

# **Safety, Quality and Patient Experience 2015-2020**

**Acting with kindness and compassion  
Improving, adapting, innovating  
Working together**

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## Introduction

Our vision is to set the standard for great care by delivering the best experience and the safest, highest quality care for our patients. We believe that by understanding the needs, expectations and fears of the people using our services, and working together with them we can achieve this aim. To do this we must create a culture where kindness and compassion prevail and put in place systems and processes that deliver what our patients value. Developing such a culture is at the root of our Values and Behaviours Programme which will support this strategy.

True kindness and compassion emerges when people seek to know and understand those around them and then intervene to make a positive difference. In order to deliver kind and compassionate care staff themselves need to be treated with kindness and compassion and from this develops a culture of safety, continuous learning and innovation.

The aim of this strategy is to look at safety and quality through the eyes of those who use our services. To do this we pose a series of six key questions that are important to patients, their families and their carers. All Trust staff should reflect on these questions and answer them by being positive and proud about what we do well, being open and honest about the things we need to do better and by being clear about what we are doing to improve.

In the development of this strategy we have carefully considered the many reports and documents relating to safety, quality and patient experience that have been published in the last few years. In particular we have paid careful attention to the recommendations of Professor Don Berwick's report 'A promise to learn- a commitment to act'<sup>1</sup>. These recommendations built on those suggested by Sir Robert Francis in the Public Inquiry into Mid Staffordshire Foundation Trust<sup>2</sup>. The key themes running through these recommendations are that by engaging, empowering and hearing patients, and equipping staff with the knowledge and skills to drive improvement we can deliver the standards of care that we strive for.

This document sets the high standards we want to achieve and some aspects will be difficult to deliver. Where specific project work is required to deliver the aspirations of this strategy, they will be described in more detail using our annual Quality Accounts and following discussion with our patients staff and partners. The Quality Account will also be used to provide honest feedback on the progress of this strategy.

We recognise that healthcare is complex and sometimes risky and on occasion we will fall short of the standards we have set; when we do we will use this document to hold ourselves to account and guide us to recover and learn. We will be happy for you to question us when you feel that we are falling short of our aims and we will listen and return our focus to these core values as quickly as possible.

We believe that by implementing this strategy we will demonstrate that we comply with the Fundamental Standards of care laid down in the 2014 amendment to the 2008 Health and Social Care Act. We will also be able to demonstrate to the Care Quality Commission that our services are

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<sup>1</sup> National Advisory Group on the Safety of Patients in England. A promise to learn –a commitment to act: Improving the safety of patients in England. Crown Copyright. August 2013.

<sup>2</sup> Sir Robert Francis QC. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London. The Stationary Office. February 2013.

safe, caring, effective, responsive and well lead. Most importantly we will be able to demonstrate to our patients that we have listened and learned from them and treated them with the kindness and compassion that they deserve.

The following strategy sets out our philosophy for the delivery of safe high quality care but also practical steps we will take to deliver our aim. It also gives an overview of the people and structures in place to monitor safety and quality in the organisation. Above all it sets the standard for great care by encouraging a kind, compassionate culture backed up by systems and processes that will deliver what you value.

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*'Place the quality of patient care, especially patient safety, above all other aims.  
Engage, empower, and hear patients and carers at all times.  
Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.  
Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.'*

-Berwick 2013

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## Section 1: Six Key Questions



## How can I be sure...

..the care I receive will not harm me?

- **In order to minimise the risk of harm, the care you receive should:**
- be delivered by people that pre-empt error wherever possible.
- be delivered by people that are proactive about recognising error and risk.
- come from people that are capable of learning from mistakes made by themselves as well as other healthcare professionals

### How can I be sure that the care I receive will not harm me?

Although it is impossible to eliminate all risks from healthcare delivery it is our responsibility to ensure that these risks are reduced to the absolute minimum. As our population gets older and people live with many illnesses, there are increasing numbers of frail, vulnerable individuals who are at even greater risk of harm. This makes it essential that we focus on reducing these risks.

In BSUH we treat over 750,000 patients per year including over 110,000 in-patient admissions. Despite this volume of work, over 90% of inpatients receive harm free care<sup>3</sup>. However, over 7000 patient safety incidents<sup>4</sup> were reported in 2014 of which approximately 800 resulted in harm to a patient. Sadly, around 150 of these patients suffered significant harm including 15 who suffered severe harm or death as a result of a patient safety incident.

Harm from health care can take many forms, for example: infections (including MRSA or 'C. Diff'), falls, mistakes with drugs (such as wrong doses being prescribed or doses not being given), skin damage due to pressure ('bed sores'), missed or wrong diagnosis (including failing to appreciate that a patient is deteriorating and needs prompt treatment). It is unusual for harm to result from the failing of a single individual; it is almost always a complex interaction of communication failures and flawed systems and processes.

A number of programmes are in progress to develop a 'culture of safety' which creates an environment where staff feel able to pre-empt, share and learn from error....can you expand on what the main programmes are?

<sup>3</sup>. Harm free care' is described as a new mindset in patient safety improvement. The aim is to deliver harm free care as defined by the absence of pressure ulcers, falls, CA-UTI and VTEThe NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free'

<sup>4</sup> Source: CQC Intelligent Monitoring report July 2014

How can I be sure ...

..I will get the best possible care?

- **In order to provide you with the best possible care it should:**
- be delivered according to the best current evidence
- be measured against appropriate outcomes for you
- be delivered in accordance with relevant national targets with regard to waiting times
- be delivered by the most appropriate, best trained people in adequate numbers

### How can I be sure that I will get the best possible care?

*-the right treatment, at the right time, by the right people*

Healthcare is increasingly complex and medical knowledge advances almost daily. It is a challenge to ensure that the care we provide is the best it can be and in line with local, national and international guidance. For care to be at its best, it not only needs to be the right treatment for your condition but also needs to be delivered by the right people (ie: appropriate numbers of trained and skilled staff) at the right time (ie: that is convenient for you and will get the best outcome for your condition) and in the right healthcare setting.

To achieve the best possible care we must ensure that we recruit the best staff and give them high quality training to ensure that they maintain these high standards. We must ensure that we are reviewing and implementing new evidence and guidance. We should also give you the opportunity to help us find new evidence by taking part in high quality research.

Our services need to function efficiently to ensure waiting times for both urgent and scheduled care are kept to a minimum and that we are honest with you about any potential delays and the actions we are taking to address these. We need to ensure adequate numbers of staff are available to look after you when you need them. Where possible these should be permanent staff and we should keep the use of 'agency' or 'locum' staff to a minimum.

We have programmes under way to review staffing levels and to prominently display these on wards. We are actively recruiting staff and we have strategies in place to train, develop and appraise our staff to ensure we are the best we can be.

How can I be sure...



...I will be  
treated with  
kindness and  
compassion?

- **In order to ensure kindness and compassion the care I receive should:**
- be delivered by a group of individuals who share a common set of values and behaviours with kindness and compassion at their core.
- Actively seek out your needs, wishes and fears as well as those of your family and carers
- Be individual to you and make you feel valued

### **How can I be sure that I will be treated with kindness and compassion?**

Places where care is truly kind and compassionate are some of the safest and best places to receive treatment. This is because kindness and compassion is about much more than 'being nice' or 'being sympathetic'. It is about understanding the needs and wishes of the people we serve and being meticulous in attending to those needs and wishes as we go about our work. It is about doing the basics well eg: attending to cleanliness and ensuring people have enough to eat and drink. It is also about going the extra mile and using initiative to ensure that our patients get the right treatment, at the right time and have the best possible experience. It is about being vigilant to risks which might harm our patients and stepping up to intervene to prevent that harm occurring.

Unfortunately, several high profile reports have shown that the NHS does not always get it right for our patients, highlighting that these values are not always enacted and can impact negatively on a patient's experience. BSUH is committed to building a culture of compassionate care and feedback suggests that we are successful much of the time. However, we are inconsistent and in a number of incidents relating to vulnerable adults where we have seen care fall well below acceptable standards.

We have a number of programmes highlighting the central role of kindness and compassion in delivering safe, high quality healthcare including the Values and Behaviours programme which is central to creating an organisational culture focussed on kindness and compassion.?

How can I be sure...

...I will be involved in decisions that affect me?

- **In order to ensure that you are fully involved in your care it should:**
- place you at the centre of any decisions (“nothing about me, without me”)
- be delivered by staff who recognise and value you as an individual
- ensure that communication with you is clear, effective and timely

### How can I be sure that I will be involved in decisions that affect me?

It is vital that you and those close to you are involved in planning and delivering your healthcare. We will seek to understand what matters to you when attending hospital. Staff working in the hospital should involve you in decisions about your care and respond positively to requests for more information.

We must ensure that, wherever possible, you are given choices in what happens to you and are able to make those choices based on information provided in a way that you can understand. If you are unable to make decisions about your healthcare (for example if you are unconscious) we will ensure that we always act in your best interests. To do this we will seek the views of those who know you best in order to arrive at these decisions. We will also ensure that we comply with any advance decisions you have made and when there is no-one who can act on your behalf we will use the services of an Independent Mental Capacity Advocate (IMCA) to understand your best interests.

We will seek to improve the quality and timeliness of information that we provide about your appointments and ensure that you have a point of contact if you have questions about your appointments or visits to our hospitals. Our booking hub have already begun making improvements in this area and will continue this work.

How can I be sure..

...my feedback  
will be acted  
on?

- **In order to ensure that your feedback on your care is used effectively we will:**
- Actively seek your feedback on the care that we provide
- Strive to adjust your care in the light of the feedback received
- Act promptly to address concerns when you raise them
- be open and honest about the reasons if your care fell below the standard expected

### **How can I be sure that my feedback will be acted on?**

Without feedback we cannot improve, however feedback is only effective if it leads to action. We aspire to collect and review feedback from all our patients, who will be partners in delivering high quality care for all. We will put systems in place so that learning from patients can be shared and acted upon immediately and staff will be supported and empowered to incorporate patient feedback into all that they do. What are these systems? Can you reference any?

If your care fell below the standard you expected we will be open and honest about what happened and what we can do to improve. We aim to respond to your concerns promptly and to carry out thorough investigations into your concerns in order to take the right actions to improve our services.

We also encourage our staff to raise concerns when things are not right. We will ensure that staff feel supported to raise concerns and that these concerns are investigated and acted upon.

The BSUH Patient Safety Ombudsman provides an independent confidential service for patients and staff to raise concerns. We will strengthen the roles and responsibilities of the Patient Safety Ombudsman's office to ensure there is an alternative route for concerns to be raised.

We are improving our mechanisms for seeking feedback and using this information for improvement. We are using patient feedback to improve our incident investigation and complaints processes.

How can I be sure...

...I will be treated  
fairly?

- **In order to ensure you are treated fairly and do not suffer discrimination we will ensure:**
- The services we deliver and the way we deliver them reflect your requirements and those of your community
- Our staff are treated fairly
- Information is provided in a form that you can understand
- You are able to access and navigate our buildings and premises

### **How can I be sure that I will be treated fairly?**

We seek to eliminate all discrimination. To do this we need to ensure that the services we provide are meeting the requirements of communities in our locality. We have a successful policy for supporting patients' communication needs, which includes face to face and telephone interpretation services to ensure that we provide information clearly in form that you can understand. We must ensure that our premises are easy to access for all those who use our services and that it is clear how to get around our buildings. We must also ensure that our staff are treated fairly and have equal opportunities to achieve excellence. It is a fact that organisations with high levels of race equality for staff also tend to be organisations with high degrees of safety and quality for patients. Staff must be supported and treated fairly when involved in clinical incidents or complaints irrespective of their personal characteristics (ie: race, religion, gender reassignment, marriage or civil partnership, pregnancy, sex, sexual orientation or disability).

Underpinning this is of course our duties under Equality Legislation – we seek to demonstrate we have considered the needs of equality in all that we do. We will work through the revised Equality Delivery System for the NHS and seek to improve in all its domains.

## Section 2: How can I be sure...? Answering the key questions

How can I be sure  
the care I receive  
will not harm me?

### Because we will:

- 1) Develop the capacity and capability to improve safety and quality:** in high performing organisations structured quality improvement (QI) programmes exist which are delivered by frontline staff. We will develop a QI education programme and create a faculty of QI experts. The ultimate aim will be to ensure all staff in the organisation have, as a minimum, introductory training in QI methods and understand their role in continuous improvement. This will give us the capacity truly to learn from events by giving us the tools to deliver the necessary improvements. As part of this programme we will develop as a Chapter of the Institute for Health Improvement (IHI). This organisation has the world leading expertise in healthcare improvement. We have formed an affiliation with them and aim to use the educational resource this provides to generate expertise to drive improvement.
- 2) Embed our Values and Behaviours:** Our staff have developed a [behavioural blueprint](#) to underpin all interactions between staff, and between staff and patients. This blueprint is based on Effective Communication, Striving for Excellence, Kindness and Understanding, Fairness, Transparency and Working together. Our Values and Behaviours programme will create a resilient workforce who feel able to speak up about concerns, support each other to prevent error and use initiative to improve patients' experience. This programme will be delivered and monitored separately from this strategy but its success is integral to the delivery of safe, high quality care in BSUH. Read more about this programme and get updates [here](#).
- 3) Be responsive to staff concerns:** staff should be able to raise concerns without fear of reprisal and should expect those concerns to be acted upon. Staff can raise concerns through a number of routes including our independent Patient Safety Ombudsman. There are numerous examples of staff concerns that have been acted upon but sadly also examples of staff who feel they have suffered as a result of raising concerns. Some staff have also felt the need to raise concerns outside of BSUH (for example direct to the Care Quality Commission (CQC)) as they have not felt able to raise concerns through internal channels or felt that their concerns were not being listened to. We are developing procedures to ensure that staff and patients who raise concerns ('whistleblowers') have those concerns acted upon and do not suffer any negative consequences. These procedures are detailed in the [Raising Concerns Policy](#) and our People Strategy.

- 4) **Broaden access to debriefing training:** [After Action Review\(AAR\)](#) is a debriefing tool which allows a rapid objective review of an incident or event. When applied correctly it encourages staff to speak up about concerns and to develop solutions to prevent recurrence. It encourages personal responsibility but discourages blaming individuals. Similar debriefing tools have been shown to reduce adverse events in other high risk industries such as the fire service.
  
- 5) **Include patients and relatives in improving safety:** there are a number of actions that patients can take to keep themselves safe during a hospital stay. We have highlighted these in our patient information leaflet Patient Safety: our number one priority. We have also posted a video on our internet site to highlight these actions. We will ensure that all patients attending the hospital for inpatient visits are directed towards [the video](#) and given the patient safety booklet. We will ensure that the booklet is available in alternative formats and languages.
  
- 6) **Measure and display risks and harms:** we will develop a selection of measurements which will indicate the performance of each ward and each Clinical Directorate. This data will include numerical data such as infection rates but also feedback from patients and recommendations from incident investigations. This data will be publicly displayed on all wards updated on a regular (at least monthly) basis. The data will also be displayed in Safety and Quality folders in staff rooms allowing ward staff and patients attending wards to identify areas of potential risk and take action to mitigate those risks. Departments and Directorate management teams will be responsible for reviewing this information and taking action where there are areas of concern. We will monitor the provision of this data and its utilization through our monthly Quality Visits (an unannounced visit to ward areas by staff volunteers who assess quality of care according to a specified standard). The data and performance of individual Directorates will be reviewed at regular performance reviews. The monthly Executive Safety and Quality Committee will maintain an overview of the data from all Directorates.
  
- 7) **Focus on safety culture in operating theatres to ensure safer surgery:** we have already implemented recommendations about safer surgery and the use of pre-operative checklists to improve team working. However, despite this patients have suffered a number of events which should not have happened (so called 'Never Events'). These have included operations occurring on the wrong part of the body and swabs inadvertently left behind inside the patient at the end of surgery. Investigation of these incidents has not discovered individual failings but rather failures of communication and processes which allowed errors to build up resulting in harm. We are developing a programme to improve our theatre processes in the light of these errors which will address the issues around processes but also the culture and practice in the operating theatres. This programme has been developed in conjunction with an expert in 'Human Factors' (the study of how human psychology, the environment and organisational processes interact to cause errors).
  
- 8) **Develop our 'Towards a safer hospital projects':** the Towards a Safer Hospital project is an attempt to take the experience of frontline staff and patient feedback and use it to develop

improvement projects. The projects will bring together frontline staff experts in quality improvement and senior leaders to maximise the effectiveness of these projects. Examples of projects currently being developed under the Towards a Safer Hospital banner are:

- a. Towards a safer transfer: when patients move between areas of the hospital we have identified that this is a time when errors occur. This project aims to reduce this risk
- b. Towards a safer ward: a project to look at how effective ward rounds can improve safety

**9) Focus on known risks:** there are a number of well-known risks faced by patients being treated in hospital. We already have projects in place to improve our performance in these areas, which will be supported and developed during the course of this strategy. These projects include:

- a. Reducing in-patient falls: we have a very successful project which has made huge reductions in patients falling whilst in hospital. We want to see further reductions and to reduce the number of falls resulting in serious harm. The successful methodology used in this project needs to be shared with other improvement projects in the Trust.
- b. Reducing skin damage due to pressure: we will apply the lessons learnt from the falls project to achieve continued reductions in hospital acquired pressure damage
- c. Reducing hospital acquired infection: we have a robust infection control process which monitors hospital acquired infection and uses root cause analysis to feed back to staff when infections occur.
- d. Improving recognition and management of acute kidney injury: kidney damage can occur due to some medicines or dehydration. Early recognition prevents the damage becoming permanent.
- e. Improving recognition and treatment of severe sepsis
- f. Improving recognition of the deteriorating patient

**10) Develop a learning and reporting culture:** a key factor in such a culture will be to ensure that staff reporting concerns or incidents receive prompt feedback on the progress of investigations and actions taken. The Values and Behaviours Programme will be a significant part of delivering this ambition. In order to ensure adequate feedback we will:

- a. increase the Trust level incident investigation capacity to ensure investigations are carried out promptly and adequate support is available to Directorates and Departments ensuring high quality prompt investigations and feedback.
- b. develop our incident reporting database ('Datix') to allow automated emails to update reporters of the progress of their incidents.
- c. monitor incident investigation in terms of speed of response and adequacy of investigation at a Clinical Directorate level to highlight areas where added focus is required.
- d. build on our strong, clinically led serious incident review process to ensure patients and staff receive feedback on the progress of incident investigation

- e. develop a communications strategy to ensure that lessons learned from significant incidents and 'near misses' are shared with as many staff as possible. Current methods include a monthly Patient's 1st Newsletter, podcasts of all Serious Incident investigations accessed via the front page of the Trust's intranet, and anonymised reports of all our Serious Incident investigations being available on the Trust intranet. We will explore other media in order to increase exposure.
- f. rapidly notify all those affected by incidents (patients, relatives and staff) resulting in significant harm and providing them with a high quality investigation report and access to appropriate support (thus, fulfilling our statutory duty of candour).
- g. increase our capacity to train staff in incident investigation and include specific sessions on our Duty of Candour with patients who have been harmed by an incident.
- h. Refresh the terms of reference of the Executive Safety and Quality Committee in order to protect its main function of triangulating information coming from all sources eg: complaints, legal claims, patient safety incidents and notifications from the coroner (regulation 28) in order to prioritize actions and spread learning.

11) **Actively engage with our regional Patient Safety Collaborative:** the Kent, Surrey and Sussex Patient Safety Collaborative has recently been created and we will work closely with them in order to share learning and provide support for their initiatives. The Executive Safety and Quality Committee will receive updates from the Patient Safety Collaborative and take appropriate action.

12) **Develop a human factors and simulation faculty:** 'human factors' is the study of the interaction between human psychology, the physical environment and the processes and procedures that humans work in. Focusing on these 'human factors' and using them to improve systems and communication has brought dramatic improvements in safety in other industries (eg: commercial airlines and the nuclear industry). These industries also routinely use simulated events to practice in a safe environment. Health care can use similar techniques to improve safety and we are developing a faculty of experts in the field from both within and outside health care to deliver regular training in 'human factors' for all clinical staff and use real incidents as the basis of training scenarios.

How can I be sure I will receive the best possible care?

## Because we will:

- 1) Ensure full implementation of NICE guidance:** NICE guidance sets the standards for high quality healthcare and encourages healthy living. The National Institute for Health and Clinical Excellence (NICE) is an independent organisation that provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. NICE is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. We will continue to facilitate, identify, disseminate, implement and review all published NICE guidelines relevant to our patients and our organisation. NICE Guidance and NICE Quality Standards are used to form the foundations for standardising treatment pathways and improving consistency of care now and in the future and we will remain committed on their delivery.
- 2) Ensure full participation in the NCEPOD programme and implementation of the recommendations** (National Confidential Enquiry into Patient Outcome and Death): this organisation requests participation from healthcare organisations across the country to gather evidence and data to drive change and produce recommendations for improvement in quality of care on specific topics. We will continue to participate, review and disseminate this information and improve our ability to ensure compliance with these recommendations is monitored through audit.
- 3) Continue to develop our work on frailty and dementia:** in particular to create pathways that span across all healthcare settings to improve patient centred care, reduce hospital admission when there are better alternatives and allow patients to recover at home once they are medically ready.
- 4) Further improve our 'Innovation Forum':** this forum allows any member of staff to seek support for their ideas for improving healthcare in BSUH. Where necessary small sums of money are allocated to selected projects in addition to providing senior expert support to get the projects started.
- 5) Use Commissioning for Quality and Innovation (CQUIN) to drive important improvement initiatives:** the CQUIN scheme attaches a financial incentive to the achievement of certain goals based on quality improvement initiatives. We will continue to deliver the national and specialist programme and work in conjunction with our local commissioners to set out local CQUINS. The development of the local CQUINS

will support the improvements important to our patient population and support services that require development.

- 6) Ensure each department develops indicators of performance in conjunction with the people who use their service:** these performance indicators should be used to drive improvement initiatives and be subject to regular, robust audit.
  
- 7) Ensure that when any patient dies in BSUH their care is reviewed** to identify any way in which their care could have been better. We will do this by expanding our medical examiner system and using an objective 'screening tool' to identify patients whose deaths require closer scrutiny by the departments involved in their care. A database has been created where all these reviews can be stored to ensure the learning can be captured and disseminated.
  
- 8) Continuing to review mortality rates at a Trust level and by speciality:** monitoring how many patients die in our organisation is a fundamental outcome measure. Any significant variation in mortality rates will trigger a detailed review to understand the cause of fluctuations.
  
- 9) Continue to monitor patient reported outcome measures (PROMS) for selected specialities** and use this data to inform areas for improvement.
  
- 10) Completing the actions we have set out in the CQC action plan relating to patient flow and bed capacity:** Ensuring that we see and treat people presenting to BSUH with minimum delay is central to raising the quality of care. This is equally important whether they require emergency (unscheduled) or routine (elective) care. Also, we must ensure that people do not stay in hospital longer than necessary as this exposes them to increased risks; particularly for those who are frail or elderly.  

The solutions are complex and are contained in the action plan created following our CQC inspection August 2014 which highlighted our challenges relating to waiting times for both emergency and routine care. Unlocking these issues and providing efficient pathways through the health (both hospital and community) and social care systems is urgent and important. This requires BSUH to work closely with other organisations to deliver the necessary change. The benefit will be that patients will be able to access emergency speciality beds when needed, routine treatment will not be cancelled due to lack of capacity and patients will stay no longer in hospital than absolutely necessary.
  
- 11) Ensuring nurse and medical staffing (nurse/doctor to patient ratio) is at or above nationally accepted levels in all departments and wards.** We will nationally report and publically display our nurse staffing levels and keep the use of agency and locum staff to an absolute minimum. We will ensure that the medical workforce meets the standards set by Royal Colleges. We will ensure that staffing levels of other healthcare professionals and support staff are sufficient to deliver a safe and high quality service.

**12) Develop a values based recruitment process** to ensure new employees not only have the necessary technical skills but also the values and behaviours required by the organisation. This will be central to the Trust's People Strategy.

**13) Ensure that all staff have access to education and professional development** appropriate to their role. The Safety and Quality team have provided input to the Trust's Education and Knowledge policy and the Deputy Medical Director for Safety and Quality continues to sit on the Education and Knowledge Board to oversee its implementation. We will also continue to ensure that all staff have an annual appraisal that focusses on how to develop and improve the quality of our services. We will ensure that where locum or agency staff are employed that they are given key information about Trust policies and procedures to allow them to operate safely.

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How can I be sure  
that I will be treated  
with kindness and  
compassion?

## Because we will:

- 1) **Implement the Values and behaviours programme** which has kindness and understanding as a key theme.
- 2) **Continue to re-enforce and embed NHS England's Compassion in Practice programme** for nurses. This vision is based around six core values, 'the 6 Cs': Care, Compassion, Competence, Communication, Courage and Commitment. We aim to embed these values, into all nursing and care-giving settings within our Trust in order to improve care for our patients.
- 3) **Participate in the 'Cultivating Compassion' Project** which has been commissioned by Health Education Kent Surrey Sussex (HEKSS), in response to a Government commitment to respond to the findings of the Francis report. "Staff wellbeing is the foundation on which compassionate care must be built ...Staff must be supported at all times to maintain a culture that is inclusive, patient focused and compassionate...." (Francis 2013). The aim of "cultivating compassion" is to support the workforce in expressing compassion in their daily working lives and to promote a culture of compassion. We have helped develop a Cultivating Compassion Awareness Toolkit that enhances compassion in practice. This toolkit facilitates activities which encourage responses in everyday care situations that make patients, families and colleagues feel cared for and respected. We are also looking for ways to encourage and support the expression of compassion for each other as it is widely acknowledged that if staff display compassion for each other they will also be compassionate to those they care for.
- 4) **Build on our experience of 'Staff Stories' as an outlet for staff to share their challenges** and successes in delivering compassionate care. Staff Stories is a monthly forum where a team of healthcare workers are invited to share a story about an aspect of a patient's care which they found challenging, uplifting or inspiring. Our Staff Stories programme is based on the experience of the Schwartz Centre for Compassionate Healthcare in the US. Schwartz Center Rounds are a place where people who don't usually talk about the heart of the work are willing to share their vulnerability and to question themselves. The program provides an opportunity for dialogue that doesn't happen anywhere else in the hospital. We are now members of the Schwartz Community and will look to expand the attendance and engagement of staff with our Staff Stories (Schwartz Rounds) programme.

5) **Measure and observe kindness and compassion through our patient voice feedback questionnaire and Quality Visits.** We will continue to ask the question “do you feel staff treated you with kindness and compassion”? The results of which will be displayed and feedback to staff using the “you said we did” displayed on each ward’s Safety and Quality Boards. Staff receive individual reports on their ward’s performance including complaints , plaudits, Patient Advice and Liaison Service (PALS) contacts and the narrative of each Patient Voice comment. We will also undertake regular Quality Visits where we observe aspects of care and interactions between staff and patients and have developed an observation tool called “Sit and See”, where experienced staff sit and observe what goes on in ward areas. In particular they observe how patients are treated and how staff respond to patients’ concerns.

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**How can I be sure I will be involved in decisions that affect me?**

**Because we will:**

- 1) Provide time for you to talk to doctors, nurses and any other professional who may be involved in your care.**
- 2) Ensure that we tell you about the benefits and risks of procedures, tests and investigations when we offer them.** We will provide you with this information, in language that you can understand, to help you make decisions about your care and treatment. We will offer appropriate communication support to ensure that language or communication barriers do not hinder your ability to be involved in decisions about your health.
- 3) Seek views from people who know you best if you find yourself in a position where you are unable to make decisions for yourself.** If you have made your wishes known in the form of an Advance Directive or assigned responsibility for these decisions to another person ('Lasting Power of Attorney') we will abide by these wishes. This will help a clinical decision maker come to a decision about your care and treatment. If we are unable to find anyone who is able to advise us on your behalf we will involve an Independent Mental Capacity Advisor in order to help us identify your best interests.
- 4) Have information readily available about the communication support we provide,** including our Learning Disability Liaison Nurses and Dementia Team – this is enabling our patients, as far as possible, to be involved with making decisions about their care.
- 5) Look for new and innovative ways of involving you in improving our services** through ongoing and increased engagement with Service User Groups and our Patient Experience Panel.
- 6) Explore new media and communication tools for more effective communication** for those who are able to use them and to make more effective use of traditional platforms for those who find these easier.
- 7) Improve our 'Booking Hub' processes** to ensure it is responsive to the needs of people needing to book appointments and also staff trying schedule visits for patients. These processes must also be responsive the needs of people with differing communication needs.
- 8) Improve our discharge process to ensure safe transfer of care and information back to community** by working with Primary Care practitioners and looking for new IT solutions.

How can I be sure  
that my feedback will  
be acted on?

### Because we will:

- 1) **Expand our Patient Advice and Liaison Service (PALS) to provide a straightforward single point of contact if you have concerns or queries.** This team will ensure that you are quickly put in contact with people who can answer your concerns and make any changes necessary. Most issues can be dealt with by this process but the team will also guide you through the more formal complaints procedure if necessary.
- 2) **Improve the way we actively seek feedback from you to make this more convenient and effective.** We already receive feedback from a variety of sources including the Patient Voice Survey, Friends and Family Test and the National Patient Survey's. However, we will review the available methods for seeking feedback and explore the use of newer media (SMS or text messaging for example). As part of this review we also need to ensure that appropriate mechanisms are available and advertised to people who do not speak English or have other communication difficulties.
- 3) **Strive to be more responsive to the feedback we receive.** Feedback from Patient Voice Survey is reported monthly to all Directorates and Specialties. We will increase communication to patients regarding Service improvements arising from such feedback via 'you said – we did' notice boards on all wards.
- 4) **Actively seek patients' views and experiences through our Patient Experience Panel** and speciality patient forums in areas such as HIV, renal, ITU, cancer, midwifery and children's services. The Trust Board meetings are open to the public and share patient stories at each meeting to better understand the patient experience provided by the organisation.
- 5) **Enable a wider cross section of communities to access our PALS, complaints and patient feedback services.** We will do this by holding monthly outreach sessions in Brighton/Haywards Heath where BSL Interpreters and other interpreting services will be used to enable patients/service users to highlight their concerns. This needs to be sometimes outside of traditional working hours to highlight we are serious about wanting feedback – then we must through varying media and drop in sessions highlight what has been moved forward as a result of the complaints/concerns we are hearing. Also, utilising the many diverse community groups to engage with the wider population.
- 6) **Actively seek feedback on handling of complaints and serious incident investigations** and use this information to drive improvement in the investigation process. In particular to

understand whether you found the process supportive, compassionate and whether you felt all your questions were answered openly and honestly.

**7) Provide a rapid route for significant concerns raised with the Patient Safety Ombudsman to be escalated to Board level** through the Patient Safety Ombudsman's Advisory Panel.

This panel, chaired by a Non-executive Director, allows serious concerns to rapidly reach the top of the organisation. We will also seek ways to ensure that all patient groups are aware of the PSO's role and are able to access their services.

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How can I be sure  
that I will be treated  
fairly?

### Because we will:

- 1) **Ensure our patient experience panel reflects and represents all groups and communities in our locality** and ensuring that issues raised by these groups are brought to the attention of those who plan and deliver services in the organisation. Where groups cannot be represented at the panel we will endeavour to find other ways to engage to ensure the views of these people are heard.
- 2) **Ensure that our current communication and interpretation services continue to improve** and staff are aware when and how to access them (click [here](#) for more information).
- 3) **Continue to improve the accessibility of patient information** by ensuring this is available in the most appropriate format.
- 4) **Ensure that access to our premises is as easy as possible for all those who use our services** irrespective of any mobility issues or sensory loss they may have. Also ensuring that signage and wayfinding in our buildings is improved for the benefit of all those who use our facilities.
- 5) **Eliminate discrimination on any grounds against staff or patients.** A particular focus within safety and quality will be to ensure staff involved in clinical incidents or complaints are treated fairly and do not suffer detriments as a result of race, gender, sexual orientation, disability or other characteristic. Delivery of our Race Equality Workforce Engagement Strategy will ensure fair treatment for staff from Black, Minority and Ethnic communities. Application of the revised NHS Equality Delivery System (EDS2) and our People Strategy will ensure fair treatment of all staff irrespective of their protected characteristics. These strategies are monitored separately from Safety and Quality but ensuring equality for staff is a key determinant of the safety and quality of the organisation.

## Section 3: People and Teams

This section summarises in brief the roles and responsibilities of those individuals and teams who are central to the delivery of this strategy.

### **Chief Executive Officer (CEO)**

The CEO is responsible for leading the Trust and implementing its strategy. This Safety, Quality and Patient Experience Strategy is a key component of the Trust's overall strategy. The CEO is line manager for the Medical Director and Chief Nurse who between them hold Executive responsibility for safety, quality and patient experience. The CEO chairs the Clinical Management Board.

### **Medical Director (MD)**

The MD is the most senior doctor in the Trust. The MD is responsible for professional standards amongst doctors, clinical effectiveness, clinical outcomes, policies and standards, education and knowledge, research and development, and maintenance of patient confidentiality (Caldicott Guardian). Specific responsibilities for development and delivery of safety and quality strategy are delegated to the Deputy Medical Director: Safety and Quality. The MD chairs the Executive Safety and Quality committee

### **Deputy Medical Director: Safety and Quality (DMD)**

The Deputy Medical Director for Safety and Quality is a doctor who is responsible for assurance and governance of Trust-wide safety and quality. The DMD is responsible for developing and delivering the Trust's Safety, Quality and Patient Experience Strategy alongside the Deputy Chief Nurse for Patient Experience. The DMD is also responsible for the system of safety and quality governance up to and including Executive Safety and Quality committee, ensuring this meets expectations of bodies including the Care Quality Commission. The DMD leads the Safety and Quality team, which includes other senior clinicians (Associate Medical Directors), to support specialties in learning from error and raising standards through continuous quality improvement.

### **Chief Nurse (CN)**

The CN is responsible for professional standards amongst nurses and Allied Health Professions (eg: Physiotherapists etc), Nurse resourcing and skill mix. The CN is also responsible for infection prevention and control, quality assurance and governance, regulation and patient experience. Specific responsibilities relating to patient experience including patient feedback/involvement and complaints are delegated to the Deputy Chief Nurse: Patient Experience.

### **Deputy Chief Nurse: Patient Experience (DCN)**

The DCN is responsible for improving patient experience. The DCN receives feedback from patients at the Patient Experience Panel and monitors information from complaints, patient feedback forms (eg: 'Patient's Voice' Questionnaire and 'Friends and Family Test') and safeguarding investigations. The DCN is also responsible for overseeing actions arising from Care Quality Commission Inspections and reports.

### **Patient Safety Ombudsman (PSO)**

The PSO provides an independent, confidential service to listen to staff and patient concerns, in addition to the Trust's other processes for eliciting staff and patient concerns. The PSO is responsible for raising these concerns at the Patient Safety Ombudsman's Advisory panel and at the

Executive Safety and Quality Committee. The PSO is responsible for ensuring that concerns are handed over to the appropriate department/individual or agency for investigation and action. The PSO is responsible for feeding back the progress of investigations to those raising concerns where those raising concern wish to remain anonymous. The PSO also has a responsibility to alert the PSO advisory panel when staff raising concerns ('whistle-blowers') appear to be suffering discrimination or detriment as a result of raising those concerns.

### **Safety, Quality & Patient Experience Teams**

These are a group of senior professionals, clinicians and staff who support the Trust's central functions of improving quality and reducing harm. Roles include investigation and reporting of Serious Incidents, investigation of complaints and safeguarding concerns, and co-ordinating patient feedback. The team provide training in After Action Review, Root Cause Analysis and quality improvement techniques. The team also provide data to on safety and quality performance to provide assurance and also identify areas where improvement is required. They provide co-ordination for CQUIN projects, national audit programmes and mortality review. (See Appendix 1 for more detail)

### **Directorate Management Teams**

These teams of senior leaders, consist of a Clinical Director (Doctor), Lead Nurse and Directorate Manager. They are responsible for supporting and challenging their Specialities/Departments to implement this strategy. They are responsible for raising concerns to the Safety and Quality Team and or Executive Team when they identify issues which cannot be solved at a Directorate level or which have wider ramifications.

### **Specialities/Departments**

These teams of front line staff are responsible for participating in the implementation of this strategy. They are responsible for identifying areas of concern and making efforts to improve. Where they are unable to solve problems these concerns should be raised with Directorate Management Teams and the Safety and Quality Team. Each Speciality or Department are responsible for monitoring their performance and sharing lessons learnt from incidents, patient feedback and improvement efforts with all relevant staff.

## Section 4: Committees and Assurance

This section describes in brief the committees of the Trust that oversee the implementation of this strategy and provide assurance/monitoring of safety, quality and patient experience. See Appendix 2 for a diagram of how information flows between committees.

### **Board of Directors**

The Board of Directors have overall responsibility for the safety and quality of services in the Trust. They receive assurance from the Quality and Risk Committee.

### **Quality and Risk Committee (QRC)**

This subcommittee of the Board of Directors is chaired by a Non-Executive Director. The Quality and Risk Committee assures the ongoing development and delivery of this Strategy and the safety and quality of services within the Hospital on behalf of the Board.

### **Executive Safety and Quality Committee**

This committee is chaired by the MD and monitors information across the Trust relating to Safety, Quality and Patient Experience. It receives reports from each Directorate, the Serious Incident Review Meeting, Patient Safety Ombudsman, Trust Mortality Review Group and Serious Complaints and Safeguarding Meeting. Issues requiring action are fed back to the Directorates or to the Clinical/Nursing Management Board as appropriate. This meeting also oversees the actions arising from Serious Incidents as part of the reports received from Directorates. It also scrutinises actions arising from external reviews and regulatory reports (eg: Care Quality Commission Inspections).

### **Clinical Management Board**

This meeting is chaired by the CEO and attended by Clinical and Executive Directors. The Clinical Management Board is responsible for the delivery of operational, income and budgetary performance, co-ordination between clinical services, and changes to operational and clinical practice. Items of concern raised in safety, quality and patient experience meetings are fed back and discussed at this meeting.

### **Nursing Management Board**

This meeting is chaired by the CN and is the major operational nursing meeting of Trust. Items of concern raised in safety, quality and patient experience meetings relating to nursing are fed back at this meeting.

### **Patient Safety Ombudsman's Advisory Panel**

This meeting is chaired by a Non-Executive Director and attended by the Associate Director of Transformation, Deputy Medical Director, Director of Human Resources, Director of Corporate Affairs and Patient Safety Ombudsman. The meeting hears concerns raised with the PSO by staff and patients. The actions taken to investigate and mitigate these concerns are scrutinised and challenged. Senior managers and Non-Executive Directors present are responsible for taking actions to the appropriate forum to ensure the concerns raised with the PSO are addressed.

### **Trust Mortality (& Medico-legal) Review Meeting**

This meeting is attended and chaired by the DMD and other clinicians including a Medical Examiner. It scrutinises mortality rates at Trust and departmental level. It reviews any cases of concern raised by Medical Examiners, Coroner, staff or relatives. Items of concern are raised at the Executive Safety

and Quality Committee. Any required actions are communicated with the Speciality, Department or Directorate concerned. As of July 2015 the meeting will also scrutinise any cases where serious issues arise as a result of medico-legal claims or Coroner's Regulation 28 letters (Notification to Prevent Future Deaths).

#### **Serious Incident Review Meeting**

This meeting is chaired by the DMD and attended by senior clinicians (Associate Medical Directors for Safety and Quality) and expert incident investigators. All incidents graded as causing 'moderate' harm or above are reviewed at this meeting to ensure the grading of harm is accurate and that the actions being taken are appropriate. Reports relating to all serious incidents are reviewed by this group before being finalised and all reports sent to patients under our 'Duty of Candour' are also reviewed by this group.

#### **Serious Complaints and Safeguarding Meeting**

This meeting is chaired by the DCN and attended by the DMD, CN, the Head of Patient Experience and Complaints and the Trust Lead for Safeguarding Vulnerable Adults. All new serious complaints and safeguarding concerns are reviewed to ensure there is senior clinical and executive oversight of these serious issues. The progress of on-going serious complaints and safeguarding investigations is scrutinised in this meeting. Where appropriate a senior member of this team will take responsibility for a specific case in order to provide senior managerial liaison with the patient or family affected.

## Section 5: Appendices

### Appendix 1: Detailed Roles and Responsibilities

Area	Expectations
Corporate (Safety, Quality and Patient Experience Team)	<b>Role:</b> Expertise, Support and Advice <b>Accountable for:</b> Disseminating, Monitoring and Reporting
Directorate Management Teams	<b>Role:</b> Scrutinising and Challenge <b>Accountable for:</b> Assurance of speciality compliance
Speciality Teams	<b>Role:</b> Participate and implement <b>Accountable for:</b> Engaging, delivery and raising concerns

Area	Corporate	Directorate	Speciality	
Governance	Divisional Quality and Safety Reports	Develop and disseminate reports to monitor performance at speciality level. Advise on how to use reports	Scrutinising and Challenge	Review at Safety and Quality meeting. Share the reports. Ensure findings are acted and concerns are picked up in Audit / Quality plans
Governance	M&M's	Oversight of HSMR and SHMI across the Trust Identifying and disseminating concerns in relation to high mortality rates Development of framework for undertaking Mortality Reviews Monitoring and reporting	Assurance that specialties are regularly meeting and have a function mortality review programme	Coordinate regular minuted mortality reviews. Review mortality data, Identify and share any learning. Monitor any required actions

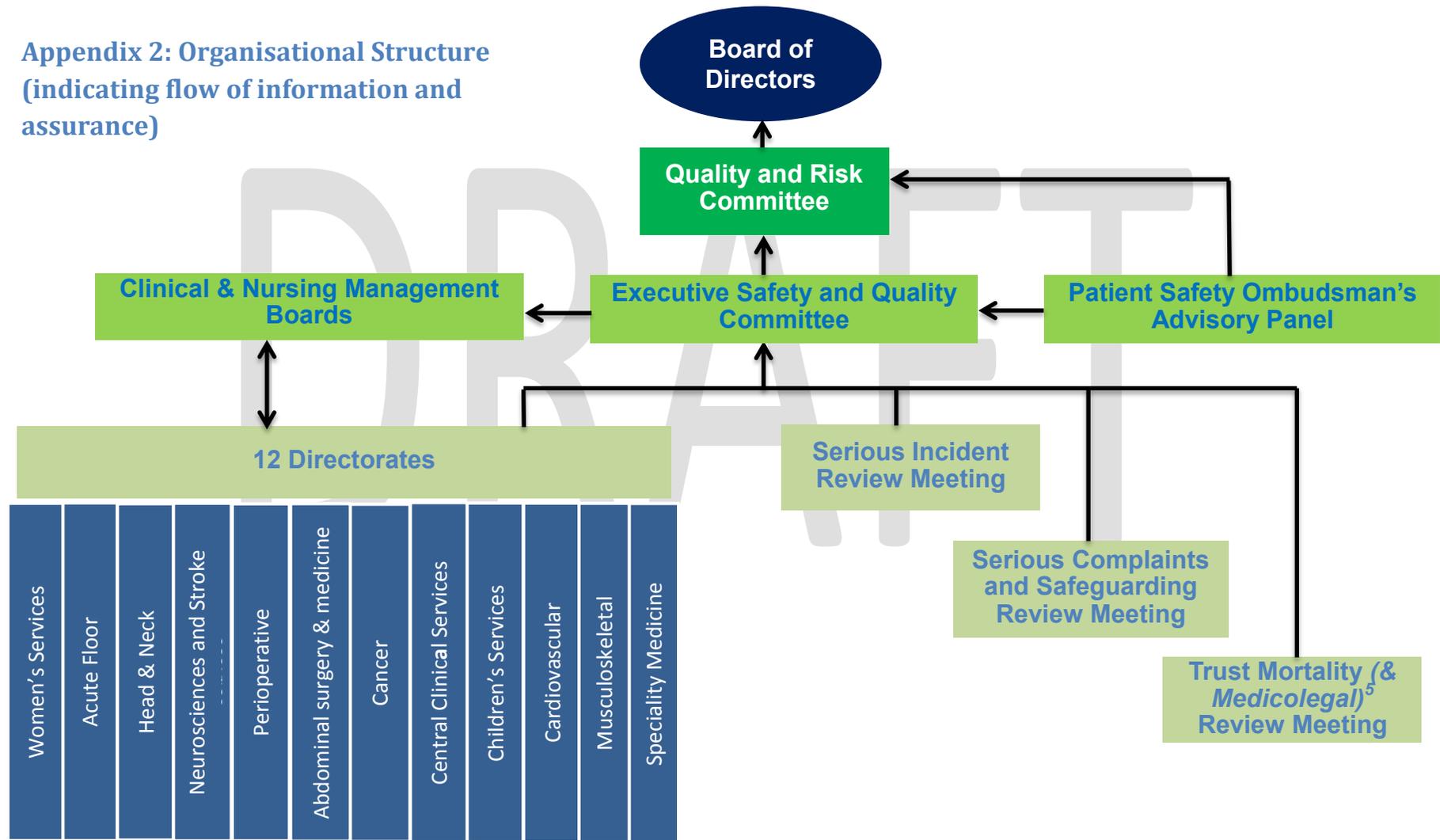
Area		Corporate	Directorate	Speciality
Governance	Quality Account / Corporate Initiatives i.e. falls, pressure damage	Engage Specialties in identifying corporate safety and quality priorities. Ensure stakeholder engagement	Engage with specialities in identifying potential priorities	Identify new initiatives and monitor progress with on-going initiatives
Governance	Speciality Safety and Quality Committees	Development of model framework and ToR for meetings. Distribution of information to support the meeting	Assurance that specialities are regularly meeting	Coordinate regular minuted meetings. Review information provided corporately and maintain and update speciality action plans
Investigations	AAR Training	Train and Advise Report on attendance	Ensure appropriate speciality attendance	Attend and use AAR Tool
Investigations	Lessons Learnt	Monitor incident reporting and investigation rates. To highlight Trust wide lessons	Ensure specialities have appropriate processes for investigating incidents and sharing lessons	Investigate incidents and feedback lessons to the reporter and to all relevant staff
Investigations	Duty of candour	Develop framework, align with policies, disseminate requirements and monitor compliance Advice and support Monitor and report	Oversee and coordinate compliance at speciality level	Comply with Duty of Candour flowchart
Investigations	RCA Training	Train and Advise Report on attendance	Ensure appropriate speciality attendance	Ensure investigation leads attend training and use frameworks
Investigations	Serious Incident Investigation	Lead on SI investigations where the incident has resulted in permanent harm or death.	Oversee and coordinate compliance with actions required by speciality	Implement actions arising out of investigation's and share the learning
Patient Experience	Complaints	Coordinate central response to all complaints	Scrutinising and Challenge	Actively engage with process. Ensure concerns are translated in to actions that can be evidenced

Area		Corporate	Directorate	Speciality
Patient Experience	Patient Voice	Developing and supporting patient experience programme. Identifying corporate themes. Disseminating	Scrutinising and Challenge	Review and actioning of feedback. Monitoring of whether feedback is improving
Quality Improvement	Audit / Quality Plans	Devise framework, advise, review, monitor and report. Advice and support	Review action plans to ensure aligns with corporate and directorate priorities	Identify audits, develop plan and programme
Quality Improvement	CQUINs	Negotiate programme, disseminate requirements. Monitor and support	Maintain oversight of speciality performance	Deliver CQUINs
Quality Improvement	Enhancing Quality	Advice and technical support Monitor and support	Support specialties in delivering programme	Active participation
Quality Improvement	Local Audits	Advice and technical support Monitoring and reporting on audit plan and activity	Scrutiny of speciality audit programme and plan	Ensure that local audits are aligned to known safety concerns, serious incident action plans, complaints, NICE guidance, national guidelines or corporate priorities. Share audit results and monitor and implement actions
Quality Improvement	National Audits	Dissemination of requirements, monitoring of participation and practical support	Scrutiny and chasing specialities if they don't engage	Participation, review of reports and development and monitoring of actions arising out of the reports
Quality Improvement	NCEPOD	Dissemination of requirements, monitoring of participation and practical support	Scrutiny and chasing specialities if they don't engage	Participation, review of reports and development and monitoring of actions arising out of the reports
Quality Improvement	NICE	Distribution of guidance, monitoring and reporting on compliance. Advice and support in evidencing compliance	Scrutiny and chasing specialities if they don't engage	Review and implement relevant guidance Monitor compliance through Local / Quality Audit Plans

Area		Corporate	Directorate	Speciality
Quality Improvement	Nursing Metrics	Development of initiative Advice and technical support Scrutiny, reporting and monitoring	Scrutinising and Challenge	Participation in capturing data. Review and actioning of reports. Development and monitoring of actions arising out of the reports
Quality Improvement	PROMS	Advice and technical support Scrutiny, reporting and monitoring	Scrutinising and Challenge	Active participation Review and actioning of reports. Development and monitoring of actions arising out of the reports
Quality Improvement	Quality Visits	To coordinate monthly visits and collate and share themes of good practice and areas for improvement.	To participate in the quality visits monthly and share any lessons with the directorate teams	To participate in the quality visits and share any lessons learned and best practice with multidisciplinary team
Quality Improvement	Safety Thermometer	Coordinate monthly survey, submit nationally	Scrutinising and Challenge	Participation in capturing data. Review and actioning of reports. Development and monitoring of actions arising out of the reports

Area		Corporate	Directorate	Speciality
Regulatory Requirements	Fundamental Standards of Care which will replace the CQC Essential Standards of Quality and Safety	Information and advice about the Fundamental Standards of Care (FSC)	Deliver the FSC and be able to demonstrate the evidence to support their delivery	Ensure that the FSC are met and be able to demonstrate the evidence to support their delivery
Regulatory Requirements	Fundamental Standards of Care Intelligent monitoring information	Provide information and advice on the quarterly CQC IM reports	Proactively monitor the outcomes and escalate any areas where there are concerns	Proactively review outcomes from the IM reports, escalate concerns with a plan to address them
Regulatory Requirements	Controlled drugs	Provide advice on any concerns relating to controlled drugs and ensure robust systems in place for the safe management of CDs	To inform the accountable officer for CDs of any concerns related to CDs	To investigated and share with the accountable officer for CDs any concerns related to CDs
Regulatory Requirements	Working with health overview and scrutiny committees	Advice on consulting with HOSCs about any major service changes. Liaise with the local HOSCs and Health and Wellbeing Boards	Ensure that major service changes are consulted on with the HOSC	Ensure that major service changes are consulted on with the local HOSCs
Safeguarding	Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Best Interest Decisions	Advice on Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Best Interest Decisions Training	To report to the team any DOLs applications	To report to the team any DOLs applications
Safeguarding	Safeguarding Adults	Advice on Safeguarding Adults Training	To complete safeguarding forms on the intranet or discuss with safeguarding team any concerns	To complete safeguarding forms on the intranet or discuss with safeguarding team any concerns
Safeguarding	Patients with a Learning Disability	Support for patients with a Learning Disability. Training	To inform the LDT of patients coming into the hospital	To inform the LDT of patients coming into the hospital

**Appendix 2: Organisational Structure  
(indicating flow of information and assurance)**



<sup>5</sup> This meeting will be reconvened in July 2015 to include a review of serious medico-legal issues

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