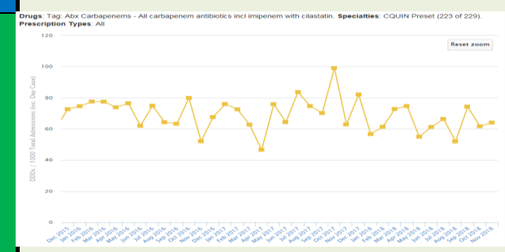
STRATEGIC PRIORITY 1 TO PROVIDE OUTSTANDING CARE TO OUR PATIENTS ADVANCING QUALITY PROGRAMME		EXECUTIVE LEADs HAYNES	SUZANNE BANKS	ANDY						
PROGRAMME/ACTION		**LEAD MANAGER**	**BENEFITS REALISATION MEASURES / KPIs**	**MILESTONES**					**RAG**	**COMMENTS**
We will deliver our Advancing Quality Programme (AQP) through the 8 workstreams below:				18/19						Updated: 11 January 2019
1	**Enhance our overall Patient Safety Culture**	**Ceri Feltbower /Dr Nick Watson**		**Q1**	**Q2**	**Q3**	**Q4**	**19/20**		
1A	Relaunch the PASCAL Safety Culture Approach for Maternity Services	**Ceri Feltbower /Dr Nick Watson**	An improvement in PASCAL Patient Safety Culture results. Developed baseline survey at start of each cohort Initial plan 10% improvement at re-audit.						C	Completed in 2017/18
1B	Refresh PASCAL Safety Culture Approach within the Emergency Department	**Ceri Feltbower /Dr Nick Watson**	An improvement in PASCAL Patient Safety Culture results. Developed for each cohort; baseline survey at start of each cohort Initial plan 10% improvement at re-audit.						C	Completed in 2017/18
1C	Socialise the outcome of the Pascal Work using a 'you said….we did' approach	**Ceri Feltbower /Dr Nick Watson**	Increase organisation resilience to risk by acting on feedback from staff. Programme to deliver inclusive staff Learning Collaborative events by creating a programme aimed at providing creative solutions to 'Wicked problems' An improvement in PASCAL Patient Safety Culture results at reaudit Increased proportion of staff reporting a positive difference in feeling listened to An increase in appropriate incident reporting Initial plan 10% improvement at re-audit						C	Completed in 2017/18

1D	To implement Schwartz Rounding to maximise and facilitate learning opportunities for the wider organisation. Effective Schewartz Rounding will improve the experience of care for patients in hospital and support staff to provide consistently good care	**Ceri Feltbower /Dr Nick Watson**	• Improve the safety culture of the organisation through improved communication between colleagues and a greater sense of teamwork • Staff will report feeling more confident to share experiences of fallibility and mistakes creating a more open and transparent culture in practice • Trained Schwartz rounds facilitators will be available in the organisation • A programme of Schwartz rounds will be implemented realising benefits to staff, patients and organisation • Staff who attend Schwartz Rounds will report feeling more supported at work • An improvement in PASCAL Patient Safety Culture results at reaudit.	✖					C	Commenced two rounds of Schwartz Rounding, further training on the 16 January 2019. Completed
1E	To reinvigirate the 'Sign Up to Safety' Campaign	**Ceri Feltbower /Dr Nick Watson**	Develop a clear brand which will raise the profile of quality and safety Aim that every member of staff will know about the campaign and how they can get involved Clear information on safety and harm accessible to all staff.						C	Completed in 2017/18
1F	Introduce Patient Safety Conversations (PSC) to promote an open culture to discuss with staff about how we can make patients safer. Identify and develop other innovative ways to listen to staff and patients about their safety concerns.	**Ceri Feltbower /Dr Nick Watson**	Improve the safety culture of the organisation through leadership and engagement of frontline staff To implement Patient safety conversations throughout the organisation Number of Patient Safety conversations taking place 100% of wards and departments visited by 2019 An improvement in PASCAL Patient Safety Culture results at reaudit						C	Completed in 2017/18

1G	Build capacity and capability within Quality Improvement to support patient safety programme.	**Ceri Feltbower /Dr Nick Watson**	To have developed a clear Patient safety improvement capability and capacity building programme/ training strategy To develop an online Quality Improvement resource (Learning Hub) to give staff practical support in taking forward improvements Establish a team with the capability in Quality Improvement Methodology Number of QI projects undertaken						C	
2	**Implement a mobile clinical digital platform that as part of the overall digital strategy gives healthcare professionals and carers access to all the data, information and knowledge they need in real time.**									
2A	Implement Nerve Centre as the replacement Trust wide system for identifying and responding to the deteriorating patient.	**Morgan Thanigasalam**	% of nurses with appropriate observations and escalations % of doctors with appropriate observations and escalations % of unplanned admissions to ITU (use of CCOT metrics) Reduction in failure to escalate deteriorating patients. Enabler for future expansion of clinical observation functionality supporting CQUIN targets. Reduction in paperwork costs.	✖					C	Completed
2B	To introduce electronic task management, allowing appropriate prioritisation and allocation of clinical tasks by the Hospital Out of Hours Team.	**Morgan Thanigasalam**	Patients receiving more efficient and correctly prioritised interventions out of hours. Key enabler of move to Hospital Out Of Hours. Improved medical staff satisfaction through shared workload and support.	✖					C	Completed
2C	Widespread issuing of handheld digital devices to the following groups; Adult/paediatric Ward based staff, doctor in training, Emergency Department staff, mobile staff such as Critical Care Outreach and Hospital Out of Hours Teams. Devices will come with Trust emails, Nerve Centre, mobile calling for mobile staff, mobile messaging for all, a range of "apps" and links to Trust protocols.	**Morgan Thanigasalam**	Significant improvement in timely clinical communication. Right patient information in the right place at the right time. Improved access to trust protocols for locum staff. Enabler for multiple future functions and apps. Increase in Trust Digital Maturity Index rating.	✖					C	Completed

2D	Significantly improve the communication, security and visibility of key inpatient information with the launch of a unified electronic handover.	**Morgan Thanigasalam**	Reduction in IG breaches related to paper handover sheets.	✖					A	There remains some incidents of IG breaches from staff where Handover sheets have been found in non-clinical areas. Many areas are now moving to e-handovers on their handheld mobile devices.
2E	Introduction of electronic observations to Ward 25 (Paediatrics) and the Emergency Department.	**Morgan Thanigasalam**	Releasing time to care.			✖			A	Currently ED are experiencing difficulties in SystmOne speaking to Nerve Centre, and the Clinical Applications team are working with the supplies to rectify this.
3	**Consistently undertake and improve our mortality reviews**									
3A	To implement a standardised approach to the Review of Mortality across all specialty areas to support the identification of defects in care and/or avoidable factors	**Elaine Jeffers/Dr Ben Lobo/Dr Esther Knight-Terlouw**	To reduce avoidable death by 1% annually						C	Completed 2017/18, annual summary for 2017/18 completed and Q1 report to go to Mortality Surveillance Group in July 2018
3B	To alert each responsible Consultant within 24 hours of the death of a patient under their care to initiate the Mortality review process	**Elaine Jeffers/Kim Kirk**	100% of accurate notifications to responsible Consultant						C	Bereavement Team undertake this process
3C	To develop the Electronic Mortality Data Collection Tool (version 2) to capture relevant intelligence on the care deliverd to the patient	**Elaine Jeffers/Dr Ben Lobo/Dr Esther Knight-Terlouw**	To demonstrate 100% of specialties review 95% of their deaths						C	Completed in 2015/16
3D	To provide training to Senior Medical Staff (representative per specialty) on the Structured Review Methodology to support the comprehensive avoidability assessment.	**Elaine Jeffers/Dr Ben Lobo/Dr Esther Knight-Terlouw**	To increase the number of competent reviewers to ensure all speciality areas can undertake a comprehensive structed judgement review 100% of Mortality Reviews where avoidable factors have been identified 100% of Mortality Reviews where avoidable factors have been identified 100% of Mortality Reviews accepted by the Coroner 100% of Mortality Reviews for all patients with a Mental Health or Learning Disability need						C	Ongoing, Dr Ben Lobo and Elaine Jeffers provide the training
3E	To provide a 'Learning from Deaths' Report to the Board of Directors Quarterly	**Elaine Jeffers/Dr Andy Haynes**	Quarterly Board Report						C	Annual report to the Quality Committee and Board of Directors in July 2018
3F	To publish data as identified through the 'Learning from Deaths' Board Report from Q3	**Elaine Jeffers/Dr Andy Haynes**	Mortality Dashboard						C	
3G	To write a write publish and implement a Trust 'Learning from Deaths' Policy	**Elaine Jeffers/Dr Ben Lobo/Dr Esther Knight-Terlouw**	Policy approved by Patient safety Quality Board on Wednesday 2nd August						C	On the intranet and is now ready for the first review and will be presented to Mortality Surveillance Group in July 2018
3H	To work with the Patient Experience Team to agree the mechanism for engaging with bereaved families	**Elaine Jeffers/Kim Kirk**	Quarterly Patient Experience Report. Board Report						C	Ongoing

4	**To ensure safe medicine prescribing**									
4A	All Medical Consultant staff will undertake a weekly review of antibiotic prescribing and treatment where required	**Dr Andy Haynes/Dr Shrikant Ambalkar**	Individualised targets for each speciality to be developed - Q1. Monthly review for all specialities to ensure the targets set out above are met - Q1-4. Uptake graphs will be available.						C	Antibiotic ward rounds are established
4B	To ensure all patients who present with an Acute Kidney Injury (AKI) are reviewed at 72 hours to ensure medication is appropriately held or restarted.	**Jo Freeman/Renal lead**	Initial medication review to be completed for all AKI patients. 72 hour review documented for all AKI patients to ensure medication continue to be held appropriately or are restarted if /when the AKI resolves. Aim for 100% for both measures. Graph data on a monthly basis to see improvements. SEE COMMENTS.				✖		G	Continues to be monitored through the Deteriorating Patient Group
4C	Implementation of a pharmaceutical record for all patients. This will allow the ongoing pharmaceutical care of patients on thee ward and adequate and appropriate handover between pharmacy professionals. This will hold valuable information relating to the patients pharmaceutical needs and discharge requirements in an easily accessible format.	**Steve May**	Development of an appropriate record - Q1. Implementation of the pharmaceutical care record - Q2. Audit / review of the record - Q3. Electronic solution to be developed alongside Nerve Centre Q4.						C	Pharmaceutical record is now fully implemented across all inpatient areas covered routinely by pharmacy and is available for all patients expected to be admitted.
4D	To prevent Antimicrobial Resistance by reducing the inappropriate use of Tazocin and Carbopenems (Meropenem)	**Jo Freeman/Dr Shrikant Ambalkar**	Antimicrobial consumption - monthly tracking of all antimicrobial usage. Tazocin and Carbopenem consumption - monthly tracking of usage. Consumption graphs available.		✖				G	 The Trust is currently one of the lowest users of Carbopenem in the East Midlands

4E	To ensure that all doctors eligible for the Epiphany programme have received their training - (to obtain numbers)	**Educational Supervisors/Jo Freeman**	Epiffany launch - Q2 (aug). Monthly tracking of prescribing audit uptake for each speciality. Annual report for the prescribing audit. On-going tracking of prescribing audit results. Introduction of prescribing huddles for ward based doctors. Pilot in May with rolling programme to begin from June 17.						C	The final report is awaited but training and feedback is completed.
4F	To ensure Junior Doctors understand and comply with the requirements around the prescribing and management of high risk medicines	**Educational Supervisors/Jo Freeman**	Zero tolernace of medication errors for high risk medicines						C	All the new FY1 doctors are undergoing a simulation session which includes prescribing with feedback from a pharmacist. There is a 'drug of the week' presented at Foundation teaching as well as formal pharmacy teaching sessions. Dr Moorby presents an update on anticoagulation to the Medical Grand Round at least twice a year. There are ward pharmacists that check inpatient and TTO prescribing with feedback to trainees.
5	**Work towards ensuring an effective, safe service across our Hospitals 24/7, including ensuring care is safe out of normal working hours and at weekends and that patients can access routine services 7 days per week where appropriate**									
5A	To implement Standard 2 of the Seven Day Services Clinical Standards - 'All emergency admissions must be seen and have a thorough clinical assessment by a suitable Consultant as soon as possible but at the latest within 14 hours from the time of arrival at the hospital'	**Dr Andy Haynes/ Paula Evans**			✖				C	Completed
5B	To implement Standard 5 of the Seven Day Services Clinical Standards - 'Hospital inpatients must have scheduled 7-day access to diagnostic services such as x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology.'	**Dr Andy Haynes/ Paula Evans**	Consultant-directed diagnostic tests and completed reporting will be available 7 days per week Within 1 hour for critical patients Within 12 hours for urgent patients Within 24 hours for non-urgent patients To insert KPIs already identified within this programme		✖		✖		C	Completed
5C	To implement Standard 6 of the Seven Day Services Clinical Standards - 'Hospital inpatients must have timely 24 hour access, 7 days a week to consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear protocols'	**Dr Andy Haynes/ Paula Evans**	Protocols to be developed and implemented for: Critical Care Interventional radiology Interventional Endoscopy Emergency General Surgery To insert KPIs already identified within this programme		✖		✖		C	Completed

5D	To implement Standard 8 of the Seven Day Services Clinical Standards - a) 'All patients on the Emergency Assessment Unit (EAU), Surgical Assessment Unit (SAU) and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE Daily (including all acutely ill patients directly transferred and others who deteriorate)' b) 'Once transferred from the acute are of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least ONCE every 24 hours, 7 days a week, unless it has been determined that this would not affect the patient's care pathway'	**Dr Andy Haynes/Paula Evans**	To insert KPIs already identified within this programme		✖		✖		C	Completed
5E	To standardise how the hospital is managed between 8am and 7pm	**Robin Binks/Cheryl Beardsley**				✖			A	Currently Saturday, Sunday and Bank Holidays are covered 24/7 by Hospital out of Hours, Urgent & Emergency Care are currently establishing cover between 5 - 8pm
5F	To standardise how the hospital is managed between 7pm - 8am	**Robin Binks/Cheryl Beardsley**							C	Hospital out of Hours Practitioners cover 8pm - 8am weekdays and 24/7 over weekends and bank holidays
5G	To review the roles for all Allied Health Professional Groups to determine what services should be delivered over a 7 day period and where there are opportunities to re-design pathways to optimise care	**Suzanne Banks/Elaine Torr**			✖				G	To be reviewed as part of the Associate Chief AHP role
	To work in conjunction with Nottinghamshire County and other external stakeholders as part of the Better Care Fund Seven Day Services Programme	**Peter Wozencroft**							C	Completed
5H	To provide a clinically driven and patient focused Hospital Out of Hours Service that uses both a multiprofessional and multispecialty approach to delivering care at night and out of hours.	**Robin Binks/Cheryl Beardsley**							C	As above
6	**Improve the discharge experience for all patients and ensure that they return to the most appropriate place of residence at the right time, with the right information, appropriate equipment and a clear plan of any required next steps.**									
6A	In conjunction with the Patient Experience Team design an evaluation tool to measure the experience and effectiveness of patient discharge	**Elaine Jeffers/Kim Kirk**	1% reduction per annum in discharge related complaints Audit of Discharge Checklist to identify non compliance						C	There is a question specifically relating to discharge to all inpatient FFT surveys. There is a bespoke survey for the discharge lounge. All audits are recorded through the Meridian system
6B	To undertake a review of all discharges reported to the Trust as 'unsafe' to drive improvements and changes in practice	**Head of Governance**	Root Cause Analysis Review of 100% of 'unsafe/failed' discharges reported through the Trust Serious Incident Reporting Framework				✖		A	Themed reviews of unsafe discharges through the Governance catch-up group meetings.
6C	To ensure that safe discharge processes are identified in relevant patient pathways and that patients are discharged to their preferred place of care inclding end of Life	**Dr Ben Lobo/ Debra Broadhurst**							C	Completed, but remains an ongoing approach. A quarterly report on Fast Track goes to Patient Safety & Quality Group, along with an Annual report and this also forms part of the Quality Account. There are systems and processes in place.
6D	To implement the Standards for 'Communication of patient diagnostic test results on discharge from hospital'.	**Dr Shafiq Gill/Elaine Jeffers**				✖			G	Dr Nigel Marshall working with Diagnostics & Outpatients division
6E	To work with external stakeholder groups and partners to ensure the consistency of the Discharge process across our partner communities	**Dr Shafiq Gill/Elaine Jeffers**				✖			G	Dr Nigel Marshall working with Diagnostics & Outpatients division
7	**To provide an equal emphasis on mental health as well as physical health**									

7A	To complete the 'Must Do' Action Plan from the 2016 CQC Inspection Report with regards to Mental Health, Mental Capacity and Learning Disabilities Awareness	**Phil Bolton/Tina Hymas-Taylor**	Reviewed and amended Policies in place taking account of the legal changes: Mental Capacity Act Policy Deprivation of Liberty Policy						C	Completed in February 2018
7B	To implement the Safeguarding Training Strategy with particular focus on the revised Safeguarding competency requirements	**Phil Bolton/Tina Hymas-Taylor**	Training Strategy approved and in place						C	Completed in February 2018
7C	To identify Safeguarding Champions (Mental Health) across the Trust and provide suitable training to support the effective execution of their roles and responsibilities	**Phil Bolton/Tina Hymas-Taylor**	Series of Training/Study days in place and delivered						C	Completed in January 2018
7D	To identify Safeguarding Champions (Learning Disabilities) across the Trust and provide suitable training to support the effective execution of their roles and responsibilities	**Phil Bolton/Tina Hymas-Taylor**	Series of Training/Study days in place and delivered						C	Completed in January 2018
7E	To implement the Safeguarding Module with the DATIX reporting system to support optimum reporting of incidents but also capture Safeguarding referrals and action plans	**Phil Bolton/Tina Hymas-Taylor**							C	Completed in February 2018
7F	To include the suite of safeguarding metrics within the Quality Dashboard presented to Patient Safety Quality Board in line with the Single Oversight Framework report to the Board of Directors	**Tina Hymas-Taylor**							C	Dashboard developed and feeds into the Safeguarding steering group
7G	To work in Partnership with the Nottinghamshire Health Community Partnerships NHS Trust to agree appropriate pathways for those patients who present with Mental Health needs	**Dr Andy Haynes/Suzanne Banks**							G	Stronger ties with Nottinghamshire Healthcare, as we are just about to sign a SLA agreement but support our mental health services. We have a Mental Health CNS in post to support our mental health services on site and with our mental health trust. The Trust is actively involved in the ICS Mental Health workstream
7H	To create the 'In your shoes' approach to fully understand the journey that individuals with Mental Health or Learning Disability Needs will take when admitted acutely to the hospital	**tbc**	To design a programme of 'In your Shoes' opportunities to determine shared learning opportunities to improve the patient pathway and overall experience To implement across all acute admitting areas						C	Completed in February 2018
8	**Ensure we provide effective Patient Information for every patient that comes into contact with our services.**									
8A	Policy **-** To review the current Trust Policy.	**Elaine Jeffers/Kim Kir**k	The Policy should: Take account of the storage and ongoing management of patient information Give consideration to access to information (including arrangements for translation services and compliance with the DDA Act 1995						C	Completed 2017/18. SharePoint on the intranet and available in different languages
8B	Policy - To implement the reviewed Policy	**Elaine Jeffers/Kim Kir**k	To promote the Policy to staff providing appropriate training and awareness						C	Completed 2017/18. SharePoint on the intranet and available in different languages
8C	Patient Information amnesty (including patient leaflets)	**Elaine Jeffers/Kim Kir**k	To develop a 'Mastersheet' (captured on a central database) of all patient information leaflets to achieve a baseline status of all current information						C	Completed 2017/18. SharePoint on the intranet and available in different languages

8D	Appoint a designated, accountable Lead for the ongoing management of Patient Information	**Kerry Beadling-Baron**	The role will include: The coordination of all new patient information requests supporting staff through the patient information development process Revising patient information to ensure the use of plain english before submitting for external review Managing the storage and publication of information, proactively managing review dates						C	Kerry Beadling-Baron is the lead for Patient Information
8E	To develop a Patient Information Advisory Panel (PIAP) in line with best practice	**Elaine Jeffers/Kim Kirk**	PIAP in place (opportunity to incvolve Governors an external stakeholders						C	Patient Forum has been developed
8F	To standardise the storage location of all Patient Information leaflets taking into account the opportunities provided by the implementation of the Trust Digital Strategy	**Elaine Jeffers/Kim Kirk**	To develop a single point of access for Patient Information for patients, carers and staff						C	SharePoint is utilised for a central storage location
8G	To consider and maximise the use of external sources of Patient information being mindful of Copyright regulations and Information Governance requirements	**Elaine Jeffers/Kim Kirk**							C	The Trust produces it's own patient information with EIDO production (Royal College of Surgeons).
8H	Develop comprehensive guidance for staff on how and when to share information in hard copy format, with a focus on ensuring quality and encouraging access via on-line methods to minimise costs	**Elaine Jeffers/Kim Kirk**							C	Direction and signposting to appropriate website is utilised