



Strategic Context



The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust

Quality Strategy

2017-2020



Strategic Context

Aspiring to deliver world class patient care

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Background

Quality is at the core of The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust, since the hospital opened at its current site in 1921 with the founding members Sir Robert Jones, a Surgeon and Dame Agnes Hunt, a Nurse. They established traditions of innovative treatment, care, dedication and professionalism which still guide the Trust today. Their legacy has been a hospital which continually raises standards, one which pushes boundaries in areas like community-based care, holistic approaches to treatment and multi-disciplinary working between clinicians, physiotherapists and other professionals.

Surgeons, Nurses, Allied Health Professionals, Physicians, Administrative/Support staff and the Board of Directors continue to strive to deliver that vision from which the hospital was founded to provide outstanding patient care to every patient every day.

Since the launch of our first Quality Improvement Strategy in 2010 we have made considerable progress in our commitment to continuous quality improvement which we have published year on year through our Quality Accounts.

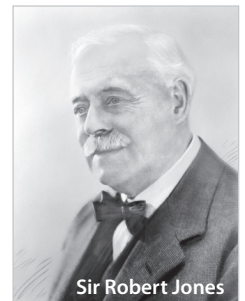
1st in the country for the 2016 inpatient survey

93% of patients rate their care as excellent at RJAH

No MRSA Bacteraemia infections since 2009

95% achievement of the Safety Thermometer implementation and monitoring

0 Clostridium Difficile Infections since 2014



Sir Robert Jones



Dame Agnes Hunt

Bev Tabernacle

Director of Nursing/ Deputy Chief Executive



Our Vision

“Aspiring to deliver world class patient care”

This vision depicts the Trust’s ambition to be the leading centre for high quality, sustainable orthopaedic and related care, achieving excellence in both experience and outcomes for our patients.

Our Goals

- Caring for Patients
- Caring for Staff
- Caring for Finances



Our Values

In order to support the quality agenda within the organisation we have been clear about what is expected from our staff through their involvement in the development of our Trust values.

These values underpin the culture required to support staff to deliver high quality care and should provide a positive environment in which quality will flourish. The values provide a framework for staff to challenge behaviours at all levels and to define what working at the RJAH means to them.

In order for quality to be consistently achieved there needs to be a culture across the organisation, one of commitment to collective quality improvement rather than individual departments focusing on their own projects. If the values of the organisation support an environment of team working then the aims and objectives of the organisation can be embraced by everyone which will lead to a cohesive approach to patient safety, engagement and quality improvement that is achievable and sustainable.

In order to deliver our goals and values the Trust has outlined three strategic aims:

Operational Excellence

Getting a real grip on the operational things that will make a significant difference to our patients.

Local Musculoskeletal Services

Establishing RJAH as a central part of the local health system, rather than a fringe specialist provider.

Specialist Work

Being a national voice in our area of expertise, working in partnership with our specialist neighbours.



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Running across all of the three areas above is one more important area of focus: **Culture and Leadership**. We must be a patient-focussed, clinically-led organisation that is spoken of as an extraordinary place to work.

Part 1

Introduction

Quality is at the core of The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust (RJAH). Since the hospital opened at its current site in 1921 with the founding members Sir Robert Jones, a Surgeon and Dame Agnes Hunt, a Nurse, they established traditions of innovative treatment, care, dedication and professionalism which still guide the Trust today.

Their legacy has been a hospital which continually raises standards, one which pushes boundaries in areas like community-based care, holistic approaches to treatment and multi-disciplinary working between clinicians, physiotherapists and other professionals.

It is important for us to recognise the contribution our staff make day in day out and to abandon blame when things go wrong. We need to be open and transparent with all types of information and learn from the experiences of our patients, their carers and our staff.

External reviews, complaints, incident reports, clinical audit and most of all our patient and staff experiences are all 'free intelligence' and should be used that way. Engaging with the users and those delivering the services across the organisation will provide us with a wealth of knowledge that can only point us in the right direction whether that is innovative changes or more of the same.

Providing our staff with the skills and knowledge to identify improvements, understand how improvement and quality can be measured appropriately not just once but throughout their careers providing opportunities to learn and giving permission to change systems without fear of reprisal. Staff should not have to seek permission to improve the care they deliver to our patients.

This strategy outlines the approach to quality within RJAH. It provides details of what we want to achieve, how we will achieve it and how we will measure that achievement over time to ensure the quality of care is sustained.

The quality strategy must not be used in isolation. Each of our supporting strategies and business plans support the delivery of a high quality service and providing outstanding patient care. In combination our organisational strategies support our overarching aims and objectives.

We need to celebrate our success no matter how big or small that success is. Supporting delivery of any success supports a culture of engagement and further improvement. Culture within the organisation and understanding will play a key role in the strategy's successful delivery across the organisation.

Defining Quality and Quality Governance

Our definition of Quality encompasses three equally important elements:



In order to improve quality is necessary, and to understand what quality means within an organisation we first must define what that meaning is and how this is then interpreted throughout the Trust.

Quality is defined by the Oxford English Dictionary as

'the standard of something as measured against other things of a similar kind'

Defining Quality and Quality Governance

Through this strategy we will ensure we are measuring quality both internally and externally, learning from each other and from best in class not just nationally but internationally and comparing ourselves to those organisations world-wide that are achieving success in ensuring we are aspiring to be world class through tried and tested methods and whose staff understand what quality looks and feels like to them and the organisation.

The Quality Strategy continues to build upon these three elements and within each specific area, aligned to the Trust's strategic objectives, programmes of improvement and development can be defined which will make up the quality priorities within the RJAH over the next three years.

The Quality Strategy builds upon previous work undertaken and incorporates both locally defined initiatives and those areas of improvement identified more recently from work undertaken nationally.

The Figure 4 below highlights the reporting structure to ensure the delivery of the Quality Strategy and associated work plans:



Our Commitment

Our commitment is to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience. The Quality Improvement Strategy is a rallying call for every single employee, volunteer, and governor to ensure that we deliver excellent care, every time to every patient.



Our aim is to create a culture of continuous improvement and learning which is both patient centred and safety-focused. To do this, we must create the conditions where we:

- listen to and include the views of our staff and key stakeholders
- fully embed the Trust Values in everything that we do in order to ensure the working environment is conducive to enable continual improvement and innovation
- actively engage with and enable staff to lead and deliver measurable change for improvement
- focus on human factors - how we deliver care as teams
- are open and honest with people when things go wrong

We must also ensure that improvement is seen and understood to be everyone's business by:

- expecting all teams and staff to be involved in improvement and innovation as part of their everyday business
- local teams regularly discussing lessons learned,
- innovation and improvement

We must ensure that we create the culture of learning, openness, transparency and candour that the Secretary of State supported in learning not Blaming, responding to the Freedom to Speak Up Report, the Kirkup Report and the Public Administration Select Committee's report into clinical incidents. The outcomes of this plan link closely to those described in the Trust's Quality Accounts and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well-led.

Whilst this Strategy and improvement plan will be delivered through the annual planning round, it is important that we continue to progress the big ticket items that will deliver improved outcomes.



Transparency is at the top of an organisation's agenda, recognising staff development and understanding of their working environments and being open at every opportunity.

“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.”

A promise to learn - a commitment to act (National Advisory Group on the Safety of Patients in England 2013)

The Chief Nursing Officer in November 2012 launched the 'Compassion in Practice strategy' which includes those values and behaviours which are important to the people we care for and are defined as follows:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

This has been updated and relaunched through the Framework for Nursing – Leading Change, Adding Value May 2016. The strategy encompasses those values which assist in the delivery of compassionate care from all health care professionals. At RJAH these national initiatives and commitments flow through our own values, commitments and strategies to ensure the care and services we deliver are of the highest quality, efficient, effective and safe with the patient's voice at the heart of our organisation.



The principles of the Leading Change Adding Value (2016) underpin the quality aims outlined.

Our Quality Aims

Aim 1 - Reducing Patient Harm

- Prevent avoidable deaths
- Managing the deteriorating patient
- Ensuring the safe transfer of patients to and from the hospital

Aim 3 - Improving Documentation

- Audit Process
- Review of Pathways
- Improving consistency

Aim 2 - Reviewing Leadership roles and accountability

- Divisional structures
- Performance review process
- Cultural Behaviour Characteristics

Aim 4 - Providing effective and reliable care

- 100% Delivery of WHO checklist
- Implementation of the Sepsis care bundle
- Continued development of the STAR accreditation process

Aim 1: Reducing patient Harm

Harm is unintended injury resulting from 'sub-optimal' clinical care which results in additional monitoring, treatment, or extended stay in hospital. Despite the hard work and good intentions of healthcare professionals, patients are harmed in hospitals every day. It is our duty and responsibility to protect patients and we are committed to providing harm free care. The Trust was an early adopter of the Sign up to Safety movement which aims to make the NHS the safest healthcare system in the world.

In order to continue our patient safety work the following areas of focus have been identified:

Prevent avoidable deaths

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards *"from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals"*.

This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Measurement:

- Learning from Deaths review policy and process implementation
- Reduction in the number of preventable deaths

Managing the deteriorating patient

Clinical deterioration can occur at any stage of a patients treatment or illness, although there will be certain periods during which a patient is more vulnerable, such as the onset of illness or during medical, surgical or dental interventions. Patients who are at risk of deteriorating may be identified before a serious adverse event by monitoring changes in physiological observations recorded by healthcare staff. The interpretation of these changes and timely institution of appropriate clinical management once physiological deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

Measurement:

- 98% with NEWS compliance
- 95% clinical staff have undertaken Managing the deteriorating patient training
- 10% reduction in unplanned admissions to HDU

Ensuring the safe transfer of patients to and from the hospital

During 2016/17 a number of reviews were undertaken following the transfer of patients from other hospitals. This identified that in order to maintain the delivery of safe care improvements in the process of transfer need improvement.

Measurement:

- 100% implementation of the Transfer Passport for patients transferred from another hospital for care at RJAH.



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Aim 2: Reviewing Leadership roles and accountability

Trust received a rating of inadequate for the domain of well-led in 2016 following the CQC inspection in October 2015. A number of actions have been implemented to ensure that both Executive and Divisional leadership have improved. However the divisional structures are embryonic and the following aspects have been identified to support the delivery of services at divisional levels:

- Divisional structures
- Performance review process
- Cultural Behaviour Characteristics

Through the implementation of these leadership band width within the divisions will be improved.

Aim 3: Improving Documentation

Good documentation is the cornerstone of the evidence to support evidence that excellent care is planned and has been delivered. During 2016/17 a number of serious incident investigations highlighted that the documentation surrounding the care of some of our patients could be improved. All professional bodies highlight the importance of good documentation to protect staff and ensure care is delivered safely to our patients.

Through the implementation of audit processes, the review of the current pathways and improving the consistency of documentation in all areas we will improve the safety for both staff and patients.

Aim 4: Providing effective and reliable care

The core domains of creating a culture of safety and a learning system to ensure reliability, improvement, and sustainability are foundational, not only for solving the kinds of safety issues we have experience with, but also for those we haven't yet imagined. The individual components of the framework - leadership, transparency, accountability - are the necessary ingredients to create a culture of safety and a system for continuous learning. Health care organisations of any type or size can build on this foundation to create systems and processes that ensure our first promise to patients - do no harm - is fulfilled.

In order to achieve this we will look at the implementation of reliable care in three areas:

- 100% Delivery of WHO checklist
- Implementation of the Sepsis care bundle
- Continued development of the STAR accreditation process

Recognising the Human element of improvement

We recognise that at the heart of our approach to quality and safety improvement, there needs to be awareness of the interactions between people, and between people and non-human elements involved in complex systems. This is known as Human Factors.

By having a holistic view of Human Factors and better understanding the interaction between all the elements present in a system, we can improve our organisational culture through better communications and team decision-making, with a positive impact on patient care. Human Factors is not a stand-alone solution, but rather a broad approach that ensures that people have a better understanding of how people are affected by the teams they work with, the systems they operate, and the environment they work within. It ensures that people know how the combination of the factors affects patient safety and wellbeing so that consistently safe and reliable care can be provided to our patients.

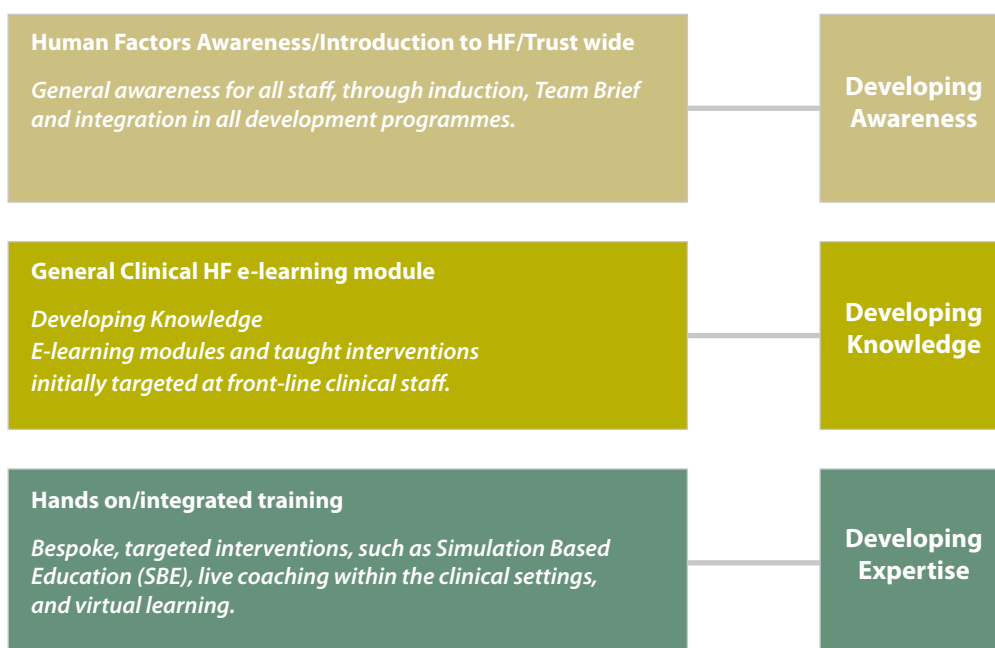
As part of our leadership development programme 'Releasing Potential' managers are undertaking a full diagnostics to support their understanding of their own and others behaviours, and the influence/impact that their behaviours have on others.

Our Behavioural Characteristics was launched in 2016, setting out the expectations for all staff to take responsibility for their professional behaviour, to work effectively with others, and to challenge and be honest where they feel things are not right. This is a key element in establishing a Human Factors approach.

Culture Feature	Required Behaviours
1. We respect people for their skills and devotion, not their grade	We treat everyone consistently-well regardless of role or seniority
2. Patient need over-rides process	We empower the best-placed person to make decisions/take action
3. We choose positivity (we look for strengths before weakness)	We look for ways to get things done (rather than reasons why they can't be)
4. The person who knows most about something is able to get on	We empower the best-placed person to make decisions/take action
5. Being humble is a sign of greatness not weakness	We recognise when we have something to learn
6. People are aware of and manage the impact they're having on others	We understand/manage the impact of our behaviour/style on others?
7. We are honest and transparent in our dealings with each other	We communicate honestly and transparently with others
8. If we see a problem we can fix it; if we see an opportunity we can grasp it	We take responsibility for resolving issues
9. We strive constantly to make things better for our patients, ourselves and the hospital	We look for better, more cost-effective ways of doing things
10. We know that our differences are valuable - we don't believe that our differences make us superior or inferior	We use our power for the good of others not our own good
11. We are do-ers not bystanders - if we see something we don't like, we say so (and do something about it) and if we see something we do like, we say so	We constructively challenge when we disagree with something

Other areas where the Human Factors will be adopted will be in supporting root cause analysis and review of clinical incidents through incorporation of human factors into clinical skills training and simulation exercises, and the adoption of Schwartz Rounds (identification of team decision making issues, feelings, and targeting support to make improvements).

The introduction of Human Factors will be through an approach that sees development in three tiers:



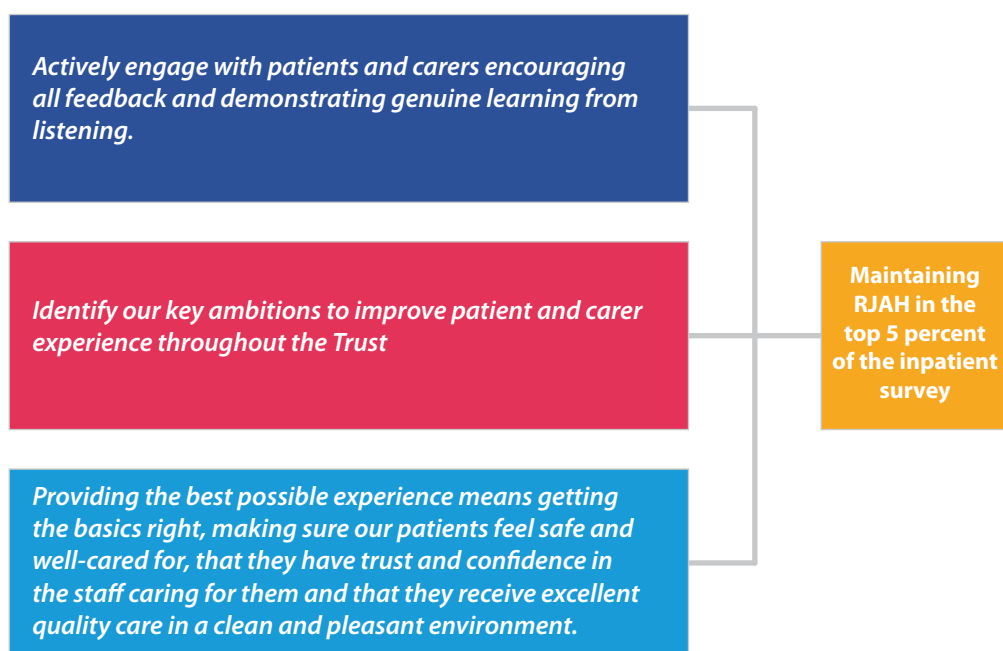
Focus on Schwartz Rounds

Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes, and organisational culture.

The Experience of our Patients

During 2016/17 we have undertaken a patient experience collaborative in order to define our 2017/20 Patient Experience Strategy. Within this we have identified 3 core areas.

The main aims of the Strategy are to:



Implementation of this Strategy will ensure that the Trust has a co-ordinated approach to listening to, and learning from, patient feedback and working together (Co-Production) with our patients and carers to continually review and improve our services.

The strategy is linked to our values and our 'Always Events' identify us as an organisation that stands out from other organisations. We as an organisation and as individuals, who work here, will be measured by how successful we abide by these and the challenge is to ensure we all strive to safeguard quality throughout the organisation at all times by keeping and supporting these promises.





Quality and Equality

At RJAH we want to ensure that everyone benefits from the quality strategy and we use the NHS Equality and Delivery System (EDS) to ensure we are meeting the needs of those people with characteristics protected by the Equality Act 2010.

There are nine characteristics in total:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership.
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

Through this work, we regularly collect information about the quality of the services that our patients receive. Feedback for the six months up to April 2016 from patients shows that our services are positively received across all ages, disability, sexes, religions and Black and Minority Ethnic groups. We will continue to review the feedback we receive and ensure all groups are represented so that the quality of our services is meeting the needs of our patients.

The Friends and Family Test, is based on a single question;

“How likely would you be to recommend our ward to friends and family if they needed similar care or treatment.” The majority of our patients from all protected characteristics report that they would recommend the Trust to Family and Friends. However, most of those who said they would not recommend the Trust, did not give information about their backgrounds and we will continue to work with patients in order to gather this information.

Significant progress has been made and we will continue to promote the well-being to all protected groups through well-being events and health promotion messages in our outpatient clinics. This will include the continued promotion of ‘Making Every Contact Count’ in which staff are trained in how to give positive messages to patients and the public about improving their health and well-being.

More information about quality and equality can be found in the Trust’s Equality and Diversity Annual Update.

Improvement requires a system of support to understand what quality looks like, to define what the goals of the organisation are and to equip the staff to be able to deliver those goals and develop the aspiration to deliver world class care.



PART 2

How will we deliver this Strategy?

Good Governance

As a Foundation Trust we are expected to provide care to our patients that is safe, effective, caring and responsive to the needs of the population we serve. The Board of Directors within the Foundation Trust are required to develop and implement a strong structure for Governance. Good governance is an important tool for ensuring the quality of care within the organisation. Effective leadership, with appropriate expertise, knowledge and independence are essential.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has developed a structure of governance through its committees and processes to ensure the quality of care is assured. Each year the Trust undertakes a rigorous review of its own performance and that of its committees which assure the quality of care provided through a self-assessment against Monitor's Quality Governance Framework to ensure the framework and systems of Governance are fit for purpose.

The Board Governance structure consists of four assurance committees chaired by Non-Executive members of the Board of Directors. The Quality and Safety Committee reviews and monitors the systems and processes required to ensure the effectiveness of the care provided, workforce issues and the patient experience.

The Finance Planning and Investment Committee provides assurance to the Board in relation to the operational performance and financial management structures and processes required for the delivery of the services.

The Risk Committee oversees risk and assurance processes and provides assurance to the Board in relation to the management of risk across the organisation.

The Audit Committee supports the formal and transparent arrangements for considering how the Board applies the corporate reporting, risk management and internal control principles which are reported through the annual governance statement within the annual report. The Audit Committee is also responsible for maintaining working relationships with the Trust's internal and external auditors.

All business cases are quality impact assessed and risks identified, monitored and mitigated to ensure quality is not affected. Clear sign off of the annual Cost Improvement Programme by the Director of Nursing and Medical Director is essential to ensure quality of care to patients and the work environment for staff is not compromised where savings have been identified these are presented and monitored by the Quality and Safety Committee.

As a Foundation Trust and as part of our Governance Framework the organisation is supported by the Council of Governors who have a statutory duty to hold the Non-Executive Directors to account for the performance of the board and to represent the interests of the Foundation Trust members and the public.

Building Capacity and Capability for improvement

We will build upon developing a culture of continuous improvement and to learn from every opportunity supporting the organisation and its staff to understand our commitment to quality through their development, clear leadership and communication of our ongoing long term commitment.

In order to assist in achieving these goals we will need to build an organisation that understands what quality continuously looks like supported by the delivery of a number of projects and initiatives that engage our staff and patients in improvement opportunities building upon our successful governance structures. Listening to patients is key to our success, understanding their needs and engaging them in the development of services (Co Production) to support a positive patient experience.

We will deliver our strategy through a suite of projects aligned to our strategic objectives and defined quality components Safe, Effective and Experience. We have already commenced work in a number of the initiatives over the past few years and made considerable progress.

Transformation Programme

This Improvement Plan will only be successful if we continue to focus on developing improvement capability throughout our workforce, and recognise, reward and celebrate those that are actively engaged in quality improvement activity. We will build on existing organisational structures and expertise to develop skills, build capacity and create opportunities for shared learning across the wider multi-disciplinary team.

The establishment of transformational projects to support the sustainable delivery of services has enabled the Trust to gain a better understanding of its project management, service improvement and change management delivery

To ensure a consistent approach to delivery of projects the Trust needed to ensure that it adopted a process where all projects were agreed, prioritised and followed standardised project management methodology. This change would ensure successful delivery of existing and future projects against agreed timescales.

The Trust project/ transformation team have now implemented a unified style for the delivery of service improvement / development of projects going forward, and at the very least; made sure that everyone working on the project is clear about their responsibilities, deadlines and objectives. The project managers have also been assigned to each of the transformational projects and project teams and governance structure agreed.

Key to the development of the learning organisation will be developing sustainable long-term partnerships with academic and NHS partners to learn with, and from, other NHS Trusts and international organisations to bring about measurable improvement. This was a specific recommendation made for all NHS organisations, from the Report of the Morecambe Bay Investigation (Kirkup Report).

Overview of Transformational Projects

Project	Aim of Project
Outpatients Transformation	<p>(1) Future capacity requirements</p> <ul style="list-style-type: none">• Calculate the capacity requirements based upon current agreed referral rates, and list size, in order to facilitate a compliant RTT patient pathway delivering first appointment within 10 weeks and then 6 weeks.• Calculate the capacity requirements based upon current agreed follow up rates and list size to see patients within three months of agreed follow up timeline.• From the capacity requirements determine both the appropriate staffing model and hours of operation <p>(2) Future model - future pathways</p> <ul style="list-style-type: none">• Development of a referral and access pathway based on standardised processes across all specialities, to minimise variation.• Ensure that the outpatient booking system optimises utilisation of resources. <p>(3) Assessment of effectiveness of outpatient pathway</p> <ul style="list-style-type: none">• Establishment of regular audit programme outpatient pathway to ensure it continues to be fit for purpose, reviewed against an agreed set of measurements in regards to capacity and utilisation. <p>(4) Improve Outpatient utilisation</p> <ul style="list-style-type: none">• Calculate current outpatient utilisation• Plan an incremental increase in utilisation with set improvement targets with agreed target deadline.• Establish suitable baseline metrics and improvement trajectories for the project, including agreed measures of outpatient clinic utilisation and slot availability.

Project

Aim of Project

Outpatients Follow-up

Areas are to be addressed to ensure adequate service provision for follow up appointments:

- (1) Clearing the Backlog of patients overdue their follow up appointment
- (2) Secure sufficient capacity to address the additional backlog of overdue patients
- (3) Reduction in the monthly shortfall in capacity due to new patients becoming overdue their follow up appointments
- (4) Review clinical protocols to agree 7 Orthopaedic sub-specialty follow up and discharge protocols which introduce alternative models of care inclusive of improved utilisation of AHPs, Virtual clinics and Advice and Guidance services whilst maintaining excellent quality of care in the service provided by March 2017

2017/18 plan for follow up activity based on Capacity and Demand modelling based on new to review ratios.

Pre-Op

Focus on the delivery of the following key objectives:

(1) Future capacity requirements

- Calculate the capacity requirements based upon current agreed referral rates, conversion rates and list size, in order to facilitate a compliant RTT patient pathway
- From the above calculation create a pre-operative pool of patients of 250.
- Embed the process of pre-operative assessment attendance within a minimum period of 4 weeks prior to admission.

(2) Improve pre-op assessment utilisation

- Calculate current pre-op assessment utilisation.
- Plan an incremental increase in utilisation with set improvement targets with agreed target deadline.

(3) Future model - future pathways

- Development of a standard pre-operative and consent pathway based on best practice that is fit for purpose.
- New pathways to ensure that it matches the intensity of the process to the patient's level of fitness and complexity of the procedure.

(4) Assessment of effectiveness of pre-operative assessment pathway

- Establishment of regular audit programme for pre-operative assessment and consent pathway to ensure it continues to be fit for purpose, reviewed against an agreed set of measurements in regards to capacity and utilisation

Theatre

To respond to general increased demand and to increase flexibility to respond to peaks of demand from different sub-specialities subsequently enabling Robert Jones and Agnes Hunt NHS (RJAH) to eliminate the RTT breaches and, develop and sustain core capacity continuously.

Menzies

Supports delivery of increased theatre capacity accommodated within the retained Menzies building with a phased approach. Initially this include relocation of non T & O activity, followed by additional upper limb/day case activity equating to 10 sessions/week (1 theatre), facilitating backfill of the vacated sessions within the main theatres by sessions from virtual theatre and increase in Out of job plan activity.

Demand and Capacity

- To eliminate RTT breaches to within the nationally agreed tolerance of 8%.
- Respond to increased levels of demand.
- Increase flexibility in sub-specialities to respond to peaks of demand.
- Create additional core capacity.
- To make a positive contribution to the sub-speciality service lines.
- To provide effective consultant succession planning.

To increase capacity to sustainable levels across sub specialities



Project

Aim of Project

E-Rostering

Implementation of an e-Rostering system appropriate to the Trusts needs that delivers efficiency savings by releasing more time for staff to deliver higher quality services as well as helping to reduce agency staff spending.

The delivery of intelligent e-Rostering system will provide end-to-end staff management based on one consolidated view of all staff groups and all staff types, whether substantive, bank or agency.

This includes health and care specific Safe Staffing that brings the workforce and patients together in a single view allowing the organisation to better match staffing levels to patient and service user needs, providing control and assurance from bedside to the board.

Measurement and assurance

Robust and ambitious targets will be set for each division to identify progress and success in achieving this improvement plan. There will be a portfolio of projects for which key performance indicators will be agreed in consultation with clinical leaders. These will be linked to our quality goals.

A dashboard will be developed to enable monitoring at the Local Improvement Team level and provide assurance to the Trust Board through the Quality and Safety Committee.

The proposed dashboard will report on four aims of the quality strategy. A standard template will be developed which will incorporate benchmark data and trends in order to facilitate clear communication of the information for the Trust Board, staff, governors, and the public.

Organisational Culture

We will build a culture of safety and improvement through supporting staff to understand simple quality improvement methodologies and how these can be measured over time. We will recruit based on our Trust values to ensure our staff are aligned to the vision of the organisation and possess the necessary skills and leadership qualities we require to deliver our objectives. We will engage with our service users and commissioners to ensure we are delivering the high quality care they expect that meets their needs.

We will ensure that our organisational culture is one which supports quality as a long term priority, ensures there are shared views on how patients and staff should be treated and achieving our aim of an organisation that has a safety culture.

Changing culture is a vital component in changing practice, if staff understand the reasons for change, know what to change and have the permission to change and can measure the outcome then quality can flourish continuously.

The main elements of an organisation with a strong safety culture are:

- Effective leadership
- Positive reinforcement
- Tackling bad behaviours
- Accountability for safety and improvement
- Effective Human Resources practices
- Open communication
- Robust reporting systems with learning
- Highly functioning service, ward and department teams
- Respect for each other and our patients

Organisational Culture

Over the next three years we will develop the organisation's culture by embedding our core values that will support our long term vision to improve the quality of care for our patients.

We will enhance communication between senior leaders and staff through regular engagement sessions including:

- Patient Safety Walkabouts
- Senior Nurse clinical engagement weekly
- Executive Buddy Scheme
- Staff Open Forum led by the Chief Executive

We will ensure professional standards are maintained and respect preserved between all staff members through effective leadership and Human Resources practices, celebrating successes and evidence of expected behaviours, learning from our mistakes in a positive manner and supporting a 'just' culture and addressing bad behaviours and persistent resisters acknowledging that:

'Quality takes precedence over Clinical Autonomy' (Mayo Clinic 2008)

We will continue to promote and support the Trust's robust incident reporting system, further developing the investigation and learning processes across the organisation. We will continue to work with our local and specialist commissioners to support our quality improvement framework through external reviews and the CQUIN programme and we will utilise 'free intelligence' from patient and staff feedback, concerns and external reviews undertaken by the Care Quality Commission (CQC), Royal Colleges and other external bodies as learning opportunities.

Communication and Engagement

We will take every opportunity to use feedback from our patients and users of our services through our Governors, engaging with members, Patient Panel involvement, stakeholders and through feedback opportunities including concerns raised, suggestions, comments, audit, research, external reviews and services reviews. We will use this information to understand the needs of our patients and how they want services to be delivered now and in the future.

The Strategy will be shared both internally and externally with relevant stakeholders for comments and as a completed document including:

- Local Clinical Commissioning Groups
- Local Providers
- Healthwatch England
- Patient Panel
- Community Health Councils (Wales)
- Local Authority via Overview and Scrutiny Committee
- Joint Consultative Group

The Quality Strategy will be promoted to patients, staff and stakeholders using existing communication systems including:

- Patient Safety Walkabouts
- Senior Nurse clinical engagement weekly
- Executive Buddy Scheme
- Staff Open Forum led by the Chief Executive
- Communicate Staff magazine
- Internal and External websites
- Promotion through specific presentations at relevant committees
- Patient Panel

Monitoring

The projects and programmes included in the strategy will be agreed and monitored through the Trust's assurance committees reporting progress as required to the Board of Directors.

The Board of Directors, on a monthly basis, will receive the performance report which includes progress against the quality dashboard and suite of specific quality indicators.

Overview of Measures

Aim	Objective	Measure
Reducing Patient Harm	<ul style="list-style-type: none"> Prevent avoidable deaths Managing the deteriorating patient Ensuring the safe transfer of patients to and from the hospital 	<ul style="list-style-type: none"> Number of unavoidable deaths Number of patients escalated to HDU News Compliance % % compliance with passport for transfer
Reviewing Leadership roles and accountability	<ul style="list-style-type: none"> Divisional structures Performance review process Cultural Behaviour Characteristics 	<ul style="list-style-type: none"> Effective and evaluated performance review process that cascades through the divisional structure. Cultural behaviour characteristics which are embedded into the Rebuilding relationship programme and into the Trust appraisal system
Improving Documentation	<ul style="list-style-type: none"> Audit Process Review of Pathways Improving consistency 	<ul style="list-style-type: none"> 98% compliance with documentation audits. Pathway documentation review programme. Reduction on baseline of incidents relating to documentation.
Providing effective and reliable care	<ul style="list-style-type: none"> 100% Delivery of WHO checklist Implementation of the Sepsis care bundle Continued development of the STAR accreditation process 98% SSI bundle compliance 	<ul style="list-style-type: none"> WHO Audit Compliance Continued roll out and development of the STAR process.
Human Factor Training	<ul style="list-style-type: none"> Year 1 - 50% compliance with HF awareness training in Quarter 3/4 Year 2 - 95% compliance with HF awareness training. Expertise programme developed Year 3 - VR Expertise programme developed and implementation agreed 	<ul style="list-style-type: none"> ESR training records Performance report
Schwartz Round Implementation	<ul style="list-style-type: none"> Year 1 - Process developed and 3 rounds delivered Year 2 - Evaluation of process and monthly rounds agreed Year 3 - Full evaluation of process 	<ul style="list-style-type: none"> Implementation Plan





Strategic Context

NHS

**The Robert Jones and Agnes Hunt
Orthopaedic Hospital**
NHS Foundation Trust

**The Robert Jones and Agnes Hunt
Orthopaedic Hospital NHS Foundation Trust**
Oswestry, Shropshire SY10 7AG
Tel: **01691 404000** / Email: enquiries@rjah.nhs.uk

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