important means of comparing our mortality against other similar hospitals
- **The Summary Hospital-level Mortality Indicator (SHMI).**
  This is similar, in many ways, to the HSMR but also includes patients who die within 30 days of being discharged from our hospital.
- **Risk Adjusted Mortality Index (RAMI)**
  This is similar to HSMR but compares us with a different group of hospitals
- **Crude Mortality.**
  This includes all deaths in our hospitals.

The detail related to our mortality figures may be found in our annual Quality Account which is the document in which, going forward, we will demonstrate our achievements against the actions in this strategy document.

In 2016-2017 the Trust reported a number of Never Events relating to processes within the operating departments. As a result, processes have been reviewed and revised and a number of learning events held within the departments with an emphasis on human factors and how to avoid such incidents happening again.

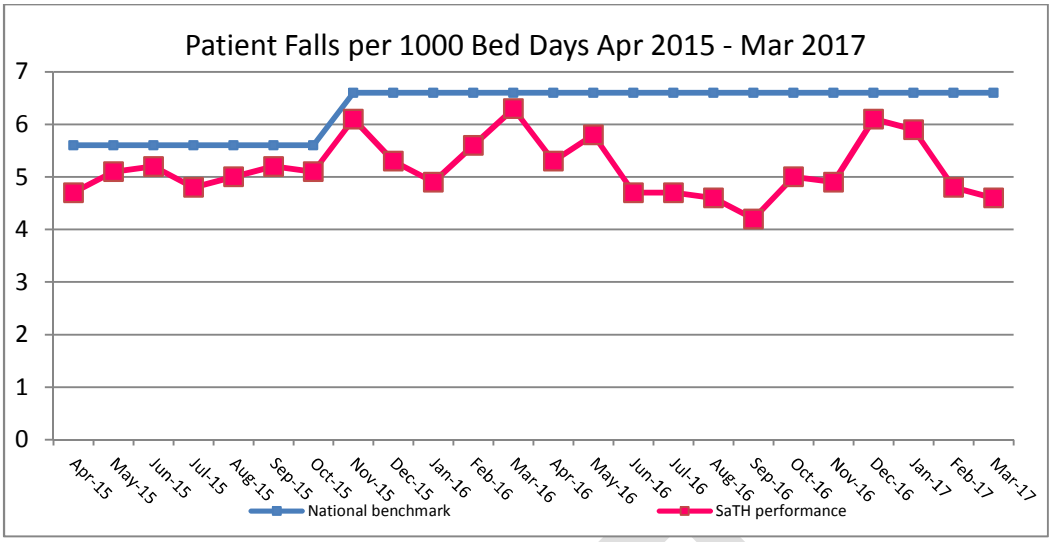
In 2015 NHS England released NatSSIPs (National Safety Standards for Invasive Procedures). NatSSIPs is a high-level framework of national standards of operating department practice. Developed in response to the recommendations of the Surgical Never Events Taskforce report, NatSSIPs has been created for local providers to use to develop and maintain their own more detailed standardised local operating procedures called LocSSIPs. The Trust has already made a great start in developing such procedures and will continue to do so going forward.

Every month we submit data nationally as part of the NHS Safety Thermometer prevalence data collection. We consistently provide harm free care as defined by the tool of between 91-95%. The data collection helps us to identify not only where we may not be delivering care that is safe but also in which areas we could work closely with our colleagues in the local health economy.

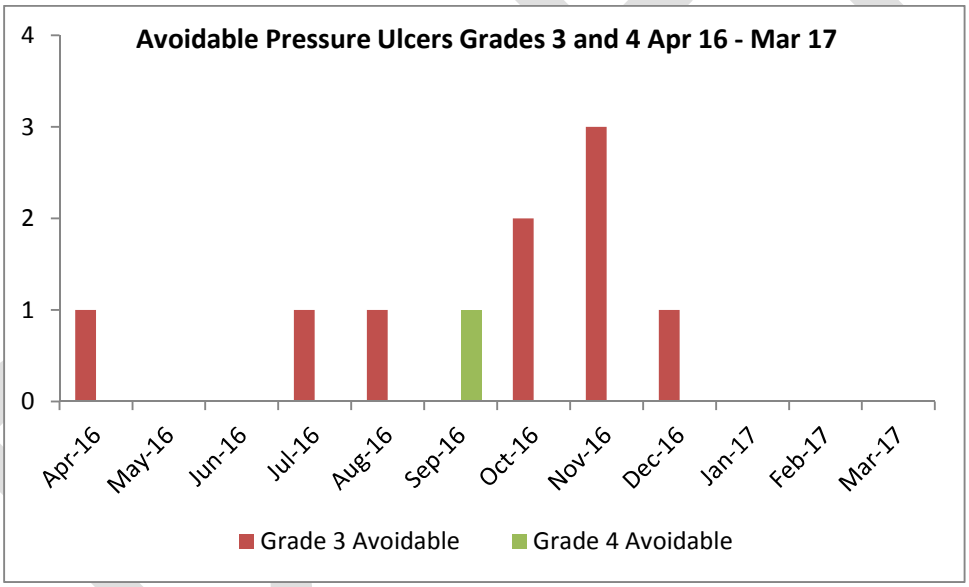
Two of the harms measured in the Safety Thermometer data are falls and pressure ulcers. Both of these are a priority for the Trust to address and as such we have specialist teams to support our staff to identify and implement improvements.

We encourage our staff to report when things do not go well so that we can learn from such incidents. This is a crucial part of a just culture, where people feel safe to raise concerns and know what actions are taken about it by their managers. We measure how well we are reporting against other NHS organisations through the National Learning and Reporting Service (NLRS) who provide regular reports enabling us to see how we are doing. We aim to move from the lowest quarter of reporters to the NRLS to the highest.

In 2016-2017 we saw an increase in the number of falls reported compared to the previous year but an overall reduction of 15% since monitoring began in 2011-2012. Using the number of falls against recorded bed day activity which is benchmarked against the average number of falls in acute Trusts in England the Trust is well within the average of 6.6 falls per 1000 bed days.



The number of avoidable pressure ulcers (grades three and four) recorded in the Trust during 2016-2017 was ten compared to nine the year before. We work hard to ensure that patients do not develop avoidable skin damage such as pressure ulcers in our care and will continue to do so to reduce the number.



Our commissioners require us to comply with the elements of the Quality Schedule within the NHS Contract with them each year. We meet with them monthly to evidence that we do this and to provide assurance to them on a range of quality issues as they arise during the year. One part of the contractual arrangement that we have with our commissioners is the Commissioning for Quality and Innovation Scheme (CQUINS) which is a percentage of the contract value dedicated to the promotion of quality improvements. In 2017-2018 for the first time all of the elements of the scheme are nationally mandated and reflect how we contribute to the national quality priorities.

The progress we make against each of these elements is monitored by the Trust and reported through our governance processes to the Board and to our commissioners.

The Trust is also “Signed up to Safety” – a national initiative set up in 2014 with the ambition of reducing avoidable harm in the NHS by 50% over three years. The priorities agreed for the Trust reflect those within other areas of our quality improvement agenda and include the improvement in outcomes for patients with sepsis, reduction in the number of falls and pressure ulcers, reduction in the number of harmful incidents due to the misinterpretation of cardiotocography foetal monitoring (CTG), improve safety in the theatre environment, reduce medication related incidents and reduce the incidence of hospital acquired acute kidney injury. Over the past three years the Trust has been taking action against all these quality indicators.

Our progress against them will be reported in the Trust Quality Account published in June 2018.

The Trust is particularly fortunate to be in partnership with the Virginia Mason Institute which is helping us to drive improvement across several areas. These Value Streams enable our staff to identify gaps and find solutions in a methodical and sustainable way. Value Stream #5, launched on 19 September 2017 is specifically around Patient Safety and the first aspect that is being looked at in detail is the development of safety huddles in clinical areas. These are one way in which clinical staff share learning on a daily basis which is a timely and effective way of doing so.

Recent improvement actions:

Development of the overarching Quality Improvement Action plan to pull together all the major action plans to better understand themes and share learning.	✓
Provision of bespoke Effective Investigation training by an external provider to improve the way that we investigate, report and share when things do not go right.	✓
From September 2017 we review and challenge moderate and severe patient safety incidents as well as complaints on a weekly basis at the Executive Rapid Review Group. This ensures that they have been correctly recorded and that immediate safety concerns have been addressed as well as themes identified, shared and acted upon within a week of occurring or being received by the Trust. This also enables us to ensure that we are compliant with the requirements of the Duty of Candour regulation	✓
Continued development of local standards (LocSSiPs) relating to the National Safety Standards for Invasive Procedures (NatSSiPs) within clinical areas some as a result of incidents that occurred	✓
Learning events held in areas where Never Events were reported in 2016 will these continue	✓
When something does go wrong we involve the patient and their family in the investigation that follows by keeping in regular touch with them and asking them what they want to know from the investigation. We share the final investigation report with them and meet to ensure that their questions have been answered.	✓
We have maintained the improved mortality levels achieved by the Trust over the last five years, and continue to improve in comparison to our Peers.	✓
We have also continued to build on and improve on the “lessons learned” practice whereby mortality reviews, where appropriate, are fed back through Clinical Governance meetings of each specialty where avoidable factors had been identified.	✓

A Positive Experience for patients, their families and our staff

Making sure that people that use our services have a good experience is very important to all of us. We know that when some people come into contact with us it is because they have a serious and life changing diagnosis and for others the only contact will be one outpatient appointment. The views of all people are equally important to make sure we get it right for everyone.

We measure how well we are doing through the use of local surveys as well as national ones such as the Friends and Family Test which we report each month to the Quality and Safety Committee. We also take part in national surveys (including CQC) and take actions to improve based on the results.

Our staff are encouraged to complete the NHS Staff Survey each October as well as regular in house electronic questionnaires and what they tell us is used from team level to improve how well supported they feel. We have seen positive improvements in responses in the staff survey over the past few years which is encouraging but we know that there is more to do to ensure that our staff feel safe to report unsafe practice and supported to provide the best care that they can. We can also triangulate the results of the staff survey with those of the various external surveys such as the inpatient and outpatients surveys carried out by the CQC which will show that our engaged workforce positively impacts on the experience of our patients.

Our People Strategy 2014-2019 sets out a clear ambition for the future and is designed to support the organisation to achieve its strategic aims. Each year the Workforce team in consultation with Care Groups, Corporate teams, the Executive team and key stakeholders (e.g. education providers) will design an annual implementation plan. The plan will ensure flexibility to the organisations changing needs and realisation of the strategic people aims. This plan will be presented to the Workforce Committee who will be responsible to provide assurance of progress to the Trust Board. Progress against our strategic aims will be provided each quarter to the Workforce Committee.

We have about 800 volunteers who give their time to make our patients stay in hospital better. We are fortunate to have these dedicated people supporting our services who improve the experience of those who are in hospital and those who visit our outpatient areas as well as helping develop our environment to make it better for everyone.

We have a Patient Engagement and Involvement Panel whose members sit on a number of committees and provide feedback from the patient's perspective on what they see and hear in our services.

What we are doing to improve how we respond to patients, members of the public and staff:

The Trust has recently employed a Community Engagement Facilitator - a new position created to encourage and enable the community to become actively involved in decision making and shaping services at SaTH.	
We held a Working in Partnership engagement event on 22 September 2017 It is being held to develop the Trust's engagement plans for the future and is open to all community, voluntary and third sector organisations.	
Themes from complaints and PALS contacts are shared widely across the Trust to embed learning and help us improve. We know that many complaints relate to communication with our staff and it is important staff are aware of this so that improvements can be made.	

We have engagement with specific groups of patients such as in maternity to look at how our services are provided for them and what improvements we can make	
Children and young people that are cared for on our Children's Ward are encouraged to use the "Tops and Pants" feedback method to tell us where they think we do well or could do better.	
Organisations such as Healthwatch are important in helping us to see our services from our patients and their families' perspectives. We will work closely with them to address the findings of their reviews.	

Engagement with our communities and colleagues in other organisations is another way that we can drive improvement and show that not only is our culture changing within the organisation but also changing in how we engage with others.

We work closely with the rest of the local health and social care economy to ensure that patients are cared for in the most appropriate place by the right people.

We are working together to improve the way we raise concerns with each other in the local health economy – called NHS to NHS concerns.	
We meet monthly with our commissioners to provide assurance to them in relation to our services.	

Delivering our Quality Improvement Strategy during 2017-2018 and beyond

Safest and Kindest Every Day is our quality strategy for the future but to ensure that it remains right for both the organisation and the people that use our services we will review it on an annual basis, monitoring our success against the priorities we have identified and adding more as we continue on our journey towards our vision.

We will use this plan to provide assurance to the Quality and Safety Committee and the Board that we are on track to deliver our priorities within timescales that have been set and where this has not happened there are actions in place to address shortfalls.

We will report on how we have done against our improvement goals in our Quality Account for 2017-2018 which is published in June 2018.

This document is not to be seen in isolation – for example, the Quality Improvement Action Plan is crucial in ensuring that we comply with the requirements of our regulators but for the purposes of this strategy is not reflected in detail, however, the plan itself will be available on line for both patients and staff to access.

In our annual Quality Account for 2016-2017 we identified three quality priorities for 2017-2018 linked to both our Trust strategic objectives and the NHS Outcomes Framework. These are:

- Making sure that people are safely discharged from our services
- Make it possible for people to tell us their stories to improve their care
- Implementation of the Values Based Leadership and Cultural Development plan in the Women's and Children's Care Group

The action plan below shows how we plan to achieve these and other quality improvements during 2017-2018 and beyond to develop leadership, culture, safety, quality governance and patient and staff experience within the organisation and ultimately to achieve our vision.

Domain	Improvement Goal	Our target for 2017-2018	Assurances for compliance
Improving Safety/A Positive Experience	Making sure that people are safely discharged from our services *(Quality Account Priority)*	Patients will know what their expected date of discharge (EDD) is so that they and their families have time to plan for them going home	Data from Patient Safety at a Glance (PSAG) supports that all patients given EDD on or close to admission that is appropriate and is the actual date of discharge
		We will routinely use the principles of "SAFER to ensure that we do not keep people waiting to go home unnecessarily.	R2G in place and being used effectively across all inpatient areas to improve the patient stay and their experience.
		We will make sure that everything they need is ready for them, including medication, information and equipment.	Systems in place to ensure this is done. Measured by number of delayed discharges
		Where necessary we will speak to other providers (such as district nurses) who may be supporting people at home to make sure that they are ready	Measured by patient feedback and number of delayed discharges due to lack of forward planning
		We will reduce the number of complaints that we get about discharge processes	Complaints and PALS trend data
		Less people will come back into hospital because something went wrong with the discharge process	Number of readmissions
		We aim to reduce the number of times we have to have extra beds on our wards at times of high escalation which can lead to reduced patient safety and experience	Improvement in discharge processes and implementation of R2G will ensure that patient flow is improved meaning patients are safer and have a better experience. Outcomes of bed realignment at PRH are positive and result in patients being nursed in the right areas.
A Positive Experience	Ensuring people have a positive experience of care *(Quality Account Priority)*	We will have a variety of methods to capture patient stories – for example by video, in person, in writing and through feedback to our partners.	Number of patients and families using varied feedback methods increased during 2017-2018
		We will make sure that if someone wishes to provide feedback we will work with them to do this in the best way for them	Evidence of support for patients and families to feedback how they wish
		We will ensure that if a patient story is presented to	We will have a process in place by which the Board receives

Domain	Improvement Goal	Our target for 2017-2018	Assurances for compliance
		a group of people such as the Trust Board that we will show how we have made changes or have actions to carry out as a result of that feedback so that we can really demonstrate a difference that the feedback has made	assurance that this has taken place
		We will work with a variety of other groups such as Healthwatch or the Young Health Champions to make sure that people who sometimes do not get their voices heard are able to do so	Employment of Community Engagement Officer to improve how we work with groups in the community more effectively- evidence of actions
Culture and Leadership	Implementation of the Values Based Leadership and Cultural Development plan in the Women's and Children's Care Group *(Quality Account Priority)*	We will use staff feedback (such as the NHS staff survey, drop in sessions and through relationships with their representatives) to show where we need to improve to provide a better experience for our staff and to measure improvement.	Summary of activity within the Care Group with actions and positive outcomes demonstrated.
		We will see a reduction in complaints and PALs enquiries particularly in relation to communication, care and compassion.	Measured through Complaints and PALS data
		We will also help and support our staff to make changes where they need to.	Measured through staff survey specific questions relating to enabling change
		We will evidence that the requirements of the Duty of Candour will be met in 100% of incidents that require it to be met	Measured through patient safety incident data
Improving Safety	We are compliant with the Sign Up to Safety (SU2S) plan for the Trust	Continue to take actions against the identified goals in the action plan agreed in 2014-2015.	Evidence that we have complied with the measures that we identified in our SU2S action plan in 2014-2015 within the timescales agreed
All domains	We have our overarching Quality Improvement Plan in place	Embed the developed plan across the Trust ensuring clinicians and managers are aware of it and the requirements of them within timescales	Evidence that we have completed all must do and should do actions for the CQC and that we are on track for completion within timescales against all outstanding actions within the plan
Improving Safety	We achieve the remaining CQUINS targets for 2017-2018	Achievement of CQUIN targets for the rest of 2017-2018	Evidence of compliance through audit and other measurement and award of financial incentives from CCGs

Domain	Improvement Goal	Our target for 2017-2018	Assurances for compliance
Culture and Leadership	The Leadership Academy contributes to patient safety	Leadership event in October 2017 focussed on patient safety including human factors and learning	Feedback from staff who attended and evidence of shared learning from the event across areas.
	Exemplar Programme	More clinical areas have taken part in the programme and awards been made	Evidence of compliance and taking part
	Continue with the actions already described in "Culture and Leadership" above	To provide evidence of a range of activities that have improved culture and leadership specifically relating to quality improvement during 2017-2018	Provision of data demonstrating improvement, patient and staff feedback Development of Values Stream #5
Quality Governance	Continue with the actions already described in "Quality Governance" above	To provide evidence of a range of activities that have improved quality governance during 2017-2018	Evidence of an improved quality governance structure and ward to board reporting
Improving Safety	Mortality Developments	Improve mortality levels further	Evidence of improvement against mortality standard measures
		Prepare for the introduction of the National Mortality Care Record Review Programme (NMCRR)	Evidence of compliance provided
		Participate in LeDeR programme	Evidence of compliance through numbers of case reviews and staff trained to take part
		Compliant with requirements of Learning from Deaths	Policy in place, submission of data
	Incident Reporting Improvements	Review incident reporting policy following training sessions in October and November 2017	New policy approved and in place by end February 2018
	Continue with the actions already described in "Improving Safety" above	To provide evidence of a range of activities that have improved the safety of our patients during 2017-2018	Provision of data demonstrating improvement, patient and staff feedback, improved incident reporting and confidence that we comply with Duty of Candour
	Collaboration with organisations such as the Patient Safety Collaborative	Develop relationship with the PSC during 2017-2018 with a view to expanding collaboration going forward	Evidence of collaboration and integration into the PSC
	Development of our workforce to reduce reliance on agency staff to improve staff experience and	Active and successful recruitment programme Reduced turnover	Increased numbers of staff recruited across all staff groups Turnover figures reduce over the year

Domain	Improvement Goal	Our target for 2017-2018	Assurances for compliance
	patient safety	Development of Nurse Associate Staff attend courses to develop their careers with funding from HEE	Feedback on Nurse Associate programme Wide range of courses to develop staff available and staff able to attend
A Positive Experience	Continue with the actions already described in "A Positive Experience" above	To provide evidence of a range of activities that have improved the experience of our patients and staff during 2017-2018	Provision of data demonstrating improvement, patient and staff feedback
	The public and our staff are engaged with our plans for the future	Public engagement and consultation relating to Sustainable Services	Evidence of process and feedback from the public is taken into account when decisions made.
	We know that our services are equitable for all	We complete our benchmark against Equality Delivery System 2	Evidence of benchmarking and action plans in place. Positive changes are seen.

References:

Department of Health (2008) *High quality care for all: NHS Next Stage Review final report.* DH, London.

NHS Improvement (2017) *Developmental Reviews of Leadership and Governance using the Well Led Framework,* NHSI, London

Woodward, S (2017) *Rethinking Patient Safety,* Bantam Publishing