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Executive Summary

It is our responsibility to ensure every patient at Cambridge University Hospitals NHS Foundation Trust receives the safest, highest quality care personalised to their needs. This will ensure that our patients have the best clinical outcomes, delivered with compassion in a safe environment, resulting in the best possible experience.

This strategy outlines the approach everyone in our hospital will take to improve quality between now and 2018. It builds on our strengths and complements our governance and safety infrastructure, but also addresses those areas where we know we need to improve. It outlines what success will look like in 2018 together with the framework for delivery and measurement and outlines our priorities. We thank everyone who contributed to the development of this strategy.

Whilst it is important that we maintain flexibility in determining our priorities and focus over the next five years, our key priorities can be summarised as:

- improving the experience of our patients – person-centred care
- improving staff experience – staff as partners
- improving safety and eliminating avoidable harm – harm-free care
- improving the reliability of care – delay-free care
- providing clinically effective care

Each priority will have a work programme which sets out its structure, processes and outcomes. An illustrative work programme for harm-free care is set out in appendix 1.

Our emphasis will be on improving our structures and systems so that they support safe practice and enable improvements in individual and team effectiveness, leading to the best outcomes. Removing inefficiency from our processes, particularly with the implementation of eHospital will improve quality for our patients and staff. Key changes to the organisational structure will drive changes in behaviour and function, complemented by a portfolio of programmes to address specific clinical risks and challenges.

Quality is only achieved if all five of the above domains are present equally and simultaneously, delivering just one or two in isolation will not be enough. High quality care must also be accessible, equitable and sustainable. In the context of rising demand, increasing expectations and limited resources, this perhaps will be our biggest challenge in the coming years.
Introduction

Each day almost 3,000 patients come through the doors of Cambridge University Hospitals NHS Foundation Trust (CUH), placing their trust in us to care for and treat them as best we possibly can. Their needs are at the heart of everything we do, and it is the responsibility of every single person at CUH to ensure that every patient receives the safest, highest quality care personalised to their needs. This will ensure that our patients have the best clinical outcomes, delivered with compassion in a safe environment, resulting in the best possible experience.

Quality defines our overarching vision: to be the best academic healthcare organisations in the world. CUH is not only the local hospital for our community, but also a national centre for specialist treatment, a comprehensive biomedical research centre, a major teaching hospital and one of only five academic health science centres in the UK. Our service is about people – staff, patients, partners and the public. Our values – kind, safe, excellent – underpin every aspect of work in the Trust, setting the quality standard for our behaviour, not just to our patients but to each other as colleagues.

Individual patients judge our hospital by the treatment they receive from the staff caring for them. Engaged, motivated and well-trained staff, working together with common purpose is key to the delivery of high quality care, and we are committed to developing our staff with this in mind, listening to and learning from their experiences, as well as those of patients and their families.

“All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.”

Sir Bruce Keogh, Review into the quality of care and treatment by 14 hospital trusts in England: overview report5, July 2013

The 2013 Francis Report into Mid-Staffordshire Hospital exemplified just how devastating the consequences for patients and their families can be if the commitment to safety and quality is compromised. It is crucial that we as an organisation fully embrace Francis and are indefatigable in our pursuit of quality, putting the needs of patients and their families at the centre of all our work. Our strategy embraces the key findings of the Francis Report and our key priorities will ensure the challenges incumbent upon us as a result of the findings of his report, are integral to our vision of quality.
Approach and context

In 2009 we published our approach to improving safety up to 2012. Central to this was the recognition of the absolute requirement for safe practice to influence and drive all aspects of the Trust’s work and future developments. The key goals established by the safety strategy at this time were:

- changing the culture
- reducing hospital mortality rates (HSMR) to one of the lowest in the NHS
- reducing unintentional harm events
- reducing infection rates ahead of PCT requirements
- reducing average length of stay
- reducing re-admission rates
- completion of a Clinical Area Safety Assessment (CASA) for every clinical department
- ensuring no ‘never events’ occur
- achieving NHSLA Level 3 compliance

The objectives in italics were fully achieved, progress was made regarding the remainder and we will continue to work towards achieving these. The improvements in safety we have made in recent years have been recognised nationally by Dr Foster Intelligence, naming CUH Trust of the Year in their 2012 Hospital Guide. The award highlighted that more patients are surviving following treatment at CUH than would be expected and that the Trust performed well against efficiency measures.

In pursuing our safety agenda over the last three years it has become apparent that there is an absolute necessity for the Trust to have a unified Quality Strategy. This Quality Strategy includes all elements of Darzi’s simple definition of Quality, first set out in High Quality Care for All2 in 2008, and which lies at the heart of the first ever NHS Outcomes Framework3.

Quality: care which is clinically effective, personal and safe

Lord Darzi², 2008

In the current year, one of our two main strategic goals at Trust-level focuses on improving quality. As part of the overall aim of making services safe and viable for the long-term, there is a Trust-wide focus on safety, efficiency, productivity, patient experience and service excellence in a way which ensures financial sustainability. In addition, the need to promote patient safety and engage patients in their own care (no decision about me without me) is already central to all divisional business plans. We have stated in the Strategic Plan Document for 2013-14 (our Annual Plan) that our aim is to achieve quality by delivering person-centred, safe and effective care that is sustained through good leadership, individual and team effectiveness. This overarching aim for year one is clearly aligned with the priorities set out in subsequent sections of this document.

Our quality strategy aims to ensure CUH will meet the requirements of the new CQC standards¹ being implemented from 2014, whilst maintaining an ability to respond to future requirements such as those of the National Institute for Health...
and Care Excellence (NICE) or of the Commissioning Outcomes Framework. We will however maintain flexibility so that we can take account of the findings and recommendations of future reviews and regulatory requirements.

To ensure what we do is informed by the best evidence, we have drawn on national guidance, as well as information specific to CUH. Key national documents outlining expectations in regard to quality processes, structures and outcomes have been reviewed and compared to those within the Trust, and a full list of sources is on page 27. We have also reviewed evidence describing the requirements for a high reliability organisation to ensure we have included all elements necessary to assure quality of care. Patients, staff and partners have been consulted, seeking their views on what our quality priorities should be. Appendix 5 details people consulted during the development of this strategy. We will continue to consult and seek feedback on the strategy as it is implemented, developed and refined.

We want to ensure that the Trust is at the national vanguard of best practice in quality in all its component parts and able to influence national debate and direction through a proven track record of delivering high quality care.
Our vision and priorities

Our aim is simple: all patients treated at CUH will receive the safest, highest quality care, personalised to their needs, in a hospital that compares well with the best in the world and has a strong academic approach to improving quality. To achieve this, we have identified five key priorities:

- improving the experience of our patients – **person-centred care**
- improving staff engagement – **staff as partners**
- improving safety and eliminating avoidable harm – **harm-free care**
- improving the reliability of care – **delay-free care**
- providing **clinically effective care**

The five priority areas are inter-linked and inter-dependent, and we will only achieve our ambition if all five domains are present equally and simultaneously. Delivering just one or two in isolation will not be good enough.

Achieving our quality vision to be one of the best academic healthcare organisations in the world is something that will require leadership, staff engagement and a willingness to innovate. **A key part of this strategy will be the establishment of a quality and safety academic unit at CUH.**

We want to measure up against the best nationally, and aim to be in the upper decile for all key performance indicators used by our regulators. Going beyond that, we will start to set our standards and measure our performance using global comparators. **By 2018 we will have submitted CUH for an external assessment through, for example, Joint Commissioning International (JCI) or an equivalent detailed assessment programme.** We will work to gain membership of Dr Foster global comparators, seeking to benchmark our performance against other leading medical institutions and looking beyond national boundaries to international standards of leading clinical practice.
What will success look like in 2018?

**Person-centred**
Every patient is treated as a person, not a number, with dignity and respect, and is fully involved in their treatment and care. "No decision about me without me."

Placing the individual at the centre of any discussion about quality is crucial. Each patient we treat is unique, with their own experience of their health, illness and care, and a key partner in shared decision-making. Increasingly patients manage their own health and illness through support and access to information for them, their families and carers. Successfully keeping the person at the heart of all we do means providing care that is responsive to individual personal needs, preferences and values, and assuring that patient values guide all clinical decisions.

We want patients to consistently report that the care they received, met, or was above their expectations. That said, we always welcome compliments, constructive feedback and complaints, as these help to identify areas where we can improve and are one indication of the level of quality we are providing. Seeking and receiving feedback on how we are doing is a very important component of the continuous improvement culture we want to strengthen.

**Staff as partners**
A fully engaged, skilled, trained and competent workforce delivering care of the highest quality. An organisation that is well-led at all levels

Investment in our staff is investment for the future: allowing for turnover, over two thirds of the people who will deliver our services in 2018 are working here already. Individual patients and their families rely upon staff working in teams to provide high quality care. We are committed to developing all our staff, listening to and learning from their experiences, and investing in the leaders of today and tomorrow as described in the Berwick Report. CUH will make an explicit commitment to provide education and training opportunities for all staff which will include specific training in quality. An engaged, motivated and well-trained workforce is key to providing high quality care. We will continue to be an organisation that our staff are proud to work for and would recommend to their families and friends.

We want to be an organisation where there is a single and shared understanding of what we mean by quality, with all staff, irrespective of their role, behaving in a kind, safe and excellent way.

**Harm-free care**
Patients will suffer no avoidable harm

Patients rightly expect CUH to be a safe place and that the healthcare we provide will help them. We must protect our patients from unintentional harm whilst they are in our care. This includes hospital-acquired infections, medication errors, surgical infections, pressure ulcers and other unintended injuries resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice). In addition, we aim to provide an appropriate, clean and safe environment for all patients at all times.
Delay-free care
Care delivered on time and to time cost-efficiently, meeting or exceeding all national standards in relation to providing timely care

We all dislike having our time wasted, and in a clinical environment treating patients promptly and appropriately can positively influence outcomes for individual patients. Consistently providing reliable, timely care also improves the experience of patients. This includes reducing avoidable cancellations of appointments or surgery and at the end of a patient’s hospital stay ensuring there are no delays to their discharge from hospital caused by factors within our control. These things will only happen when we treat our patients’ time as more valuable than our own.

Clinically effective
Care that achieved the best outcomes possible for each patient and which is delivered using the latest evidence-based techniques

As the local hospital for our community, a national centre for specialist treatment, a comprehensive biomedical research centre, a major teaching hospital and one of only five academic health science centres in the UK, CUH prides itself on providing evidence-based medicine, soundly grounded in academic research. We want all care we provide to be clinically effective care, following national and international best practice, with each patient receiving the most appropriate treatments, interventions, support and services. Reducing avoidable variations in practice will not only improve outcomes for patients, but will also allow us to use scarce NHS resources optimally.
How will we measure our success?

Some aspects of our success will be qualitative, whilst others will have quantitative measures. Both are important in assessing the progress we are making and to know whether the strategy has been successfully implemented. A simple test of whether we have improved quality will be whether the right thing to do, is always the easiest thing to do.

We will measure progress against:

- **Each of the five priorities** identified in the section above, and **quality indicators** within these domains
- **National quality indicators** as mandated by regulators and NHS England
- **National standards and targets**, for example on waiting times under delay-free care
- **CQUINs** (Commissioning for Quality and Innovation) agreed with Commissioners (increasingly we will seek for these to be aligned as closely as possible to our overarching quality priorities)
- **Accreditation** – achievement of JCI or equivalent
- **Establishment of an academic quality and safety unit**

Illustrative individual metrics and standards we could to use to measure our success are provided in Appendix 2, although these will be subject to further development and approval during year one, and as new regulatory requirements emerge. Monitoring of and reporting on progress will be carried out at all levels from individual services to board, and the section on delivery framework provides an overview of indicative structures and processes.
Delivery framework

The successful implementation of this strategy will depend on quality priorities and objectives being genuinely owned by individuals and teams at a local level. Teams need to be empowered to focus on clinically relevant areas and outcomes, as well as the priorities identified in this document, that they know need most attention in their area. However, alongside this devolved structure, there will be robust governance arrangements providing assurance at all levels regarding progress and management of risks.

The first step in delivering our quality priorities will be developing the systems, structures and the processes to support them. We intend to move from quality being dispersed across many portfolios, to accountability being with the medical director and the chief nurse, but with the delivery of quality being devolved to individual divisions, specialties, services and teams, with a small central support and monitoring function, as illustrated below. A diagram setting out the indicative structure for quality management is at Appendix 3.

The implementation of this strategy will see regular structured meetings at divisional level focussed solely on quality. These meetings will provide a forum for discussion, resolution and escalation of all quality matters between divisions and the executive, and provide the opportunity for challenge. The information discussed will provide assurance that delivery is on track. The agenda for these meetings is set out in Appendix 4 and will broadly follow the priorities in the strategy and the monthly CUH integrated report on quality, performance and finance. The detail considered will inform the divisional monthly performance meetings, which will inform and assure the quality committee, the board and (where required) external stakeholders and regulators.
However there is more to delivering our quality priorities than systems, structures and processes. Our whole culture must be one in which every member of staff understands their personal role and responsibility in delivering the highest standards of quality and work within their team(s) to ensure this goal is achieved for every single patient. To do this, the Board and senior teams will ensure that everybody's personal objectives are aligned with the priorities in this strategy and in our quality account. We will need to learn and embed new approaches to quality improvement, enabling every member of staff to develop their expertise in quality.

The five priority areas will be delivered using a systematic approach to quality improvement that aims to develop in CUH the attributes of a High Reliability Organisation (HRO)\textsuperscript{6}. At the core of high reliability organisations (HROs) are five key concepts, which are essential for any improvement initiative to succeed:

a. **Sensitivity to operations.** Preserving constant awareness by leaders and staff of the state of the systems and processes that affect patient care. This awareness is key to noting risks and preventing them.

b. **Reluctance to simplify interpretations.** Simple processes are good, but simplistic explanations for why things work or fail are risky. Avoiding overly simplistic explanations of failure (unqualified staff, inadequate training, communication failure, etc) is essential in order to understand the true reasons patients are placed at risk.

c. **Preoccupation with failure.** When near-misses occur, these are viewed as evidence of systems that should be improved to reduce potential harm to patients. Rather than viewing near-misses as proof that the system has effective safeguards, they are viewed as symptomatic of areas in need of more attention.

d. **Deference to expertise.** If leaders and supervisors are not willing to listen and respond to the insights of staff who know how processes really work and the risks patients really face, regardless of grade and not to be confused with hierarchy, we will not have a culture in which high reliability is possible.

e. **Resilience.** Leaders and staff need to be trained and prepared to know how to respond when system failures do occur.

Specifically, this will include developing over the next five years:
• a safety and quality management system (SQMS) the key features of which are a safety and quality policy that includes a requirement for a senior management committed to quality, an organisational manual with operational standards and trained and competent personnel

• safety risk management, that includes a safety reporting system and a just and equitable culture

• a compliance and performance monitoring system

• a trust-wide staff framework providing a systematic approach to training, development and engaging staff in the delivery of high quality services.

We recognise that we need to maintain flexibility over the coming years, to enable us to remain responsive to external issues, events and emerging regulatory requirements. Through our Quality Account we will conduct an annual stock-take of the previous year’s priorities, review progress, and then set key priorities for the following year. Each year we will work with our commissioners to agree meaningful and stretching CQUIN (Commissioning Quality and INnovation) measures that support our quality priorities.

This flexible approach means that we can set out clear objectives for 2013-14, whilst the ambitions outlined for future years provide a framework within which more detailed objectives can be developed at the appropriate time. For illustrative purposes, a detailed example timetable for one work programme (Harm free care) is included at Appendix 1.
Objectives for year one: 2013-14

A key step in enhancing our quality structures and leadership will be to complement existing expertise with the appointment of a director for quality. As set out in the previous section, and in line with the emerging divisional accountability, the responsibility for the delivery of improvements in quality will be devolved to the divisions. A central team will be responsible for the monitoring, assurance and challenge required to ensure the successful delivery of the quality strategy.

The objectives for 2013/14 will include:

- Obtain the commitment from the board and executive team to ensure quality and provide the means to achieve this.
- Agree that the attributes of a high reliability organisation (HRO) should be embraced by CUH.
- Consult widely about our strategic approach to quality, including patients, carers, staff and partner organisations.
- Establish a multi-disciplinary steering group to ensure the recommendations made within the Francis Report are assessed across CUH and, where necessary, actions are implemented and evaluated.
- Agree the quality strategy and appoint a director for quality.
- Articulate, agree and resource an integrated structure for managing, improving, monitoring and assuring quality throughout the Trust. This will include reporting and monitoring processes.
- Agree the programme of training for board members and senior clinicians in Quality Improvement methodologies.
- Develop and agree a detailed implementation plan for the quality strategy that sets out the year-on-year objectives, responsible leads, key indicators, criteria that define success, and methodology for measurement.
- Align the objectives set out in relevant Trust strategies and developments eg clinical strategy, data quality strategy, estates strategy with our agreed quality strategy.
- Agree the process for aligning staff objectives to those set out in this strategy from 2014/15.
- Work with our Commissioners to agree meaningful and stretching CQUIN (Commissioning Quality and INnovation) measures for 2014/15 that will support the priorities set out in this strategy.
- Complete an assessment of the Trust's approach to quality using the Monitor Quality Governance Framework.
Conclusion

This strategy sets out our ambition for improving quality at CUH, through a focus on a small number of priority areas, centred around our individual patients. Quality is only achieved if all of the priorities are delivered equally and simultaneously. Our main objectives for year one are set out, and indicative work programmes will be developed for each priority up to 2018, whilst retaining the flexibility to review and develop these over the five years as a result of feedback, consultation, external events and emerging regulatory requirements.

In the context of rising demand, increasing expectations and limited resources, ensuring care is also accessible, equitable and sustainable may be our biggest challenge in the coming years.
References and other written sources


4. A new start: Consultation on changes to the way CQC regulates, inspects and monitors care. Care Quality Committee. June 2013


Appendix 1: **Indicative work programmes (final sequence subject to consultation & approval)**

<table>
<thead>
<tr>
<th>Harm-free care work plan</th>
<th>Year 1</th>
<th>Years 2-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement an integrated structure for managing, improving and assuring safety according to the SQMS</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Implement a single database (DATIX) for reporting of incidents &amp; complaints. This will be integrated into EPIC.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Establishment of an Information Quality group to interrogate and challenge mortality data and assure BoD of accuracy.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• The appropriate structure and resource are in place to allow the Board, divisions, clinical departments and individual clinical areas to review and understand their level of safety.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Processes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information about quality and safety will be fully integrated into the ongoing education of staff to ensure we continually learn as a result of a near miss or harm event.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Process to ensure all unexpected cardiac arrests and deaths are reviewed using an agreed methodology and the results reported in a uniform manner by the clinical team responsible for care.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Trust-wide agreement of escalation procedure for deteriorating patient, fully integrated into electronic recording of vital signs and communication systems.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Process established to ensure all new developments are reviewed for potential impact on the safety of patients and delivery of harm free care.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SQMS written and agreed by BoD</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Database (DATIX) in use for reporting of critical incidents &amp; complaints.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• DATIX system integrated into EPIC.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Less than 0.1% of patient contacts result in a reported incident associated with harm</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Data Quality committee established and assurance provided by minutes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• 99% of care recorded via the safety Thermometer is harm free</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Upper decile HSMR &amp; SHIMI performance, having achieved a year on year reduction</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Year on year reduction in unexpected cardiac arrest in in-patients</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• No avoidable <em>C. difficile</em> infection</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• No hospital acquired MRSA bacteraemia</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendix 2: Possible Metrics

An agreed set of final metrics will need to be developed, including what level each should be set at. Some will be based on agreed external standards, whilst others will be goals we set within our organisation. This list is included to illustrate possible measures against each priority. These will be owned by and agreed with divisional teams.

**Improving the experience of our patients – person-centred care**

1. Percentage of patients who report the care received met, or was above expectations
2. Percentage of patient contacts resulting in a formal complaint
3. Themes emerging from complaints
4. Year on year improvement in our score for the ‘friends and family’ test, increasing by at least 10 points in the first year.
5. How many patients who have complained are satisfied with the outcome?
6. How many patients report being treated with kindness?
7. How many patients report being treated with dignity and respect?
8. How many patients report being given enough privacy when discussing their condition or treatment
9. How many patients report finding a member of staff to talk to about their worries and fears
10. How many patients report being involved in decisions about their care and treatment

**Improving staff experience – staff as partners**

1. Proportion of staff reporting in the national survey that they are able to contribute towards improvements at work
2. Proportion of staff reporting in the national survey that they would recommend the Trust as a place to work
3. Proportion of staff reporting in the national survey that they feel motivated at work
4. Proportion of staff reporting in the CUH Staff engagement survey they feel valued and recognised within their area of work
5. Proportion of staff reporting in the CUH Staff engagement survey that this organisation is committed to training and developing its staff
6. Proportion of staff reporting in the CUH Staff engagement survey they are motivated to make a difference to patients *(even if I don’t have direct contact with patients)*
7. Themes from exit interviews and questionnaires
8. Training compliance rates
9. Staff turnover
10. Staff immunity
11. Appraisals
12. Grievances & whistleblowing
13. Long-term sickness rates
14. All objectives aligned to strategic objectives
15. External expert advice
16. Staff training and study leave
17. Leadership training & training in quality improvement

**Improving safety and eliminating avoidable harm – harm-free care**

1. 97% of care are recorded via Safety Thermometer is harm free
2. Less than 0.2% of patient contacts result in a reported incident associated with harm
3. Minimise the number of avoidable hospital acquired infections (zero MRSA bacteraemias in 2013-14; no more than 39 hospital-acquired *Clostridium difficile* cases)
4. Have a Hospital Standardised Mortality Ratio (HSMR) that places the hospital in the top 10% of our peer group and have an aggregate hospital HMSR of less than 90
5. SHMI performance
6. Deteriorating patient
7. Medication incidents
8. Handover
9. Patient identification
10. Primary consultant

**Improving the reliability of care – delay-free care**

1. 95% patients attending A&E are seen, treated, and discharged or transferred within 4 hours
2. 90% patients who require elective (planned) admission to hospital who are admitted within 18 weeks
3. Number of operations cancelled on or after the day of admission is less than 1%
4. Delayed transfers of care: more than 95% of patients should have their assessment within the agreed timeframe.
5. By 2018 there should be zero delayed transfers of care due to processes within the Trust’s control.

6. Bed days time to assessment metric – target ceiling 10 per month

7. Home by lunchtime

Providing clinically effective care

1. Keep the level of avoidable readmissions below 10% (patients admitted to hospital within 30 days as a result of a complication or failure related to their initial admission)

2. Year on year improvement in patient-reported outcomes, measure at a specialty and Trust level (optimise use of available PROMS)

3. Each division/specialty has X locally-defined measures... etc

4. Reduction in variation of care measures, e.g. adoption of EPIC care pathway

5. Stroke care metric
Appendix 3:

High level indicative structure for Quality management

Note: Final structure will be finalised when Director for Quality is in post
Appendix 4: Illustrative agenda for divisional quality meetings

Data to be reviewed will be provided in a standardised format across all divisions to ensure consistency.

1. Current Risks
2. Cross-divisional issues
3. Person-centred care
4. Harm-free care
5. Delay-free care
6. Clinically effective care
7. Staff as partners: engagement and training
8. Review of Quality Account
9. CQUINs
10. Regulatory Compliance
11. Risk Register
12. QIA for Turnaround
Appendix 5: People we consulted

A wide range of individuals and groups have been consulted during the development of this document. As the work programmes and metrics are developed there will be an ongoing process of involvement and consultation, and this will continue as yearly objectives are set within individual work programmes over the next five years.

Groups and individuals consulted so far include:

- Divisional Directors
- Divisional Patient Safety Leads
- Senior nurses
- Chief Pharmacist & Pharmacy Consultants
- Clinical Directors and all consultant staff
- ADOs & Heads of Departments circulation list
- Trust staff working on quality, e.g. PALS, PSU staff
- Management Staff Forum
- Consultant Staff Council
- GP Interface Group
- The Care Quality Commission
- Cambridgeshire CCG
- Healthwatch
- Cambridge University Engineering Design Centre
- Patient Safety Council
- Board of Directors
- Board of Governors
- A patient focus group was held specifically to discuss our quality strategy

In addition, individuals from the patient safety unit visited organisations believed to have demonstrated an outstanding commitment to quality improvement (Salford Royal NHS Trust and University College Hospital NHS Trust, London). We are immensely grateful for their generosity in giving of their time and in sharing key documents.