4ward

NHS
Worcestershire
Acute Hospitals
NHS Trust

Quality Improvement Strategy | 2018 - 2021

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Introduction

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Text to follow from Vicky and Michelle after QGC.

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How we define quality

In the past few years the NHS has had a number of inquiries that have identified poor practices and raised concerns about the quality of the services being delivered. These have been reported widely in the press and have caused the public to loose confidence in the services they may receive. Reports such as the *Francis Report* into Mid Staffordshire Hospital, the Morecambe Bay inquiry and the report into care at Winterbourne View Care Home are just a few.

The *Five Year Forward View* published in October 2014 challenges NHS organisations to make improvements in quality to deliver the change required for the next five years. Within the document the ambitions on quality are described as follows:

Five year ambitions on quality

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission (CQC) is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between Clinical Commissioning Groups (CCGs) in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

The *Five Year Forward View* can be found online at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Quality Improvement is a formal approach to analysing performance and systematic efforts to improve. Improving quality is about making what we do of the highest quality possible, ensuring that we do the right thing at the right time for the right patient. To deliver this it is key that all staff are empowered to lead and make improvements in their everyday work and that all performance is measured and monitored in a systematic manner to ensure that quality improvements are made and sustained.

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Underpinning the many and varied policy initiatives designed to improve the quality of care have been multiple approaches to improving quality, reflecting competing beliefs on how improvements are best achieved.

We define quality as being three main equally important elements.

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What are we trying to accomplish?

We aim to deliver safe care which is clinically effective and is a positive experience for our patients, their families and our staff.

What has happened so far?

The Chief Inspector of Hospitals visited the Trust in November 2016 and published the findings in July 2017. The Trust was rated overall as *'Inadequate'*.

Overall rating (Nov 2016) - Inadequate		
Are services safe?	●	Inadequate
Are services effective?	●	Requires improvement
Are services caring?	●	Good
Are services responsive?	●	Inadequate
Are services well-led?	●	Inadequate

This section provides a summary of the CQC's findings about services at Worcestershire Acute Hospitals NHS Trust.

The Summary report and full CQC report can be found on our website www.worcsacute.nhs.uk or the CQC website www.cqc.org.uk.

1. Ensuring services are safe

The CQC rated the safety of our services as *'inadequate'*. They found a culture of reporting, investigating and learning from incidents but inconsistencies in external reporting for serious incidents. Staffing within the Emergency Department at the Worcestershire Royal site was not in line with national guidance; however, most other areas had adequate staff to ensure patients received safe care and treatment. Management and storage of medicines was poor with a lack of a robust process being in place for monitoring and reporting fridge temperatures. Too many patients were receiving care in the corridors of our Emergency Departments, particularly at the Worcester site, sometimes being placed near exit doors and out of the line of staff's sight. Mandatory training was, across most areas, below the trust target of 90%. This meant that we could not be assured that staff had sufficient knowledge to manage the care and welfare of patients. Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the patient's stay in hospital. Patient records were not always stored securely. Aging and unsafe equipment was used in the radiology departments across the trust that was being inadequately risk rated. There was a lack of capital rolling replacement programmes in place. Medical patients on non-medical wards were not always effectively managed.

2. Ensuring services are effective

The CQC rated the effectiveness of our services as *'requires improvement'*. The Trust mortality indicators (HSMR and SHMI) at the time were both above the national average. Our performance in national audits was poor with some areas performing significantly worse than the England average. Robust action plans were not in place to ensure improvement and there was no standardised approach to local audits. Mandatory training for staff was below

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the Trust standard in most areas and not all staff understood their obligations under the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS), meaning our most vulnerable patients were potentially at a higher risk of not receiving all the care they need.

3. Ensuring services are caring

The CQC rated the caring of all our services as *'good'*. They observed staff delivering compassionate care, involving patients in decision making, whilst providing good emotional support to patients and people close to them. However, the privacy and dignity of patients being cared for in corridors within the ED departments was often compromised.

4. Ensuring services are responsive

The CQC rated the responsiveness of our services as *'inadequate'*. The Trust was consistently failing to meet the national performance standards (Emergency Access; Cancer; Referral to Treatment and Diagnostics) with the flow of patients through the hospital being poorly managed. However, the Trust did have systems in place to ensure that patients living with dementia had safe care that was tailored to their needs. Staff could also demonstrate good examples of where they had altered care to ensure patients beliefs and diverse needs were met.

5. Ensuring services are well led

The CQC rated the Well Led aspect of the Trust as *'inadequate'*. They had significant concerns about the interim nature of the Board at the time and felt that the executive team did not have effective processes to ensure communication was embedded from ward to board. A revised framework for governance and assurance had been put in place but the CQC felt that it was not operating effectively and so the board did not have clear oversight of the risks affecting the quality and safety of care for patients. The CQC also raised concerns about reported high rates of bullying of staff from patients, relatives and other staff. In addition they noted the lack of BME staff employed in senior posts within the Trust.

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What are we trying to achieve?

Our Vision:

Our vision is to provide the highest possible standards of compassionate care and the very best patient and staff experience by ensuring that the right patient is given the right care in the right place every time.

The Quality Improvement Strategy is a high level document that sets out our intentions to deliver excellent care every time to every patient.

Our aim is to create a culture of continuous improvement and learning which is both patient centred and safety-focused.

Our aim is to create a safety culture in all areas so we do the right thing first time every time.

To do this, we must embed the four Signature Behaviours in all our actions by:

- Listening to staff and patient's views
- Making the working environment conducive to continuous improvement
- Actively engaging with staff in continuous improvement through the development of divisional improvement plans and local action plans
- Focusing on the human factors to ensure support and development of team working
- Being open and honest with people when things go wrong
- Sharing lessons learnt from incidents and improvements
- Creating a culture of openness and candour in line with the *Learning not to Blame Report*, the *Freedom to Speak up Report* and any other publications that support incident reporting and learning
- This strategy will be closely linked with delivery of the Quality Improvement Plan, the Trust's Quality Accounts, The Care Quality Commission's (CQC) domains of safe, effective, caring, responsive and well-led and be supported by annual planning.

Working together – putting patients, their carers and the community at the forefront of all we do will ensure we collectively lead the changes required in the provision of safe, effective and reliable care and services.

This is the foundation required to ensure we deliver for our patients and their carers.

Signature Behaviours	
We listen, we learn, we lead	Do what we say we will do
No delays, every day	Work together, celebrate together

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How was our strategy developed and how will it be delivered?

SEPTEMBER TO DECEMBER 2017
Development of the Quality Improvement Strategy (QIS) with staff and patient engagement on all sites

DECEMBER 2017
Strategy to Quality Governance Committee (QGC) for approval

JANUARY 2018
Strategy to be approved at public Trust Board

JANUARY TO APRIL 2018
Development of divisional Improvement Plans to underpin the strategy as delivery plan

APRIL 2018
Formal launch of QIS underpinned with the QDP. Publish Quality Account for 2017/18

SEPTEMBER 2018
Half yearly Divisional Quality Review

APRIL 2019
Review of year 2018/19 and launch of Divisional plans 2019/20

APRIL 2019
Publish Quality Accounts for 2018/19

WHO WAS INVOLVED?

- Allied Health Professionals (AHPs)
- Doctors
- Nurses
- Patients
- Informatics
- Operational staff
- Estates
- Relatives
- Carers
- Staff from other organisations
- Domestic staff
- Administrative staff

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Our model for improvement

Our staff and patients are best places to identify, create and deliver the improvements that need to be made to our services. It is our ambition to create a culture of learning, openness and transparency, supporting staff with the training and development needed to support their care delivery.

Our four Signature Behaviours will drive the culture change we need to ensure the Trust creates the intentional culture we want.

Our behaviours are:

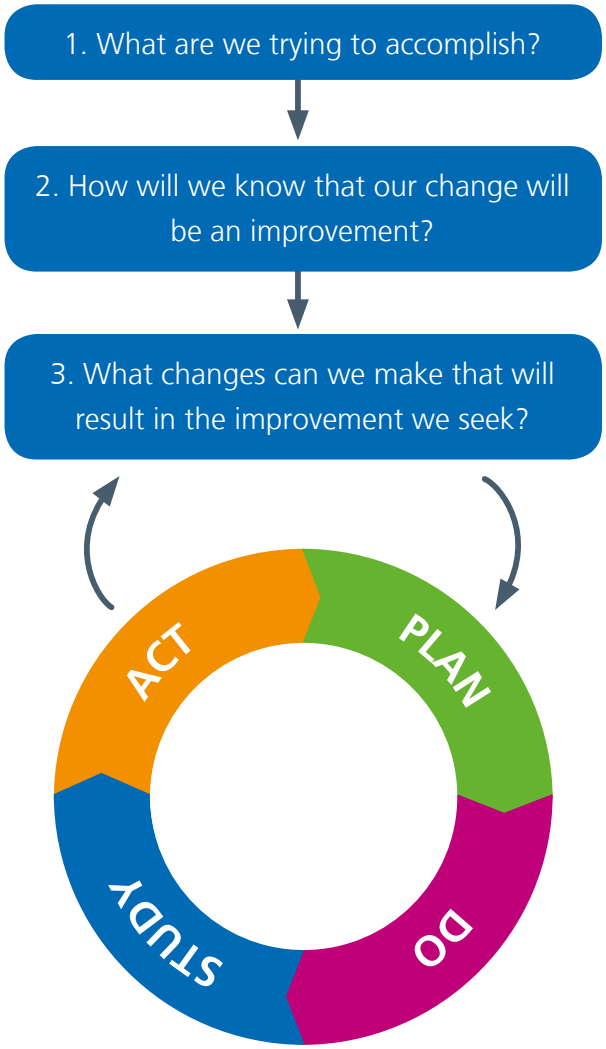
- Do what we say we will do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together

Our Model for Improvement is that promoted by the Institute for Healthcare Improvement. It focuses on answering three questions to clearly define our improvement aims, measure our improvement and select the right changes to ensure success. Plan Do Study Act (PDSA) cycles enable changes to be tested before they are fully implemented, thus making sure the changes we select have a positive impact.

Process Flow Conversations provide a framework to bring the correct staff and patients together to solve the problems preventing us from delivering the care we aspire to. As well as learning from incidents we also learn from successes through our Learning from Excellence programme.

Part of our journey will be achieved through working with our partners in improvement such as the University of Worcester, West Midlands Academic Science Network and West Midlands Quality Review Service.

Other partners that work with us are those who assess our services for accreditation against national standards such as Joint Advisory Group in GI Endoscopy (JAG), International Standards Organisation (ISO), Health & Safety and our regulators.



References: Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. (2009) The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers.

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Our approach to Human Factors

Our Trust recognises that understanding Human Factors is key to improving the performance of individual staff and teams. It is critical in enabling us to deliver safe care.

Learning from the aviation industry has been incorporated into a Trust training programme. Training is open to all staff. We have developed a group of medical, nursing and managerial staff who act as trainers, thus bringing together Human Factors principles and in depth knowledge of clinical practice and operational processes.

In 18/19 we will expand the programme further, linking specific safety priorities to the training programme further enabling us to improve our safety culture.

We are fully committed to developing a robust and sustainable process to continually improve the services we provide. This will enable us to deliver safe and effective care for our patients.

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Our strategic aims

AIM 1

Improve patient safety

- We aim to give every patient consistently safe, high quality and compassionate care.
- We aim to protect every patient from unintended or unexpected harm whilst in our care.
- We will learn from our excellence and our mistakes and improve care provided as a result.
- Staff will be taught both clinical and improvement skills to continually improve care. We will work together to achieve excellence.

AIM 2

Enhance our clinical effectiveness and efficiency

- Adhering to evidence, guidelines and standards to identify and implement best practice.
- Using quality improvement tools (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatment.
- Development and use of systems and structures that promote learning across the organisation and services.
- Measurement of performance to assess whether the team/ department/ organisation is achieving the desired goals and outcomes.

AIM 3

Delivering person centred care enhancing our compassion and communication

- We will develop a culture where patients, their carers' are at the forefront of all we do.
- We aim to achieve this through the development of a culture that supports continuous improvement by delivering services to the patients, their carers and the community that is responsive to the information they are telling us.

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L&S BP Completed

How do we use information and data?

Information and data lie at the heart of improving quality and safety within the Trust. From nationally mandated standards and levels of compliance, to local Trust agreed metrics; raw data is triangulated with qualitative evidence to provide intelligence about quality and safety priorities in the Trust.

Information is used to ensure that everyone in the Trust can be held to account, consistently, for the work that we do. The Trust can proactively identify trends, track improvements, and identify hotspots for focus.

Safety and Quality Information Dashboard (SQUID)

A board to ward Safety and Quality Information Dashboard was launched in early 2017. Known as SQUID, the dashboard is open access to all and provides the Trust with a user friendly electronic assurance system giving ward to board sight of key quality and safety information. It also provides a single source of the truth for quality and safety information.

SQUID supports organisational hierarchy with escalation and assurance running from ward to board, and direction and steer running board to ward. Areas of good and poor performance are highlighted, and the system encourages real time feedback. SQUID is supported operationally by Datix, which is used within the Trust to manage incidents, complaints and risk. Operational real time dashboards are available through Datix.

SQUID will continue to be used to monitor, challenge, manage and report progress on the Trust Quality Strategy.

Information priorities for quality and safety data

- Continue to develop data quality flags for quality and safety information
- Ensure benchmarking is in place for all indicators to allow the Trust to compare itself nationally against peers.
- Further develop use of SPC charts in tracking improvements
- Ensure that data is collected as part of an electronic system where possible, allowing clear audit trails

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How will we know how we are doing?

AIM 1
Improving patient safety

As measured by:

- Improved Safety Culture score
- Reduction in avoidable harm
- Improved Hospital Standardised Mortality ratio (HSMR and SHMI)
- Demonstrable and sustained improvements in priority safety objectives
- Maintaining incident reporting and reduction in Serious Incidents

AIM 2
Enhancing our clinical effectiveness and efficiency

As measured by:

- Compliance with National clinical audits
- A range of clinical outcome measures
- Delivery of NHS Constitutional standards
- Compliance with National clinical audits
- A range of clinical outcome measures
- Delivery of NHS Constitutional standards

AIM 3
Delivering person centred care enhancing our compassion and communication

As measured by:

- Effective and timely response to patient and carer complaints
- Annual patient survey
- Friends and family test
- Real time patient feedback

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Patient, carer and community engagement

The strategy is underpinned by the values of the Trust embedded within our cultural change programme launched in 2017.

This strategy puts at its heart active engagement with patients, their carers and the community as is our statutory duty to do so. Our patients and carers have told us that they need us to listen, care and act with compassion. This will be achieved through further development of person centred care – leading a programme of change and transformation.

Whilst it is recognised there is no one single definition of person centred care, we see person centred care as defined from active engagement with our stake holders, (patients and carers being our key stakeholder group) to ensure that how we deliver care and services to patients and their carers is designed in conjunction with them and not the other way round.

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AIM 1: To develop a culture where patients and their carers are at the centre of what we do.	**AIM 2: Developing a culture that supports continuous improvement by delivering services to the patients, their carers and the community that is responsive to the information they are telling us.**	**AIM 3 :To develop a culture of person centred and family centred care.**
HOW WE WILL GET THERE:	**HOW WE WILL GET THERE:**	**HOW WE WILL GET THERE:**
• Strengthen patient experience team to better support engagement and enable better reporting and analysis of feedback which is more visible and user friendly, which can really be used to drive targeted • Gain a proper divisional overview of patient involvement already taking place and develop a consistent structure for this • Celebrate our successes and ensure we acknowledge and reward innovation and achievement • Appoint a Patient Experience Associate Non-Executive Director to work alongside the patient experience team to drive improvements to engagement and involvement and ensure board ownership and oversight of patient experience work and initiatives • Provide a menu of involvement opportunities which will enable a more diverse and representative number of people to work with us, give their views and suggestions to improve what we do • Build on the work and learning we have gained from participation in the Kings Fund Collaborative Pairs Programme.	• Develop Patient Experience Leads • Links within divisions to work alongside corporate team to drive and embed improvements • Develop a process to proactively recruit patients and community members to work alongside us and develop and drive continuous improvement, ensuring that we increase diversity and broaden representation • Reduce the number of complaints, waiting times • Increase the satisfaction of the responses to complaints • Increase response rates to Friends and Family Test (FFT) and better utilise data • Strengthen our understanding of the links between patient and staff FFT and improve how we use this information to make improvements and cultural change. • Implementation of IHI Always Events Framework • Build on the learning from our recent involvement in the Kings Fund Collaborative Pairs Programme to develop and strengthen a culture of collaboration and patient leadership • Explore development of patient experience research opportunities in conjunction with the University of Worcester • Review our current feedback mechanisms, modernise where necessary and ensure we are optimising value for money which produces effective outcomes.	• We will empower our staff to be receptive, open and honest in response to patient feedback, incidents through learning and reflective practices, • Build on the positive partnership links we have been developing over the past couple of years to help develop more holistic approaches to involvement which support changing healthcare expectations and the requirements of the STP • Work closely with our existing volunteers and use their feedback and suggestions in a much more structured way to enhance patient experience.

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Framework - 5 key attributes in change programme

1. Coordination

Our approach to this will involve a cross system partnership with organisations that are equal in supporting patients and the community namely: Clinical Commissioning Group, Health and Wellbeing Scrutiny Board, Health Watch and the on going work in dementia, mental health, learning disabilities, autism, frailty and end of life care strategies.

2. Equality

Enhancing staff understanding across all aspects of equality and diversity to ensure they can provide appropriate care.

Meeting the requirements of the Accessible Information Standard – ensuring individual communication needs are recorded and acted upon.

Ensuring all our facilities are accessible and clearly signposted.

3. Measurement

Three areas of care that have been recognised by patients as strong indicators of satisfaction are those of information, communication and partnership. (National voices 2017). These three areas will provide the framework for measurement and our ability to do what our patients and their carers ask us to do for them.

4. Self and family centred care

The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients / carers, agreeing a plan of care that utilises their abilities and resources and builds upon these strengths. It is important that patients are given information on the treatment options being proposed in a way that suits their individual needs, and that healthcare professionals act as facilitators to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

5. Co-production

Building upon our work with the Kings Fund Participative Pairs Programme to develop patient leadership and participation to drive service design and improvements which maximise patient and carer experience.

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Delivering the key aims

To be able to deliver the key aims of the strategy we need to identify areas that require specific support or where there are areas of best practice where we can share our learning and celebrate our success. We need to identify different ways of doing this for all wards and departments. For our wards we are working on development of a ward accreditation programme.

Ward accreditation programme

The Care Quality Commission (CQC) assessed the Trust as *'good'* against the care domain in November 2016. This gives staff and patients confidence in the care that wards and departments are providing. To ensure that trust and confidence is maintained it is key that there is an understanding of the standards that each area is achieving. The approach being developed is a programme of ward accreditation which will build on the existing quality audits to establish sustained performance against a series of set standards;

The ward accreditation framework will use a variety of information from a variety of sources which will be triangulated and used to form a judgement of the quality of care being provided in the clinical area.

The inspections will be undertaken by senior nurses including the matrons and ward managers from other areas. Each ward will have a Quality Champion identified which in most cases will be the ward or departmental manager. The Quality Champion will lead the preparation of the evidence, meet the inspection team, receive the feedback and a written report and develop and manage the local action plan.

The ward accreditation programme will be developed with the ward managers to ensure that they influence the framework to reflect their views. This will be done through surveys, workshops and a pilot which will commence in April 2018.

Ward accreditation levels:

White	Below basic standards of care	Risk summit and targeted support
Bronze	Meets the basic standards expected for that area	Improvement plan, tailored support and buddying for Ward leader
Silver	Meets all the standards expected for that area with a clear plan and evidence of improvement	Leadership development programme for band 7 and band 6 ward leaders
Gold	Meets all the standards and is deemed excellent	Support to ward team to undertake service improvement projects
Blue	Sustained Gold for one year	Ward used as buddy for other areas and used as beacon site for new initiatives

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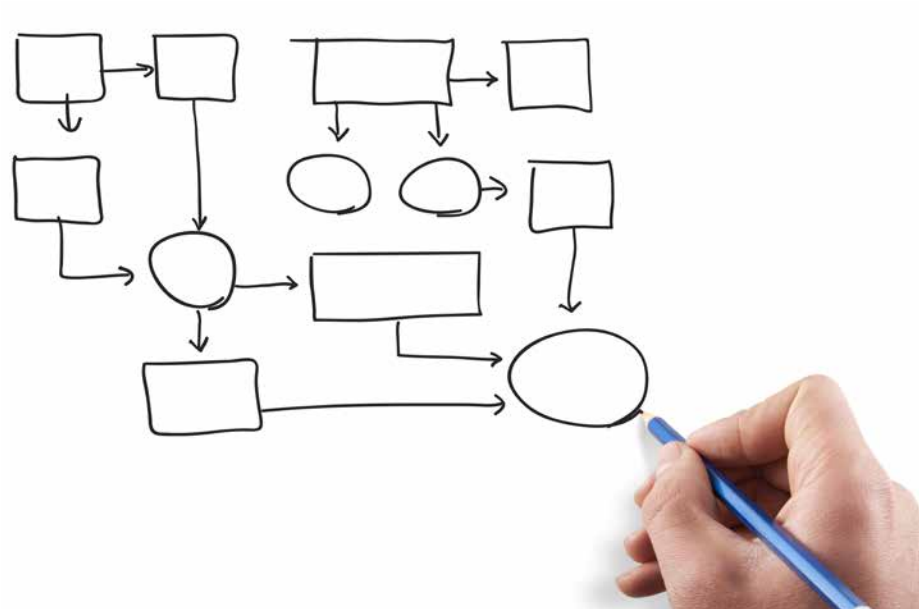
Delivering the plans

Each clinical division will develop a divisional improvement plan which will be the vehicle to deliver the aims of this strategy but localised to the issues and ambitions of each directorate. Each plan will be developed with the divisional leadership team and will include all of the improvement plans required to deliver the divisional business plan. The divisional improvement plans will be the single plan that will draw together and monitor all action plans across the division. Within each ward and department there will be a lead who will own their local plan which will be the single plan to deliver all quality improvements in their area.

The divisional improvement plans will be managed through the monthly performance review process and will be reviewed formally at the Quality Improvement Board.

The plans will be led at ward and department level by Quality Champions who will lead quality in their area as part of their leadership role. It is expected that this role will be undertaken by the ward or departmental manager. Each division will support their Quality Champions to deliver local improvement plans. This will include engagement of ward and departmental teams. Quality Champions will have enhanced access to service improvement training and support from the service improvement team.



Our Signature Behaviours:

- We listen, we learn, we lead
- No delays, every day
- Do what we say we will do
- Work together, celebrate together

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Delivering our Strategy

Our Signature Behaviours

- We listen, we learn, we lead
- No delays, every day
- Do what we say we will do
- Work together, celebrate together

Quality Improvement Strategy

Care that is safe

Care that is clinically effective

Care that is a positive experience for patients and their carers

Corporate and Divisional Quality Improvement Plans

Clinical Skills Development and Improvement Training

Cultural change through our Signature Behaviours

Quality Improvement Faculty

- Quality Hub to triangulate learning
- Quality Informatics and Quality Improvement Training to support teams
- Ward Accreditation System

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Enc H2 attachment 2

Worcestershire Acute Hospitals NHS Trust

Our Patient Safety Plan 2018-2021

Worcestershire Acute Hospitals NHS Trust

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Worcestershire Acute Hospitals NHS Trust

Strategic Patient Safety Plan to underpin the Quality Improvement Strategy 2018-2021

Our Ambition: Our ambition is to be one of the safest healthcare providers in the UK.

Introduction: By safe care we mean that no patient should suffer avoidable harm whilst in our care. Safe care should be consistently delivered to our patients regardless of their condition, when they are treated or by whom they are treated.

Improving patient safety is the responsibility of every single staff member in our trust. It is a core component of quality alongside clinical effectiveness and patient experience.

Purpose: The purpose of this strategic Safety plan is to establish the key safety objectives and define our ambition, areas of focus and pledges for the next 3 years to ensure that all Divisions and corporate teams are working together to deliver the safety improvements required.

Overall aims of the Patient Safety Plan:

- We aim to give every patient consistently safe, high quality and compassionate care.
- We aim to protect every patient from unintended or unexpected harm whilst in our care.
- We will learn from our excellence and our mistakes and improve care provided as a result
- Staff will be taught both clinical and improvement skills to continually improve care. We will work together to achieve excellence

The Patient Safety Plan supports delivery of the Quality Improvement Strategy 2018-2021.

Supporting programmes and strategies

The 4ward culture programme will provide a vehicle to support consistent behaviours and positive working environment to enhance improvements in patient safety. The People and Culture Strategy will support the professional development and training.

NHS Improvement have provided a national guidance document **"Our approach to patient safety – NHS Improvement's focus in 2017-18"** which provides context and support to the priorities set out in this plan.

Measuring Outcomes: Annually the outcomes and effectiveness of this Patient Safety Plan will be demonstrated through the annual Quality Account.

Enc H2 attachment 2

Worcestershire Acute Hospitals NHS Trust

Building on Foundations

A Trust Quality Improvement Plan has been in place during 2017. The Plan has enabled us to focus on improvements in patient outcomes and has been fundamental to establishing the base line for this Plan.

For the first time every clinical area now has access to their patient safety data through the Safety and Quality Improvement Dashboard (SQUID).

Providing visibility of data to each area allows total visibility of performance for staff within the areas themselves and also those of peers. Clinical teams can identify areas that are performing well and learn from their successes.

We have a robust incident management process, incidents are graded and analysed, root cause analysis undertaken and learning disseminated through divisional governance structures.

The Trust has implemented the new Mortality Review process as adopted from the Royal College of Physicians. Our completion of primary mortality reviews have increased. The new process provides us with a mechanism to identify important themes from which clinical teams can learn to improve the safety of care provided to patients.

We have seen an overall improvement in the percentage of patients screened for venous thromboembolism (VTE) following admission to hospital. The National Early Warning Score has been introduced; the accuracy of how patients are assessed has increased significantly month on month.

Sepsis screening and treatment has improved for both patients attending as emergencies and inpatients. This has been enabled by systematic adoption of the National Early Warning Score (NEWS) or PEWS (Paediatric Early Warning Score) to identify deteriorating patients; this has been supported by improving escalation processes.

Core processes fundamental to improving safety are being rolled out across the Trust.

Work has started to improve handover, thus creating a consistent approach and reducing the risk of vital information being missed.

The processes with the greatest potential for improving safety includes electronic observations, patient tracking and electronic prescribing and the Trust will be actively reviewing how we can introduce these.

Safety huddles provide a focus on ensuring all members of the team are clear on the plans to ensure patient safety.

SBAR (situation, background, assessment and recommendations) communication is refining how we pass messages about clinical care.

Management of the patient journey is being co-ordinated to ensure clear plans to enable safe and timely discharge.

Checklists to increase safety for procedures outside of surgery are being rolled out as part of our LoCSiiPS programme.

However, we are not consistent with these safety processes and Year 1 of our Plan will focus on a campaign to consistently applying all of these safety principles. Signing up to the **"Sign up to Safety Campaign"** will provide support for us to lead those improvements. There will be important national patient safety initiatives which are relevant to Clinical Divisions and the Trust through the Quality Improvement Strategy makes a clear commitment to support teams to join those relevant safety programmes

We have also been able to join some of the national safety collaborative established by NHSI which will support our Improvement journey. One of these includes phase 3 of the Maternity and Neonatal Health network where the national target is to reduce still births and neonatal deaths by 50% before 2025.

Delivering our Ambition

Pledge 1: We will give every patient consistently safe, high quality and compassionate care.

Do what we say we will do

We will give every patient consistently safe, high quality and compassionate care.

- We will reduce variation in care provided. Every patient should expect their care to reflect best practice.
- We will provide written care assessments and care planning within 4 hours of admission.
- Every patient will have an expected date of discharge, care will be co-ordinated to ensure this is achieved
- Medical, Nursing and Allied Health Professionals will document their agreed clinical plan for patient care on a daily basis.
- We will consistently administer the patients prescribed medications when they are required
- Board rounds and ward rounds will meet internal professional standards to ensure the patient is supported through their clinical pathway as effectively as possible.
- We will adopt NICE guidance and adopt best practice
- We will respond effectively to safety alerts in a timely manner, co-ordinating changes to practice and policy as required.

Pledge 2: - We will protect every patient from unintended or unexpected harm.

No delays every day

We will protect every patient from unintended or unexpected harm.

- We will participate in the national campaign designed to support the NHS to reduce avoidable harm by 50%.
- Staff, patients and their carers will be actively encouraged to identify risks to patient safety and to resolve them at a local level where possible. If not we as leaders will work with our teams to support them in resolving specific safety issues.
- We will recruit staff who actively demonstrate our Trust behaviours.
- Our culture will ensure patients and staff are at the heart of decision making and involved in developing safer care, they are the experts in how it feels to receive and deliver care in our trust.
- We will work with our partners to safeguard our patients from harm.
- We will work with national collaborative to ensure we work effectively to implement best practice

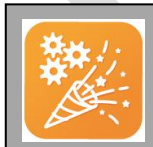
Pledge 3: **We will improve care by learning from our mistakes.**

We listen, we learn, we lead

We will improve care by learning from our mistakes.

- Our first safety culture survey will provide a frank baseline of where we are now and enable us to set clear aims and objectives to improve care
- We will provide high quality Mortality Reviews systematically understanding the care provided prior to the deaths of our patients. We will identify themes for improvement, we will share the learning and ensure improvements are made
- We will investigate and learn from serious incidents implementing improvements where required
- All staff will be encouraged to speak to our Freedom to Speak up Guardian, creating a culture of openness and honesty.
- Patients will be encouraged to identify and highlight risks and issues they perceive to their care. We will commit to resolve them
- We will develop our network of safety champions ensuring both patients and staff have access to advice, guidance and support
- We will undertake a program of targeted clinical improvement projects.
- We will develop an innovative workforce plan beyond 2020 to ensure a competent NHS workforce to deliver the best possible patient care

Pledge 4: **Our staff will be taught the clinical and improvement skills required to provide high quality care. We will work together to achieve excellence.**



We will work together, celebrate together

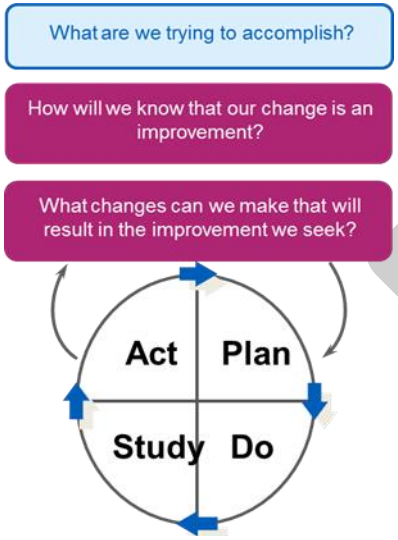
Our staff will be trained in the clinical and quality improvement skills required to provide high quality care. We will work together to achieve excellence.

- We will work with patients and their carers to develop high quality pathways designed to meet their needs.
- We will learn from excellent practice ensuring the principles are spread across the Trust.
- We will learn from our peers ensuring best practice is adopted at WAHT.
- We will work with our system partners to develop smooth transitions for patients between all our organisations.
- All staff will have access to improvement training designed to enable them to identify where improvements can be made and to implement sustainable improvements.
- Staff will be taught Human Factors skills thus improving their own performance and that of their teams.
- We will work with experts in training and development such as West Midlands Academic Health Sciences Network, NHS Improvement, Health Education England and the National Collaborative.

Measuring and Sustaining Improvements

The Model for Improvement underpins our methodology for Improvement.

We are committed to measuring our progress to ensure we continue to provide the standards we aspire to. The model focuses improvement efforts through three questions ensuring clarity of aim and systematically testing ideas for change through Plan, Do Study, Act (PDSA) cycles. The 4ward programme provides an improvement framework through the process flow conversations to understand our baseline position and systematically improve patient safety in each of our priority areas.



The overall progress within each pledge will be measured along with specific safety improvement objectives (Appendix 1).

A summary of high level examples are provided within the component areas of the Plan.

We will give every patient consistently safe, high quality and compassionate care.

Outcome: Improved Hospital Standardised Mortality Ratio

- Standardised hospital mortality indicator
- Specific Project Measures
- % primary mortality reviews undertaken within 30 days of death
- % patients screened for sepsis according to Trust policy
- % patients treated within 1 hour of confirmed sepsis
- % patient for whom NEWS / PEWS score has been calculated correctly
- % patients identified as deteriorating escalated per trust protocol

We will protect every patient from unintended or unexpected harm.

Outcome: Reduction of avoidable harm

- Reduction in Infections across a range of nationally mandated figures
- Reduction in the number of avoidable hospital acquired pressure ulcers
- Improved Hand hygiene compliance in inpatient areas
- Reduction in the number of patient falls resulting in harm per 1000 bed days
- Prescribe, administer and supply the right medicines at the right time for the right patient.

We will improve care by learning from our mistakes.

Outcome: Improved Safety Culture Score

- Mortality rates which are improving year on year
- % Root cause analysis Investigations which are fully completed within 45 days
- % of action plans completed from complaints and Serious Incidents within agreed timescales
- Themes from Serious incidents and complaints learning triangulated with lessons learned from mortality reviews and utilised to prioritise our improvement programme.

Our staff will be trained in the clinical and quality improvement skills required to provide high quality care. We will work together to achieve excellence.

Outcome: Demonstrable and sustained improvements in priority safety objectives

- Number of staff involved in improvement projects
- Number of staff who have undertaken Human Factor Training
- Number of staff have completed Level 1 Quality Improvement Training
- Staff who are confident & competent to deliver patient care according to their professional scope of practice.
- Working with national collaborative in specific improvement areas to ensure we achieve excellence

Patient Safety Plan, 2018-2021 – Objectives and Timelines

Working together – putting patients, their carers and the community at the forefront of all we do will ensure we collectively lead the changes required in the provision of safe, effective and reliable care and services.

This is the foundation required to ensure we deliver for our patients and their carers for whom we serve the trusts values to:

 **Do what we say we will do**

 **No delays, every day**

 **We listen, we learn, we lead**

 **Work together, celebrate together**

Safety Objective	Baseline position **(outturn 2017-18)**	**Year 1 Trajectory 2018-19** % reduction and actual number	**Year 2 Trajectory 2019-20** % reduction and actual number	**Year 3 Trajectory 2020-21** %reduction and actual number
To reduce avoidable Mortality	HSMR	HSMR of 100	Below HSMR of 100	Top Quartile of national mortality indicators
Reduction of avoidable hospital acquired pressure ulcers(HAPU)	Baseline position for 2017-18	**2018-19**	**2019-20**	**2020-21**
• Grade 4	Zero	Category 4: zero occurrence of avoidable hospital acquired pressure ulcers	Category 4: zero occurrence of avoidable hospital acquired pressure ulcers	Grade 4: zero occurrence of avoidable hospital acquired pressure ulcers.
• Grade 3 & • Deep and Ungradable (D&U)	17	<15 x grade 3 &/or D&U avoidable HAPU per annum- Demonstrating a 12% reduction	< 13 x grade 3 &/or D&U avoidable HAPU per annum- Demonstrating a 13% reduction	< 11 x grade 3 &/or D&U avoidable HAPU per annum- Demonstrating a 15% reduction
• Grade 2 avoidable	84-89 (5 to validate)	<80 grade 2 HAPU (avoidable) per annum demonstrating a 10 % reduction (9 patients)	<72 grade 2 HAPU (avoidable) demonstrating a 10 % reduction (8 patients)	< 65 grade 2 HAPU (avoidable) demonstrating a 10% reduction (7 patients

Reduce the number of patients who fall whilst under our care	Baseline for 2017-18	2018-19	2019-20	2020-21
Reduce the number of patients who fall whilst under our care	4.66 falls per 1000 bed days (to be validated for year-end) 1352- actual falls (subject to validation)	< 4.219 falls per 1000 bed days representing a 10 % improvement to remain further below the national average of 6.63 falls per 1000 bed days	To reduce the number of falls Trust wide by a further 5% and demonstrate further improvement below the national average of 6.63 falls per 1000 bed days	Reassess national benchmarks to ensure below national average and review trajectory for improvement but focus on maintaining the 15% reduction in falls achieved in the previous two years. Total number of falls reduced to < 1156
To reduce the number of patient who have a fall resulting in harm	0.08 Falls per 1000 bed days resulting in serious harm (22 patients)	< 0.076 falls per 1000 bed days representing a 10 % improvement and remain below the national average of 0.19 falls with harm per 1000 bed days (2 patient)	To reduce the number of falls Trust wide by a further 10% (2 patients) and demonstrate further improvements below the national average of 0.19 serious incident falls per 1000 bed days.	Re-assess national benchmarks to ensure below national average and reduce the number of falls Trust wide by a further 10% (2 patients) and demonstrate further improvements below the national average of 0.19 serious incident falls per 1000 bed days. Total number of falls resulting in harm reduced to 16

Infection, prevention and Control	Baseline position for 2017-18	2018-19	2019-20	2020-21
MRSA bacteraemia	zero	Sustain zero Trust attributable MRSA Bacteraemia	Sustain zero Trust attributable MRSA Bacteraemia	Sustain zero Trust attributable MRSA Bacteraemia
MSSA Bacteraemia	16	< 12 MSSA bacteraemia demonstrating 25% improvement	< 10 MSSA bacteraemia demonstrating 16% improvement	< 8 MSSA bacteraemia demonstrating 20% improvement
Reduction in the cases of Clostridium difficile ***Underpinned by:-*** Root cause analysis which demonstrates reduction in C-Diff red lapses of care	31 against a trajectory of 32	< 30 C Diff bacteraemia demonstrating 6 % improvement.	< 28 C Diff bacteraemia demonstrating 7 % improvement	< 26 C Diff bacteraemia demonstrating 7 % improvement
Gram negative Blood stream Infections- GNBSI Including:- -E-Coli - Pseudamonas - Klebsiella	55 (National requirement to reduce by 50% by 2021)	< 45 GNBSI demonstrating 18 % improvement in line with national trajectories	< 35 GNBSI demonstrating 22 % improvement in line with national trajectories	< 27 GNBSI demonstrating 22 % improvement in line with national trajectories
Hand hygiene compliance for Inpatient areas	98.6% compliance in 70.4% of inpatient wards	>95% compliance in 100% of Inpatient wards >95% compliance in 100% of OPD	>97% compliance in 100% of Inpatient wards >97% compliance in 100% of OPD	> 98% compliance in 100% of Inpatient wards >98% compliance in 100% of OPD

Medicines Safety	Baseline position for 2017-18	2018-19	2019-20	2020-21
Increase the reporting of medicines near misses and incidents across the Trust	Baseline Trust position: **3.52 reported incidents per 1000 bed days**	Achieve NHSE national average of: **4.47 reported incidents per 1000 bed days**	Achieve NHSE upper quartile: **4.88 reported incidents per 1000 bed days**	Exceed NHSE upper quartile: **>4.88 reported incidents per 1000 bed days**
Reduce the percentage of medicines incidents causing harm across the Trust	Baseline Trust position: **19.53% harm per 1000 bed days**	Halve the difference in % harm between Trust baseline and the NHSE national average: **15.62% harm per 1000 bed days**	Achieve the NHSE national average: **11.71% harm per 1000 bed days**	Reduce % harm below the NHSE national average: **<11.71%harm per 1000 bed days**
Implement Nursing/Midwifery staff medicines e-competency assurance programme to assure Trust that staff able to competently administer medicines safely.	Current medicines training in place on induction for all staff, for newly qualified nurses/midwives on appointment, as part of the preceptorship programme and mandatory training updates for clinical staff	**30% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency	**60% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency.	**90% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency

Medicines Safety	Baseline position for 2017-18	2018-19	2019-20	2020-21
Implement E-prescribing and administration (EPMA) system across Trust to reduce prescribing and administration errors	Electronic Discharge Summaries only in place	Secure funding for EPMA system and complete tender process	Implement EPMA system across Trust according to roll-out plan	Optimise EPMA system across Trust according to roll-out plan
Provide Assurance that Medicines are safely and securely handled Non-compliance and action plans -Ward level are not part of Divisional dashboards	100% of wards/clinical areas are audited annually 100% of wards/clinical areas are audited quarterly	**Safe and Secure medicines handling annual audits**: 100% of wards are audited annually Wards are >80% compliant with standards **Quarterly CD audit**: 100% of wards are audited quarterly Wards are >90% complaint with standards	**Safe and Secure medicines handling annual audits**: 100% of wards are audited annually Wards are >90% compliant with standards **Quarterly CD audit**: 100% of wards are audited quarterly Wards are >90% complaint with standards	**Safe and Secure medicines handling annual audits:** 100% of wards are audited annually Wards are >90% compliant with standards **Quarterly CD audit:** 100% of wards are audited quarterly Wards are >90% complaint with standards
Ensure that all patients presenting post fall have a comprehensive in-patient medication review **(**Metrics on in-patient medication reviews not currently collected)	Medication review pro-forma under development by Frailty team.	**50%** of patients who present post-fall receive an in-patient medication review (Implement standardised reviews)	**80%** of patients who present post-fall receive an in-patient medication review (deliver national target)	**90%** of patients who present post-fall receive an in-patient medication review (review national target to validate % improvements- standard to be to exceed national target)

Identification and escalation of deteriorating patients (Sepsis)	Baseline position for 2017-18	2018-19	2019-20	2020-21
Emergency Department (ED) Sepsis screening	83%	>85%	>90%	95%
Inpatient Sepsis screening	67%	>75%	>85%	>95%
Sepsis 6 Bundle compliance (ED)	50%	>60%	>70%	>80%
Sepsis 6 Bundle compliance (Inpatients)	80%	>85%	>90%	>95%
Preventing VTE - Compliance with screening	92%	>95%	>95%	>95%

Our continued thanks go to our patients, their carers, our staff and the public and our patient's representatives for their involvement in the development of this Plan and in our journey of continuous improvement

Enc H2 attachment 3

Worcestershire Acute Hospitals NHS Trust

Clinical Effectiveness Plan, 2018-2021

CREATING A CULTURE OF CONTINUOUS IMPROVEMENT AND LEARNING

Our purpose to have a Clinical Effectiveness Plan

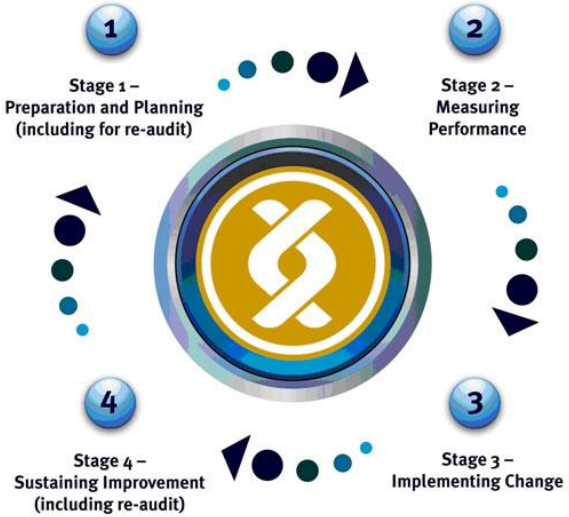
The purpose of a Plan for clinical effectiveness is to articulate our ambitions for how the Trust will improve its clinical effectiveness over the next three years, with the aim of providing patients with the best possible clinical outcomes for their individual circumstances.

What is Clinical Effectiveness?

Clinical Effectiveness is an umbrella term describing a range of activities that support clinicians and healthcare professionals to examine and improve the quality of care. Clinical audit is the best known example, but clinical effectiveness stretches beyond this to include the implementation of nationally agreed guidance as well as agreed standards/clinical performance indicators reflecting 'best practice'.

Clinical Effectiveness is "the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing and monitoring practice" *(Department of Health (1996) Promoting Clinical Effectiveness).*

Clinical Audit cycle



Aim

The Aim of this Clinical Effectiveness Plan is to provide patients with the best possible clinical outcomes for their individual circumstances. We will do this by;

- adhering to evidence, guidelines and standards to identify and implement best practice
- using quality improvement tools (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatments and services based on:
  - the views of patients, service users and staff
  - evidence from incidents, near-misses, clinical risks and risk analysis
  - outcomes from treatments or services
  - measurement of performance to assess whether the team/ department/organisation is achieving the desired goals
  - identifying areas of care that need further research
  - information systems to assess current practice and provide evidence of improvement
  - assessment of evidence as to whether services/treatments are cost effective
  - development and use of systems and structures that promote learning across the organisation

Pledge 1 – We will do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid and reliable evidence.

Do what we say we will do

Our aim is to ensure that clinical care is delivered in accordance with patients' preferences, and in line with the best available clinical evidence, Royal College guidelines, recommendations arising from national confidential enquiries and by working in partnership with our regional academic partners to facilitate research into practice and evidenced based care/commissioning.

Objectives

We will;

- Implement recommendations arising from national confidential enquiries, where relevant to the Trust.
- Participate in all relevant national clinical audits that we are eligible to participate in.
- Consider all published national audit reports and have produced a management summary and action plan, where relevant, for all national audit published reports.
- Complete an annual programme of local clinical audit.
- Ensure NICE guidance is implemented where possible and embedded into every day clinical practice by considering the relevance and implementation of relevant NICE guidance. We will do this by completing NICE assessments, with an exception/ risk report for all partially and non-compliant guidance.
- Implement recommendations from the Getting it Right First Time Programme (GIRFT), where possible, and relevant.
- Be one of the best Trusts in England delivering emergency laparotomies. (Measured through the National emergency laparotomy audit.)
- Progress our R&D strategy for 2018 -2021

Pledge 2 – We will work in the right way by developing a workforce that is skilled and competent to deliver the care required.


Work together, celebrate together

We already have a highly skilled workforce, committed to delivering compassionate, high quality individual care, but we know that there is more we can and must do to deliver even higher quality care to patients. In response to some of challenges, key initiatives have already begun include developing a cultural change programme of 'collective leadership' through the 4ward Pulse programme. It is also important to recognise the difficulties we face recruiting to specialist areas/ roles, set in a national context of a limited supply of professionals working in the health sector.

Objectives

We will;

- Implement the priority clinical standards for seven day hospital services

Pledge 3 – We will provide treatment at the point of need in a timely manner.

No delays, every day

The national Strategy and Transformation framework sets out a clear direction for trusts' priorities for timely access to services. Over and above the four national access standards, cancelled clinics and cancelled or delayed operations as well as delays in outpatient clinics cause an immense amount of distress for patients and our staff. Further problems are encountered by patients being looked after in clinical areas that are less than ideal and on occasion sub-optimal.

Objectives

We will;

- Cancel fewer operations by achieving the national target for patients' operations cancelled on the day of admission.
- Ensure that our time to theatre for patients with a fractured neck of femur will be amongst the best in England.
- Ensure that the number of patients being cared for in inappropriate areas (e.g. corridors) will be zero if not by exception.

Pledge 4 – We will ensure patients have the right outcome to ensure maximum health gain for their clinical circumstances.

We listen, we learn, we lead

In contrast to clinical audit, clinical outcome measures are designed to measure the outcomes of a service without reference to a particular pre-determined standard. Its aim is to give an indication of the standard achieved by the service. For some patients, clinical outcomes cannot be improved but nevertheless we must treat them with compassion and dignity. Examples of those used within the Trust are Intensive Care National Audit and Research Centre (ICNARC), risk adjusted mortality rate (HSMR & SHMI), Sentinel Stroke National Audit, Sepsis mortality and mortality reviews. Since 2009, patient reported outcome measures (PROMs) data has been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein . These can help us understand the outcomes which matter most to patients (including quality of life), highlight areas with significant variation in outcome and indicate potential areas for service improvement.

Objectives

We will;

- Monitor and seek to reduce patient mortality and morbidity whilst under our care.
- Reduce mortality due to sepsis so that we are in the top quartile of Trust in England with the lowest HSMR over the next 3 years.

Worcestershire Acute Hospitals NHS Trust

Clinical Effectiveness Plan on a Page

 Do what we say we will do	 Work together, celebrate together	 No Delays every day	 We listen, we learn, we lead
• Participate in relevant national clinical audits and implement recommendations. • Complete an annual programme of local clinical audit. • Ensure NICE guidance is implemented where possible and embedded into every day clinical practice. • Implement recommendations arising from national audits, national confidential enquiries & Getting it Right First Time Programme (GIRFT), where possible, and relevant. • Be one of the best Trusts in England delivering emergency laparotomies. • Progress our 3 year R&D strategy	• Implement the priority clinical standards for seven day hospital services.	• Cancel fewer operations. • Ensure that our time to theatre for patients with a fractured neck of femur will be amongst the best in England. • Ensure that the number of patients being cared for in inappropriate areas (e.g. corridors) will be zero if not by exception.	• Monitor and seek to reduce patient mortality and morbidity whilst under our care. • Reduce mortality due to sepsis and overall mortality.

Clinical Effectiveness Plan – 2018-2021 -Objectives and time lines

Working together – putting patients, their carers and the community at the forefront of all we do will ensure we collectively lead the changes required in the provision of safe, effective and reliable care and services.

This is the foundation required to ensure we deliver for our patients and their carers for whom we serve the trusts values to:

 **Do what we say we will do**

 **No delays, every day**

 **We listen, we learn, we lead**

 **Work together, celebrate together**

Effectiveness Objective	Baseline position **(outturn 2017/18)**	**Year 1 Trajectory 2018/19**	**Year 2 Trajectory 2019/20**	**Year 3 Trajectory 2020/21**
Implement recommendations arising from national confidential enquiries (NCEPOD), where relevant to the Trust.				
	No NCEPOD reports published in 2017/18.	Develop monitoring process to more closely monitor implementation of action plans.	Clear outcomes from all reports considered at divisional and trust level.	Clear outcomes from all reports considered at divisional and trust level.

Effectiveness Objective	Baseline position **(outturn 2017/18)**	**Year 1 Trajectory 2018/19**	**Year 2 Trajectory 2019/20**	**Year 3 Trajectory 2020/21**
Participate in all relevant national clinical audits.				
	92%	Resolve obstacles to participation. Participate in additional 2 audits.	95% participation	95% participation
Consider all published national audit reports and have produced a management summary and action plan, where relevant, for all national audit published reports.				
	97% Feb 2018 (March unavailable)	95% management summaries and actions for which the trust and its staff are responsible' within 12 weeks	95% management summaries and actions for which the trust and its staff are responsible' produced within 8 weeks	95% management summaries and actions for which the trust and its staff are responsible' produced within 6 weeks

Complete an annual programme of local clinical audit.				
	47% complete at Feb 2018	Develop achievable audit programme that meets local guidance issued. 60% completion.	>70% completion	>80% completion
Ensure NICE guidance is implemented where possible and embedded into every day clinical practice by considering the relevance and implementation of relevant NICE guidance. We will do this by completing NICE assessments, with an exception/ risk report for all partially and non-compliant guidance.				
	Feb 2018 84% of NICE guidance assessed within 6 weeks of publication.	85% assessed within 6 weeks.	90% assessed within 6 weeks.	95% assessed within 6 weeks.

	Feb 2018 74% of non/partially compliant NICE guidance has an exception and/or risk report.	85% with an exception and/or risk report.	90% with an exception and/or risk report.	95% with an exception and/or risk report.
Implement recommendations from the Getting it Right First Time Programme (GIRFT), where possible, and relevant.				
	Not available.	Develop a process to determine the extent to which recommendations from GIRFT are implemented. 80% of GIRFT recommendations implemented for 80% of GIRFT reports.	80% of GIRFT recommendations implemented for 80% of GIRFT reports.	80% of GIRFT recommendations implemented for 80% of GIRFT reports.

Be one of the best Trusts in England delivering emergency laparotomies. (Measured through the National emergency laparotomy audit.)				
	Quarter 1, 2017. Above the national average in 8/10 parameters.	Above the national average in 9/10 parameters	Top quartile for 6/10 parameters.	Top quartile for 8/10 parameters.
Implement the priority clinical standards for seven day hospital services				
	Non-compliant in 4 standards	Compliant in 2/4 standards.	Compliant in 3/4 standards.	Compliant in 4/4 standards.

Cancel fewer operations by achieving the national target for patients' operations cancelled on the day of admission.				
		TBC	TBC	No more than 0.8% cancelled operations in the day of admission.
Ensure that our time to theatre for patients with a fractured neck of femur will be amongst the best in England.				
		85%	86%	87%
Ensure that the number of patients being cared for in inappropriate areas (e.g. corridors) will be zero if not by exception.				
		TBC	TBC	<10

Monitor and seek to reduce patient mortality and morbidity whilst under our care.				
	12 month rolling average HSMR 102	HSMR 12 month rolling average ~ 100	HSMR 12 month rolling average better than the median	HSMR rolling average in top quartile of acute Trusts in England

Our continued thanks go to our patients, their carers, our staff and the public and our patient's representatives for their involvement in the development of this plan and in our journey of continuous improvement

Enc H2 attachment 4

Worcestershire Acute Hospitals NHS Trust

Patient, Carer and Community Engagement Plan 2018-2021

WORKING TOGETHER

PUTTING PATIENTS, THEIR CARERS AND THE COMMUNITY

AT THE FOREFRONT OF ALL WE DO.

Worcestershire Acute Hospitals NHS Trust

Contents

Worcestershire Acute Hospitals NHS Trust

Strategic Patient, Carer and Community Engagement Plan

Introduction: The Trust expects that all healthcare professionals will provide for patients and their carers clinical care and offer services in line with best practice. In offering and delivering best practice approaches, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients / carers bring.

It is expected that they will work in partnership with patients, agreeing a plan of care or services that utilises the abilities and resources of patients and builds upon these strengths. It is important that patients are offered information on the care/treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises patient experience and community engagement resources available that can further support decision making of patients and their carers.

The Trust recognises that patients and their carers are critical stakeholders in their health care and decision making; we recognize that patient, carer and community engagement has a major role in improving quality and safety of health care interventions, service delivery, and promoting ideal health care and personal health experiences and in going forward making the tough decisions required together.

Overarching Aims of this plan:

- We will develop a culture where patients, their carers are at the forefront of all we do.
- We aim to achieve this through the development of a culture that supports continuous improvement by delivering services to the patients, their carers and the community that is responsive to the information they are telling us.

A Plan to underpin the Quality Improvement Strategy

Our Patient, Carer and Community Engagement plan is underpinned by the Values of the Trust embedded within our cultural change programme launched in 2017. It is a key pillar in our overarching Quality Strategy (2018-2021).

Our Ambitions:

- To ensure that each and every patient and their carers/ family have a positive person centred experience and we will be one of the recommended Trust for patients to receive their care in the UK.
- We will be a trust recognised for its proactive community engagement and participation programme.
- We will be recognised as making a positive difference within our local community and make them proud of our hospitals and service.

Our Trust's signature behaviours

Do what we say we will do	We listen, we learn, we lead
No delays, every day	Work together, celebrate together

Building on Foundations

This plan puts at its heart active engagement with patients their carers and the community as is our statutory duty to do so.

Our patients, their carers and our community have told us that they need us to **listen, care and act with compassion.**

LISTEN, CARE and act with COMPASSION

To enable us to actively listen, provide appropriate quality care with compassion at all times, we will focus our approach of being a Trust that is recognised for promoting person centred care.

This plan launches an programme of change over the next 3 years which builds on current understanding of patient experience that will see cultural transformation throughout our organisation which will see us move to active and real time gathering experience, promote participation and engagement at all levels with patients their carers, families and the community we serve.

PERSON CENTRED CARE

Whilst it is recognised there is no one single definition of person centred care, we recognise that this is framed around the principles of:

1. Affording people dignity, compassion and respect offering personalised supportive coordinated care, or treatment.
2. A focus on the sole needs of the individual patient, ensuring their or where required their carers preferences and values, guide our clinical decisions.
3. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.
4. Focusing on equality and narrowing inequalities.
5. Identifying and involving patients' carers and families.
6. Providing and creating services in partnership with patient, their carers/families and the community.
7. Voluntary and community partners are involved as key partners and enablers of providing person centred care.

Delivering our ambition understanding what is important to our patients, their carers and the community is important to us

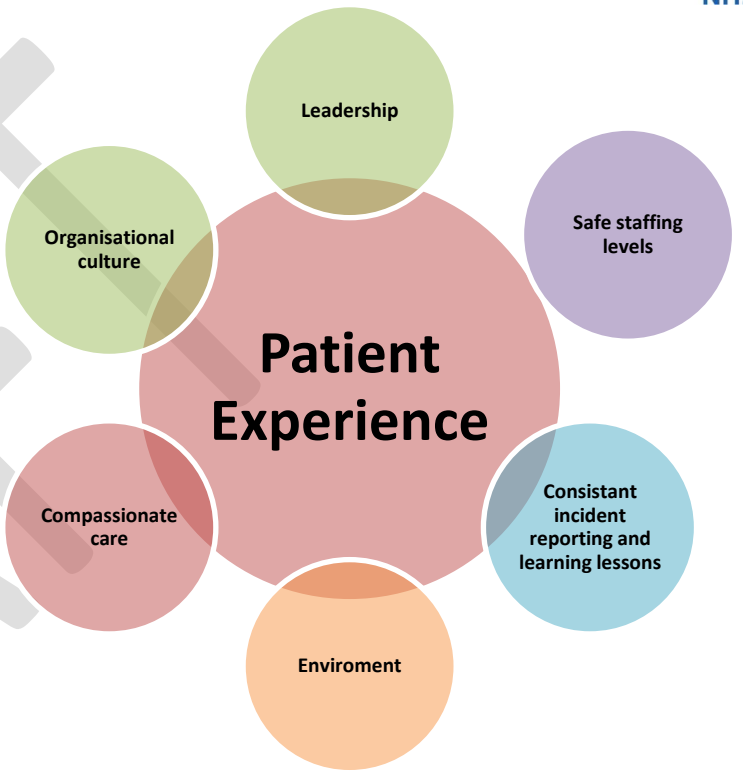
Worcestershire Acute Hospitals NHS Trust

Patient Experience Improvement Framework Methodology

Understanding what is important to patients nationally is important to us.

To further inform our patient experience plan we are an early adopting trust in the roll out of patient experience improvement framework (Dunderdale@NHSI 2018).

This framework is a self-assessment approach that integrates policy and findings from analysis of the outcomes from hospital inspections by CQC. It embraces continuous learning methodology.



Understanding what is important to patients nationally is important to us.

This plan is our commitment to working collaboratively with patients and their carers/ families going forward and using patient feedback and experience to design and improve services. Enhancing patient and carer involvement and communication is central to delivering this throughout our organisation.

As an organisation we collect a significant amount of patient feedback. In addition in November 2017, our Patient and Public Forum spent time at all 3 of our sites asking patients and visitors what quality meant to them and how as a Trust we could improve. Key themes have been collected.

This combined intelligence from local information gathering and nationally from patient improvement framework we have identified 4 specific objectives of focus to improve patient / carer experience.

Our Objectives

- **Communication**
  A need to be better informed and involved throughout.
- **Discharge**
  Ensuring patients and families are fully involved and aware of the discharge plan including any rehabilitation stage.
- **Pain Control**
  Ensuring patients understand their condition, treatment and pain management options
- **Privacy & Dignity**
  Ensuring we maximise and maintain privacy and dignity throughout their time with us.

Delivering our ambitions – what is important to our community is important to us

We believe that people have a right to be actively engaged in decisions that affect their lives and well-being. We recognise that meaningful engagement enables people to make informed choices and decisions and services to be developed which more closely reflect the needs of the communities we serve.

We have many groups and stakeholders who support us and our services. These groups and their volunteers undertake many roles and tasks for us. These relationships bring several mutual benefits including integrated engagement activity, a greater reach into the community and a more comprehensive and mutual understanding. Our volunteers and patient representative and public forum members are our eyes and ears and represent us in local communities. We believe that listening, learning and improving will become an everyday part of the Trust's culture through greater community engagement.

Our community engagement plan will achieve cultural transformation, promoting a genuine shift in power and control.

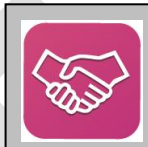
Delivering our Ambition: Patient and carer experience matters to us.

Pledge 1: **We will develop a culture where patients, their carers are at the forefront of all we do.**

Work together, celebrate together

- We will strengthen patient experience team to better support engagement and enable better reporting and analysis of feedback which is more visible and user friendly, which can really be used to drive targeted.
- We will gain a divisional overview of patient involvement already taking place and develop a consistent structure for this.
- We will build on the positive partnership links we have been developing over the past couple of years to help develop more holistic approaches to involvement which support changing healthcare expectations and the requirements of the STP.
- We will celebrate our successes and ensure we acknowledge and reward innovation and achievement.
- We will work closely with our volunteers and patient representatives and use their feedback and suggestions in a structured way to enhance patient, carer and community experience.

Pledge 2: **To develop a culture of person centred and family centred care.**



Do what we say we will do

- We will empower our staff to be receptive, open and honest in response to patient feedback, incidents through learning and reflective practices.
- We will ensure patients understand their condition, treatment and pain management options.
- We will provide a menu of involvement opportunities which will enable a more diverse and representative number of people to work with us, give their views and suggestions to improve what we do.
- We will ensure we maximize and maintain privacy and dignity throughout the patient's time with us.

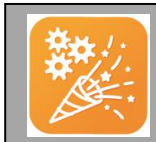
Pledge 3: **To develop a culture that supports continuous improvement by delivering services to the patient, their carers and the community that is responsive to the information they are telling us.**

No delays every day

We listen, we learn, we lead

- We will develop Patient Experience Leads.
- We will develop a process to proactively recruit patients, their carers, patient representative and community members to work alongside us and develop and drive continuous improvement,
- We will increase the diversity of representation on our membership groups from under those representative groups we serve
- We will ensure patients and their families report they are better informed and involved throughout their time with us
- We will have response rates for patient experience surveys that provides a positive experience for patients trust wide
- We will ensure patients and families are fully involved and aware of the discharge plan so that they are confident they have everything they need to continue their treatment or recovery including any rehabilitation stage
- We will develop a range of approaches that will gather real time as well as retrospective feedback to patients and their carers/family from information they provide.
- We will be recognised in the development of patient experience research opportunities in conjunction with the University of Worcester.
- Review our current feedback mechanisms, modernise where necessary and ensure we are optimising value for money which produces effective outcomes.

Pledge 4: **We will include patients, their carers and our community partners in our Patient Experience plan and Engagement Plan that will achieve a cultural transformation, promoting a genuine shift in power and control.**



We will work together, celebrate together

- We will be open and transparent to patients their carers and our community partners, what we do well now and where we need to improve.
- We will develop new ways of working: from involving patients, carers and the community in a range of actions, roles and activities.
- We will involve patients, their carers and the community in the recruitment, education and training of our workforce.
- We will involve patients, carers and the community in the redesigning, or designing of services.
- We will implement and roll out always events.
- We will have community engagement through representation on hospital committees.
- We will develop a community involvement programme
- We will conduct a comprehensive annual survey of our community membership to understand their needs and aspirations which will inform our community involvement program
- We will develop a range of mutually beneficial options for professional stakeholders and voluntary organisations to work in collaboration with trust in delivering patient care and care pathways

Worcestershire Acute Hospitals NHS Trust

Measuring and Sustaining Improvements

We will deliver a culture where patients, their carers are at the forefront of all we do.

Outcome:

- We will respond to 80% complaint before 25 days of receipt and ensure that we reduce the numbers of complaint returns from complainants dissatisfied with their response, improving complainant satisfaction
- We will have response rates for patient experience surveys that provides a positive experience for patients trust wide
- We will have a response rate for Friends and family test that provides a positive experience and they will recommend us as a place to receive care. We will risk assess and monitor patients experience when there have been occasions to move patients at night at times of high escalation which can lead to reduced patient experience.

Develop a culture that supports continuous improvement by delivering services to the patient, their carers and the community that is responsive to the information they are telling us.

- We will develop Patient Experience Leads by September 2018 and keep a live database of membership and skills.
- We will ensure patients and their families report they are better informed and involved throughout their time with us through annual patient surveys published in annual patient experience report every year.
- We will have response rates for patient experience surveys that provides a positive experience for patients trust wide through development of real time feedback and friend and family test each month
- We will ensure patients and families are fully involved and aware of the discharge plan so that they are confident they have everything they need to continue their treatment or recovery including any rehabilitation stage
- We will develop a range of approaches that will gather real time as well as retrospective feedback to patients and their carers/family from information they provide with report each quarter.
- We will be recognised in the development of patient experience research opportunities in conjunction with the University of Worcester and publish outcome by September every year.
- Review our current feedback mechanisms, modernise where necessary and ensure we are optimising value for money which produces effective outcomes through our annual assessment and publish outcome by March each year.

Develop a culture of person centred and family centred care

Outcome:

- We will appoint onto the board a non-executive for patient, carer and public engagement
- We will implement tool kit of story-telling that facilitates continued use and benefits from patient stories at board and in directorate meetings.

We will include patients, their carers and our community partners in our Patient Experience Strategy and Engagement Plan that will achieve a cultural transformation, promoting a genuine shift in power and control.

Outcome:

- We will grow our patient, carer and community membership
- We will achieve a positive satisfaction rating for our patient and community members involvement activities
- We will conduct, publish and maintain an annual patient, carer and community involvement programme by September every year.
- We will develop a range of mutually beneficial options for professional stakeholders and voluntary organisations to work in collaboration with trust in delivering patient care and care pathways

References

Kings Fund (2017); Our work on patients experience of using health and care services, London

National Voices (2017); Person centred care in 2017. Evidence from service users, London

Our thanks go to our patients, their carers, our volunteers, patient public forum committee, patient representatives, health and care trust, the clinical commissioning Group, health watch, voluntary organisations: speak easy, NHSI and the general public and our patient representatives for their involvement in the development of this plan and in our journey of continuous improvement.

Patient, Carer and Community Engagement Plan, 2018 – 2021 – Objectives and Timelines

Working together – putting patients, their carers and the community at the forefront of all we do will ensure we collectively lead the changes required in the provision of safe, effective and reliable care and services.

This is the foundation required to ensure we deliver for our patients and their carers for whom we serve the trusts values to:

 **Do what we say we will do**

No delays, every day

 **We listen, we learn, we lead**

 **Work together, celebrate together**

Objective	Baseline position **(outturn 2017/18)**	**Year 1 Trajectory 2018-19** % reduction and actual number	**ear 2 Trajectory 2019-20** % reduction and actual number	**Year 3 Trajectory 2020-21** % reduction and actual number
We will ensure patients and their families report they are better informed and involved throughout their time with us				
We will respond to 80% complaint before 25 days of receipt.	TBC at year end	80%	80%	80%
We will reduce the numbers of complaint returns from complainants dissatisfied with their response	TBC at year end	TBC	TBC	TBC
We will appoint onto the board a non-executive for patient, carer and public engagement	No specific PE NED	NED in place	NED in place	NED in place
We will implement tool kit of story telling that facilitates continued use and benefits from patient stories at board and in directorate meetings	Story presented at all public Board meetings	Continue to present patient story at public Board meetings and implementation of tool kit	Continue to present patient story at public Board meetings with analysis against tool kit	Build on finding from analysis of tool kit and story telling and develop an approach from findings

We will have response rates for patient experience surveys that provides a positive experience for patients Trust-wide				
We will have response rates for Picker surveys that provides a positive experience for in patients ensure identification of those lowest scores and ensure each of these have a focus on a monthly basis through divisional plans	TBC at year end	Scores will have improved significantly from lower quartiles	Scores will have improved significantly from middle quartiles	Reassess best practice and ensure we are in line with top quartile performance against Picker benchmark
We will have response rates for Picker surveys that provides a positive experience for out patients ensure identification of those lowest scores and ensure each of these have a focus on a monthly basis through divisional plans		Scores will have improved significantly from lower quartiles	Scores will have improved significantly from middle quartiles	Reassess best practice and ensure we are in line with top quartile performance against Picker benchmark
We will have response rates for Picker surveys that provides a positive experience for Emergency care ensure identification of those lowest scores and ensure each of these have a focus on a monthly basis through divisional plans		Scores will have improved significantly from lower quartiles	Scores will have improved significantly from middle quartiles	Reassess best practice and ensure we are in line with top quartile performance against Picker benchmark

We will have response rates for patient experience surveys that provides a positive experience for patients Trust-wide				
We will have response rates for Picker surveys that provides a positive experience for Maternity care ensure identification of those lowest scores and ensure each of these have a focus on a monthly basis through divisional plans		TBC	TBC	TBC
We will have a response rate for Friends and family test that provides a positive experience for patients trust wide Trust-wide Friends and family score (inpatient)		Trust wide response rate 30% Representing XX improvement Recommended rate <95%.	Reassess the national benchmark to ensure we are above the national average Trust wide Recommended rate <95% and reassess best practice and ensure we are aiming for top quartile performance.	Reassess the national benchmark to ensure we are above the national average Trust wide Recommended rate <95% and reassess best practice and ensure we are aiming for top quartile performance.
We will ensure patients and families are fully involved and aware of the discharge plan so that they are confident they have everything they need to continue their treatment or recovery including any rehabilitation stage.				
We will ensure patients will know their expected date of discharge or transfer for ongoing care so that they and their families have time to plan	TBC	TBC, following triangulation with the Operational Plan for 18-19	TBC, following triangulation with the Operational Plan for 19-20	TBC, following triangulation with the Operational Plan for 20-21

We will ensure patients understand their condition, treatment and pain management options				
National Picker Inpatient Survey 'staff did everything to help control pain'	2017 baseline 29%	In line with national average (as defined in Picker benchmarking)	In line with top quartile (as defined in Picker benchmarking)	In line with top quartile (as defined in Picker benchmarking)
We will ensure we maximize and maintain privacy and dignity throughout the patients' time with us				
We will risk assess and monitor patients experience when there have been occasions to move patients at night at times of high escalation which can lead to reduced patient experience	New risk assessment. Baseline to be established	Establish baseline in Q1/2 18/19. Set trajectories for remaining part of 18/19 and 19-21	TBC in Q2 18-19	TBC in Q2 18-19
We will risk assess and monitor, patients experience when there have been occasions to have extra beds in clinical areas at times of high escalation.	New risk assessment. Baseline to be established	Establish baseline in Q1/2 18/19. Set trajectories for remaining part of 18/19 and 19-21.	TBC	TBC
We will risk assess and monitor patients experience for patients in the ED corridor when there have been occasions to have extra beds at times of high escalation	TBC	Establish baseline in Q1/2 18/19. Set trajectories for remaining part of 18/19 and 19-21.		

We will support better empowerment of people and communities				
We will improve patients, their carers and community satisfaction of their experience of the trust specifically through their involvement in service development and change through	None currently	Role out of always events in 5 service areas	Build on our learning from year one of always events and role out to 10 service areas	Build on our learning from year one of always events and role out to 15 service areas
We will improve the representation on trust wide initiatives from under representative groups of patients, their carers and community increase their satisfaction of their experience of the trust	No assessments in place of current memberships trustwide	Establish baseline in Q1/2 18/19. Set trajectories for remaining part of 18/19 and 19-21		
We will implement objectives from dementia strategy across the trust with implementation of pledges in inpatient wards	No assessment	Assessment of current position of pledges on wards and a relaunch to all wards and reassessment wards. Carryout patient and carer satisfaction survey	Reassess the national benchmark to ensure we have improved patient and carer satisfaction based on last years survey results	Reassess the national benchmark to ensure we have improved patient and carer satisfaction based on last years survey results
We will conduct a comprehensive annual survey of our community membership to understand their needs and aspirations which will inform our patient, carer and community involvement programme	No survey in place	Develop and carry out annual survey	Annual survey	Annual survey

Our continued thanks go to our patients, their carers, our staff and the public and our patient's representatives for their involvement in the development of this strategy and in our journey of continuous improvement