CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS – 31 OCTOBER 2018

EXECUTIVE SUMMARY AND BRIEFING PAPER

Agenda item:
Quality Strategy 2018-21

Board lead:
Lynn Andrews, Director of Nursing and Patient Care

Reason for the item:
The refreshed Quality Strategy is being presented to the Board for approval on the recommendation of Quality Delivery Group.

Briefing on the item

The Strategy sets out our ambitions for the next three years to support our aim to provide 'outstanding' care and treatment. These ambitions have been developed through review of our past performance and consideration of national priorities, and build on the work done over the past 2 years since the publication of our previous strategy.

This Quality Strategy supports delivery of the Trust's strategic plan, in particular the strategic objective relating to quality to "Provide high-quality, safe and person-centred care" with the strategic outcome to be rated as "outstanding" by the CQC.

The strategy uses the three domains of quality as defined by the National Quality Board: Positive experience, Effective and Safe. Within each of these domains 3 key priorities for improvement have been identified, as follows:

- Positive experience – Communication, Always Events, Learning from Incidents
- Effective – Learning from Deaths, Implementing Best Practice, Learning from Audit
- Safe - Recognition and escalation of deteriorating patients, Patient and family involvement and Learning from Incidents

Recommendation:

The Board is asked to approve this strategy.

Related strategic outcome(s):

- [✓] 1: To be rated as 'outstanding' by the CQC
- [✓] 2: To have a solid foundation of core acute services meeting all national standards
- [ ] 3: To have effective partnerships – locally through more integrated care and regionally through networked clinical service models
- [ ] 4: To be in the top 20% of all NHS employers for staff experience as measured by the national staff survey and our own Your Voice survey
- [ ] 5: To have from NHS Improvement a financial sustainability risk rating of '4' and a 'green' governance rating, and to be deemed 'well-led' by NHS Improvement

☐ 6: To be in the top 20% of NHS providers for PLACE scores and to reduce CO^2 emissions from 11,298 tonnes to 10,634 tonnes (2% per year); to have an IM&T capability that is fit for purpose for 2018 and beyond
Board Assurance Framework (BAF) risks relating to this item: BAF risks 1.1, 1.2 and 1.3
Other risks relating to this item: ID: 2192 risk of not meeting quality ambition “Caring” ID: 2045 Failure to achieve overall CQC rating of “good” with breaches of regulation
Financial impact: There will be resource requirements to support delivery of this strategy for which detailed proposals will be developed.
Equality impact: None
Environmental impact: None
Partnership working: Delivery of this strategy will require us to work in partnership with key stakeholders.

Chesterfield Royal Hospital NHS

NHS Foundation Trust

Quality Strategy 2018-21

Introduction

I am pleased to share with you our refreshed quality strategy, where we set out our ambitions for the next three years to support our aim to provide 'outstanding' care and treatment.

The ambitions for 2018-20 have been developed through review of our past performance and consideration of national priorities, and build on the work done over the past 2 years since the publication of our previous strategy.

Our continued focus to be 'outstanding' will ensure that:

- Patients[1] are truly respected and valued as individuals and services provide informed choice and continuity of care
- Outcomes for our patients are better than expected
- Patients are cared for within strong, comprehensive safety systems, and that we focus on openness and learning

We also intend to carry on improving in the areas of care where we have already seen a positive outcome. Since our last Quality Strategy was published in 2016 we have:

- Improved our Friends and Family scores for inpatients and daycase; we are now scoring in the top 25%
- Decreased the number of complaints relating to communication
- Introduced our dignity and respect standards, which have led to improved patient experience
- Worked to improve the engagement and support we give to carers, which was nominated for Nursing Times and Health Service Journal Awards.
- Introduced the Saving Babies Lives care bundle which has led to a decrease in our stillbirth rate and improved the care for patients who develop Sepsis through implementation of the Sepsis 6 care bundle.
- Improved the care of patients with delirium through the introduction of evidence based assessments and care pathways
- Increased the number of clinical incidents reported, so that we can identify what went wrong and put measures in place to prevent it occurring again.
- Reduced the number of patients who acquire pressure ulcers or fall in our care
- Sustained our low levels of hospital acquired infections.

This strategy builds on this success by focusing on those areas where we have further work to do and by utilising our improvement strategy and strengthening our learning processes to ensure that we respond appropriately to the themes and trends identified.

Lynn Andrews
Director of Nursing and Patient Care

[1] Throughout this document we have used the term patients to represent all our services users including those people who are important to patients e.g. carers, relatives, friends.

Context

Who are we?

At Chesterfield Royal we deliver a full range of acute services, including 24 hour emergency care and community children's services to the population of Chesterfield and North Derbyshire. We see approximately 260,000 outpatients, deliver 3,000 babies, care for 60,000 patients on our wards and treat 60,000 patients in our Emergency Department each year. Our 5-year business plan recognises the importance of providing outstanding care and services which is central to our vision and objectives.

We are committed to ensuring that this Quality Strategy delivers its outcomes, so that we can meet the expectations of our patients, staff and key stakeholders.

Why have a quality strategy?

The main purpose of this strategy is to make clear for our patients, carers and staff the areas we plan to focus on to ensure we deliver outstanding levels of care. It is also important that we demonstrate to the public, our Governors and our regulators that we are continuously striving to improve services and the quality of care.

How was the Strategy developed?

This Strategy builds on the work undertaken since the publication of our previous strategy in 2016 and aims to address those areas where further progress is required and build on our learning culture to ensure that we respond to the themes and trends identified via our intelligence.

In addition to the Trust-wide priorities, our care units (Including Royal Primary Care) have identified their priorities to ensure that there is a local focus on quality.

How will the strategy be delivered?

The Board is committed to ensuring that the Trust delivers safe and effective care and the patients have a positive experience. The Director of Nursing and Patient Care is accountable for ensuring the Quality Strategy is well planned, organised, evaluated and reported on throughout the Trust.

Within the Trust, care is delivered within clinical divisions and with leadership teams (made up of a lead doctor, lead nurse and a general manager) are responsible for working with their staff teams to achieve the aims of this strategy.

The Director of Nursing and Patient Care and the Executive team will ensure that this Quality Strategy remains live and at the forefront of staff minds through regular communication.

Strategic Framework

This Quality Strategy supports delivery of the Trust's strategic plan which is based upon our CARE values (Compassion, Achievement, Relationships and Environment). The strategic objective relating to quality is to "Provide high-quality, safe and person-centred care" with the strategic outcome to be rated as "outstanding" by the CQC.

This strategy sits alongside our other Trust strategies, such as the People strategy, to support the delivery of outstanding patient care.

This Quality Strategy uses the three domains of quality as defined by the National Quality Board: Positive experience, Effective and Safe. Within each of these domains we have identified 3 key priorities for improvement and within each of these priorities we will consider on the needs of vulnerable patients.

Our Quality Strategy on a Page

Our Quality Ambitions

The following sections describe the priorities within each of the Quality Ambitions. For each priority we have identified:

- Why we think this is important
- What we are aiming to achieve.
- How we will do this
- Our success measures

Quality Ambition 1: Positive Experience

To be outstanding we need to ensure that patients are truly respected and valued as individuals and empowered as partners in care. We want to listen to patient's experiences and learn from them to provide the best care possible. We have identified the following three priorities for improvement over the next two years:

- Communication
- Always events
- Learning from Feedback

Communication

Why is it important?

Good communication is vital in helping patients make informed decisions. Feedback from our patients suggests that this is a key opportunity for improvement.

What do we want to do?

We want to ensure patients are cared for by staff who can communicate in a clear and understandable way.

How will we do this?

We have identified 3 areas of focus:

- Communication training
- Empowering patients
- Communication regarding discharge

Communication Training Framework: A key strategic priority for the Education Team in 2018/19 is to improve communication training provision, which is likely to impact upon consistency. This includes:

- Human factors training
- Clinical Supervision and reflective practice
- Golden thread communication training
- Advice for alcohol and tobacco use
- Increasing equality of access to information for all patient groups (including vulnerable patients)

Empowering Patients: Building on the success of the 'About Me' booklets which have been developed by the Trust to support patient communication and empowerment particularly for vulnerable patients, the Trust will continue working with patients, carers and staff to co-produce "OK to Ask" leaflets, which aim to empower patients to ask questions during their care and treatment.

Communication Regarding Discharge: The trust will continue to communicate with patients and those close to them as part of the Red2Green process; as a priority, staff will ensure that 4 question cards are given to patients on admission, to encourage them to ask relevant questions, enabling them to be fully aware and involved in care planning from admission to discharge.

Key themes identified from patient feedback are:

- Ensuring the discharge process is explained clearly to patients, including any potential reasons for delay
- Explaining medications appropriately
- Ensuring families and carers are informed of, and involved in, discharge plans

- Ensuring patients have access to guidance about post-discharge care, including who to contact if they have any concerns

Success Measures

Improvements in communication will be measured via Friends and Family Test (FFT) feedback, results from National Surveys and levels of complaints

Always Events

Why is it important?

The key to a positive experience is ensuring the consistency of those aspects of the patient experience that should always occur when patients interact with healthcare professionals and the delivery system. These aspects are referred to as "Always Events".

What do we want to do?

We want to ensure that patient experience is supported by Always Events®.

How will we do this?

In January 2018, the Trust signed up for NHS England's Always Events® programme and Maternity services are piloting the Always Events methodology in Postnatal Care. Co-production with staff and patients is in progress, with the intention that a new change idea is agreed by the end of 2018. Using the PDSA cycle (Plan, Do, Study, Act) the team will test, improve and embed the change as appropriate during 2019.

As part of the Patient Experience Delivery Plan, we intend that each Care Unit will have developed an Always Event by 2020.

Success Measures

In line with the Always Events methodology process and outcome measures to assess improvement will be developed as part of each; project.

In addition, improvements in FFT feedback, local and national surveys, complaints and concerns will help us to measure success.

Learning from Feedback

Why is it important?

Learning from patient experience feedback is key to improving services.

What do we want to do?

We want to ensure that we respond to feedback, however it is received, at all levels of the organisation in order to drive improvements to patient experience.

How will we do this?

Key priorities include:

- Development of a Patient Experience Delivery Plan and Aim Statement, which will set out objectives and expectations for Divisions/Care Units, including in relation to vulnerable patients
- Driving improvements in our real time patient feedback system to ensure that staff have easy access to the themes and trends arising from feedback and are able to evidence the impact of improvements.
- Refresh of the Patient Experience Committee and Terms of Reference, to further support and embed Patient Experience improvements
- Care Unit improvement plans relating to patient experience, to be regularly reviewed at Governance meetings and Patient Experience Committee

Success Measures

Improvements in Friends and Family Test (FFT) feedback and results from National

Surveys will tell us if our learning from feedback has improved.

Quality Ambition 2: – Effective – the best outcomes for our patients

To be outstanding we need to ensure that outcomes for patients who use our services are consistently better than expected. To do this we will focus on:

- Learning from deaths
- Implementing best practice
- Learning and improvement from audits

Learning from deaths

Why is this important?

Many people experience excellent care in the months or years leading up to their death. However there is scope for improvement; by reviewing deaths and ensuring that learning is identified we can improve care for future patients and reduce avoidable deaths.

What do we want to do?

Embed effective processes for the review and investigation of deaths in hospital and ensure that the learning identified is implemented in practice. Triangulate this with existing patient safety data to ensure we capture learning from all data sources.

How will we do this?

Building on our learning from deaths policy, we will:

- Undertake an initial review on at least 90% of deaths.
- Increase the number of deaths which are subject to a structured judgement review to 20% of the total and complete reviews for all patients with learning disabilties.
- Use our intelligence to identify areas e.g. diagnosis groups, where mortality is higher than expected and undertake focussed reviews in these areas.
- Oversee, via the Mortality Steering group the implementation of identified learning.

To date the key themes identified for learning are as follows:

End of Life care: Action is underway to strengthen the palliative care team and end of life care processes; later in 2018 our refreshed End of Life Care strategy will be published.

Recognition and escalation of deteriorating patients: This is a priority area for action within the Safe domain (see page 9).

Antibiotic prescription and administration: This area has been the priority for work by the Sepsis group, and improvements in care have been demonstrated as a result. We will continue to focus on this area to ensure good practice is embedded.

Documentation: The reviews to date have identified many examples of excellent documentation, however this is not a consistent picture. This is a complex and longstanding problem and local measures alone will be sufficient to deliver a sustained improvement. A long term strategy is required which needs to be constructed in association with partners. Work already planned includes:

- A video about the importance of good record keeping for use at doctor induction.
- a refresh of the joint admissions proforma to improve ease of use and its ability to prompt recording of key details.

Decisions relating to resuscitation: In July 2018, the Trust launched of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process and

documentation, in conjunction with service across Derbyshire. This process creates personalised recommendations for a person's clinical care in a future emergency. In the lead-up to the launch staff training was delivered and extra point of care teaching is planned. We will continue to audit the use of ReSPECT and take action to ensure that this process is embedded.

Success Measures

Completion of initial reviews and SJR's will be monitored to assess the implementation of our learning from deaths process.

Improvements in the overall hospital standardised mortality rate (HSMR) will tell us if the action taken in response to these reviews is having the desired impact.

Audits of the ReSPECT process show good compliance with the process including appropriate completion of Mental Capacity assessments

Implementing best practice

Why is this important?

Healthcare is constantly changing and achieving the best outcomes requires us to understand and implement evidence-based best practice.

What do we want to do?

Deliver care in line with best practice to ensure the best outcomes for our patients.

How will we do this?

The Trust will strengthen its processes to assess compliance with NICE guidance and identify actions to address non-compliances.

In addition, the Trust will fully engage with the national Getting It Right First Time programme which aims to improve the quality of care within the NHS by reducing unwarranted variations.

Success Measures

We can evidence high levels of compliance with NICE guidance through robust audit.

We are assured of compliance with the GIRFT implementation plan and engagement with GIRFT reviews and recommendations.

Learning and improvements from Clinical Audit

Why is this important?

Clinical audit is our key method for finding out if healthcare is being provided in line with standards and helps care providers know where their service is doing well, and where there could be improvements with the ultimate aim of improving outcomes.

What do we want to do?

Improve clinical outcomes for patients by ensuring that where clinical audits identify scope for improvement action is taken.

How will we do this?

In order to achieve this we will strengthen our clinical audit programme and processes to:

- Focus on the priorities as informed by our risk register and identified themes from patient safety intelligence.
- Ensure that shortfalls in clinical practice are addressed systematically and that changes are evidence based.
- Ensure that there is robust oversight of Clinical audit and that this is integrated with Divisional Governance Structures .
- Encourage multi-professional involvement in audit including nursing.
- Introduce an annual audit celebration event to showcase local audits.

Success Measures

Key national audits for the Trust show improving compliance over time

We are able to evidence action taken as a result of clinical audit via quarterly clinical effectiveness report.

Quality Ambition 3 – Safe – Protecting our patients from harm

To be outstanding we need to ensure that patients are protected by strong comprehensive safety systems, which focus on openness and learning. To do this we will focus on:

- Recognising deteriorating patients
- Patient and family involvement
- Learning from incidents

Recognising and escalating deteriorating patients

Why is this important?

Patients who are admitted to hospital have a right to believe that they will receive the best possible care. This means that patients who become acutely unwell in hospital should receive optimal care because their deterioration is quickly recognised and acted upon.

What do we want to do?

Avoid serious health problems developing by ensuring that we monitor patients appropriately while they are in hospital and take action if they show signs of deterioration.

How will we do this?

In line with new national guidance the Trust will launch the revised National Early Warning Score chart (NEWS 2). To support this, there will be a relaunch of the escalation policy and procedures.

Simulation training will be used to help staff translate this policy and procedures into practice and departmental specific guidance will be developed to ensure there is clarity for junior medical staff to enable them to react to deterioration appropriately, and empower nursing staf to be able to challenge decisions taken

As part of the IM&T strategy for 2018/19 the Trust will be introducing an e-observations platform and task management system which will provide further opportunities to improve the safe escalation of the deteriorating patient.

Success Measures

Our nursing care audit shows over 90% compliance with the observations care bundle.

There is a reduction in clinical incidents relating to recognition and response to deteriorating patients causing moderate or above harm.

Patient and Family Involvement

Why is this important?

Open and honest communication with patients is at the heart of health care. Being open when things go wrong can help patients and staff to cope better with the after effects of a patient safety incident. In line with the duty of candour every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

To achieve this we must involve patients as much as they want to be, in serious incident investigations, for example setting the terms

of reference and treating their recollection of events as equal to that of a staff member, and ensure that we feedback the outcome and lessons learnt.

What do we want to do?

Ensure that patients and/or their families' are supported, engaged and involved immediately following a patient safety incident and throughout the subsequent investigations.

How will we do this?

We will strengthen our current processes to:

- Ensure duty of candour is applied in all cases where an incident has caused moderate or above harm.
- Review previous serious incident investigations to identify scope for improvement in terms of engagement.
- Ensure that for serious incident investigations; a lead contact is identified who will liaise with the patient throughout the process.

Success Measures

Duty of candour is applied in 100% of relevant cases.

We can evidence patient engagement in all serious incident investigations

Learning from Incidents

Why is this important?

When something goes wrong in health and social care, the people affected and staff often say, "I don't want this to happen to anyone else." In order to ensure we can respond to incidents we need to be aware of what has gone wrong (reporting) and view all incidents as an opportunity to learn.

What do we want to do?

We want to be recognised by our staff and stakeholders as a true learning organisation, with a culture that actively promotes reporting of all incidents irrespective of harm as an opportunity to learn and continuously improves the quality of services, outcomes and safety.

How will we do this?

By delivering our learning from incidents strategy we will.

- Develop a positive culture where reporting of all incidents
- Strengthen the learning processes by ensuring actions identified in response to incidents are SMART and develop mechanisms to support broader learning across specialties and divisions.
- Evaluate the impact of these actions to determine whether effective learning has taken place following an incident.

Success Measures

80% of clinical incidents reported are no harm or near missed.

Staff report (via the national staff survey) that the Trust has a positive incident reporting culture.

We can evidence the impact of actions taken as a result of serious incident investigations

Strategy Delivery

Governance

A senior lead will be identified for each area of focus and where a delivery plan is not currently in place this will be developed. In many cases there are working groups or committee's responsible for delivery of the priorities identified and these will continue. Where this is not the case, consideration will be given as to what support structure is required.

The 3 domain specific sub-groups of Quality Delivery Group; Patient Experience Committee, Clinical Effectiveness Committee and Harm Free Care Group will monitor delivery of the relevant ambitions and provide expert advice and guidance as required.

Delivery of this strategy will be overseen by the trust's Quality Delivery Group who will receive quarterly updates on all of the ambitions via the Quality Report. The Director of Nursing and Patient Care will provide assurance on progress to the Quality Assurance Committee.

Improvement methods

To enable delivery of this strategy we will need to draw upon a range of improvement methods. The Trust has adopted the Listening into Action 7 steps to engagement and improvement which is putting staff at the forefront of service improvement. .

To build on this the Trust is working with NHS Improvement to implement the Quality, Service Improvement and Redesign (QSIR) programme which has been delivered over many years to hundreds of staff involved in healthcare. The aim of the programme is to equip staff with the knowledge and skills to apply a range of tried and tested improvement tools and approaches.

Implementation Plan

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Quality Ambition 1: Caring – a positive experience						
Communication - ensure patients are cared for by staff who can communicate in a clear and understandable way.	Develop a communication training framework which includes: • Human factors training • Clinical Supervision and reflective practice • Golden thread communication training – a resource which can be included in all relevant training courses.	Dec 2019	SMPD	DWOD	Mar 2019 • Trajectories from completion of training will be agreed as part of the development of the framework. • FFT Trajectories: - Outpatients – achieve upper quartile - ED – achieve national average - Inpatients and Daycase – maintain upper quartile • 5% reduction in number of complaints with communication as primary subject (compared to 17/18) Jun 2019 • National inpatient survey results show improvements in scores for questions relating to general communication, communication at discharge and communication of post-discharge information (see appendix 1 for detail) •	Jan 2020 • Maternity – All sections of national survey in upper quartile by 2019 survey Mar 2020 • Inpatients and Daycase – to achieve top 10% nationally for FFT • ED and Outpatient FFT trajectories to be agreed in line with the highest point during 18/19. • 5% reduction in number of complaints with communication as primary subject (compared in 18/19) Jun 2020 • National inpatient survey results show improvements in scores for questions relating to general communication, communication at discharge and communication of post-discharge information (see appendix 1 for detail)
	Work with patients, carers and staff to co-produce "OK to Ask" leaflets, which aim to empower patients to ask questions during their care and treatment for: • Outpatients (by Dec 18) • GP Services (by March 19) • Maternity (by March 19) • Discharge (by June 19) • Surgery (by June 19)	Dec 2019	PEM	DoN		
	Evaluate the usage and impact of the Red2Green process question cards to ensure that these are achieving the aim of patients being fully aware and involved in care planning from admission to discharge.	April 2019	PEM	COO		
	Evaluate the systems and processes in place for ensuring that patients have access to guidance about post-discharge care, including who to contact if they have any concerns and make recommendations for improvement.	June 2019	PEM	DoN		

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Always Events – ensure that patient experience is supported by Always Events®.	Implement a programme to support each Care Unit to have developed an Always Event by 2020.	Dec 2020	PEM	DoN	Mar 2019 • Always Events will have been developed and implemented in 3 care units. • In line with the Always Event methodology process and outcome measures will be developed as part of each project. Targets will be set for each of these which will be used to assess success.	Mar 2020 • Always Events will have been developed and implemented in 6 care units. • In line with the Always Event methodology process and outcome measures will be developed as part of each project. Targets will be set for each of these which will be used to assess success.
Learning from Feedback – ensure that we respond to feedback, however it is received, at all levels of the organisation in order to drive improvements to patient experience.	Develop a Patient Experience Delivery Plan and Aim Statement, which will set out objectives and expectations for Divisions/Care Units	Dec 2018	PEM	DoN	Mar 2019 • FFT Trajectories: - Outpatients – achieve upper quartile - ED – achieve national average - Inpatients and Daycase – maintain upper quartile Jun 2019 • National inpatient survey results show improvements in scores for questions relating to general communication, communication at discharge and communication of post-discharge information (see appendix 1 for detail) Sept 2019 • All relevant clinical areas have real time feedback displayed.	Mar 2020 • Inpatients and Daycase – to achieve top 10% nationally for FFT • ED and Outpatient FFT trajectories to be agreed in line with the highest point during 18/19. • National patient surveys show improvements in scores on those questions deemed important to patients (as defined by Picker analysis) – trajectory to be set based on 2018 survey results • Maternity – All sections of national survey in upper quartile by 2019 survey (2020 publication)
	Through re-tendering the service drive improvements in our real time patient feedback system to ensure that staff have easy access to the themes and trends arising from feedback and are able to evidence the impact of improvements.	Mar 2019	HQG	DoN		
	Support Care Units to further develop their improvement plans to include actions relating to patient experience, to be regularly reviewed at Governance meetings and Patient Experience Committee	Mar 2019	PEM	DoN		

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Quality Ambition 2: Effective – the best outcomes for our patients						
Learning from deaths - embed effective processes for the review and investigation of deaths in hospital and ensure that the learning identified is implemented in practice.	Use our intelligence to identify areas, e.g. diagnosis groups, where mortality may be higher than expected and undertake focussed reviews in these areas	Ongoing	QDM	MD	Mar 2019 • Initial reviews are undertaken on at least 90% of deaths. • Increase the number of deaths which are subject to a structured judgement review to 15% of the total. • HSMR is reduced to bring it in line with national average. • Audits of the ReSPECT process show improved compliance with the process including appropriate completion of Mental Capacity assessments	Mar 2020 • Initial reviews are undertaken on at least 90% of deaths. • Increase the number of deaths which are subject to a structured judgement review to 20% of the total • HSMR demonstrates a reduction in mortality rates to better than national average. • Audits of the ReSPECT process show a minimum of 90% compliance with all aspects of the process including appropriate completion of Mental Capacity assessments
	Assess the impact of actions to strengthen the palliative care team and end of life care processes on the quality of care given	Mar 2019	QDM	MD		
	Develop a long term strategy to improve the consistency of documentation.	Mar 2019	AMD	MD		
	Audit the use of ReSPECT and take action to ensure that this process is embedded.	Nov 2019	QDM	MD		

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Implementing best practice - deliver care in line with best practice to ensure the best outcomes for our patients.	Strengthen the processes to assess compliance with NICE guidance and identify actions required to address non-compliances.	Mar 2019	QDM	MD	Apr 2019 • Audit plans include a range of audits relating to NICE guidance • High levels of assurance are available to evidence compliance with the GIRFT implementation plan and engagement with GIRFT reviews and recommendations Jun 2019 • Number of overdue reviews is reduced to 10% of the total issued during 18/19 Sept 2019 • All of the guidance assessed as non-compliant in 18/19 is reflected on divisional risk registers	Apr 2020 • Audit annual reports show completion of NICE audits and plans include a range of audits relating to NICE guidance • High levels of assurance are available to evidence compliance with the GIRFT implementation plan and engagement with GIRFT reviews and recommendations Jun 2020 • There are no overdue reviews for guidance issued during 19/20 Sept 2020 • All of the guidance assessed as non-compliant in 19/20 is reflected on divisional risk registers
	Fully engage with the national Getting It Right First Time programme which aims to improve the quality of care within the NHS by reducing unwarranted variations	Mar 2019	DDs	MD		

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Learning and improvements from Clinical Audit - improve clinical outcomes for patients by ensuring that where clinical audits identify scope for improvement action is taken.	Strengthen our clinical audit programme and processes to ensure: • Audit plans focus on the priorities as informed by our risk register and identified themes from patient safety intelligence. • Shortfalls in clinical practice are addressed systematically and that changes are evidence based • There is robust oversight of Clinical audit and that this is integrated with Divisional Governance Structures	Mar 2019	QDM	MD	Oct 2018 • Action taken as a result of clinical audit is clearly evidenced by the quarterly clinical effectiveness report. Jul 2019 • Clear baselines have been established for all key national audits	Apr 2020 • Action taken as a result of clinical audit is clearly evidenced by the quarterly clinical effectiveness report. Jul 2020 • Key national audits are showing improving compliance over time
	Work with Heads of Nursing to identify opportunities to increase nursing involvement in audit.	Mar 2019	QDM	MD/DON		
	Introduce an annual audit celebration event to showcase local audits	Oct 2019	QDM	MD		
Quality Ambition 3: Safe – Protecting our patients from harm						
Recognising and escalating deteriorating patients - avoid serious health problems developing by ensuring that we monitor patients appropriately while they are in hospital and take action if they show signs of deterioration.	Launch the revised National Early Warning Score chart (NEWS 2).and relaunch the escalation policy and procedures.	Nov 2018	LNIPC	DoN	Mar 2019 • Our nursing care audit shows over 90% compliance with the observations care bundle • Clinical incident data shows a reduction in incidents relating the recognition and response to deteriorating patients causing moderate or above harm.	Mar 2019 • Our nursing care audit shows over 90% compliance with the observations care bundle • Clinical incident data shows a reduction in incidents relating the recognition and response to deteriorating patients causing moderate or above harm.
	Commence delivery of a programme of simulation training to help staff translate this policy and procedures into practice.	Sep 2018	CSM	DoN		
	Introduce an e-observations platform and task management system which will provide further opportunities to improve the safe escalation of the deteriorating patient.	Mar 2019	CCIO	DoF		

Ambition	Action	Target date	Lead	Exec	Success measures	
					Year 1	Year 2
Patient and Family Involvement - patients and/or their families' are supported, engaged and involved immediately following a patient safety incident and throughout the subsequent investigations.	Strengthen current processes to ensure duty of candour is applied in all cases where an incident has caused moderate or greater harm	Jul 2019	PSL	DoN	Jul 2019 • Duty of candour is applied in 100% of relevant cases • We can evidence patient and/or family engagement in all serious incident investigations • Evaluation of engagement suggest that the we met their expectations.	Mar 2020 • Duty of candour is applied in 100% of relevant cases • We can evidence patient and/or family engagement in all serious incident investigations • Evaluation of engagement suggest that the we met their expectations.
	Review previous serious incident investigations to identify scope for improvement in terms of engagement.	Mar 2019	PSL	DoN		
	Ensure that for serious incident investigations; a lead contact is identified who will liaise with the patient throughout the process.	Dec 2019	PSL	DoN		
Learning from Incidents - be recognised by our staff and stakeholders as a true learning organization, with a culture that actively promotes reporting of all incidents irrespective of harm as an opportunity to learn and continuously improves the quality of services, outcomes and safety.	Through delivery of our learning from incidents strategy we will: • Develop a positive safety culture where reporting of all incidents • Strengthen the learning processes by ensuring actions identified in response to incidents are SMART and develop mechanisms to support broader learning across specialties and divisions. • Evaluate the impact of these actions to determine whether effective learning has taken place following an incident.	Dec 2019	PSL	DoN	Mar 2019 • 80% of clinical incidents reported are no harm or near missed. • There is an improvement in the proportion of staff who report (via the national staff survey) that the Trust has a positive incident reporting culture from 3.64 to 3.73 (national average – acute trusts). • We can evidence the impact of actions taken as a result of serious incident investigations	Mar 2020 • 90% of clinical incidents reported are no harm or near missed. • There is an increase in the proportion of staff who report (via the national staff survey) that the Trust has a positive incident reporting culture to 3.77 (national upper quartile – acute trusts). • We can evidence the impact of actions taken as a result of serious incident investigations

Key:

AMD – Assistant Medical Director
CCIO – Chief Clinical Information Officer
COO – Chief Operating Officer
CSM - Clinical Skills Matron
DDs – Divisional Directors
DoF – Director of Finance
DoN – Director of Nursing and Patient Care
DWOD – Director of Workforce and Organisational Development
LNIPC – Lead Nurse Infection Prevention and Control
MD – Medical Director
PEM – Patient Experience Manager
PSL – Patient Safety Lead
QDM – Quality Delivery Manager
SMPD – Senior Matron Practice Development

National Inpatient Survey Targets

Question	2017 score (out of 10),				Targets*		
	CRH	National average	Lower quartile	Upper quartile	2018	2019	2020
Communication - general							
Q23 When you had important questions to ask a doctor, did you get answers that you could understand?	8.18	8.24	8.01	8.47	8.24	8.36	8.47
Q26 When you had important questions to ask a nurse, did you get answers that you could understand?	8.47	8.40	8.14	8.55	8.51	8.55	8.55
Q34 Were you involved as much as you wanted to be in decisions about your care and treatment?	7.39	7.34	7.13	7.61	7.5	7.61	7.61
Communication – discharge							
Q48 Did you feel you were involved in decisions about your discharge from hospital?	6.90	6.96	6.70	7.26	6.96	7.11	7.26
Q49 Were you given enough notice about when you were going to be discharged?	7.21	7.15	6.96	7.47	7.34	7.47	7.47
Communication – post-discharge information							
Q55 When you left hospital did you know what would happen next with your care?	6.84	6.82	9.68	7.09	6.97	7.09	7.09
Q64 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.00	7.73	7.42	8.04	8.04	8.04	8.04

* These targets will be reviewed annually on publication of the national inpatient survey results and will be adjusted upwards if the results show an improvement in scores nationally. If there has been a national decline in scores the targets will remain as set.