Quality improvement strategy 2015-2020

Safe and compassionate care, every time
Quality Improvement Strategy  
Version 2.0 and Issue number

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<td>Deputy Chief Nurse</td>
</tr>
<tr>
<td>Lead Director:</td>
<td>Chief Nurse and Director of Patient Care Standards</td>
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## Document History

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Quality Strategy 2015-2020

1. Introduction

The Five Year Forward View’s sets out the five year ambitions for quality for the NHS in England. Achieving safe, effective care with a good patient experience occurs when a caring culture, professional commitment and strong leadership are combined to serve patients.

Buckinghamshire Healthcare NHS Trust is an integrated organisation caring for children and adults within community and hospital settings. A key priority for us is to reduce variation across our services and ensure that patients receive safe, compassionate care, every time.

This Quality Strategy outlines how Buckinghamshire Healthcare NHS Trust will ensure that the culture to promote quality and continuously improve the care for our patients is at the heart of everything we do. The strategy also describes the specific quality goals for the organisation, how they will be monitored and reported so that our patients and their families and carers can have confidence in the quality of care we provide.

We aspire to be the best in the country in terms of quality. We want our patients to choose to come to us to receive their healthcare because they have confidence in our reputation for providing high quality services.

This vision will only be realised if we are constantly ambitious and continue to stretch ourselves to achieve excellence.

2. Purpose

All Trust staff have a role to play in ensuring that the quality of care delivered meets the standards our patients expect. Together we form a first line of defence against quality failure.

Organisational culture is crucial to achieving the ambition of delivering high quality care consistently. As Berwick observed “culture will trump rules, standards and control strategies every single time”

The behaviour and actions of an individual member of staff is predominantly shaped by their attitudes. The Trust’s organisational culture emanates from the repeated behaviours of its staff. Similarly both staff attitudes and behaviours are influenced by the prevailing culture at the Trust. This strategy outlines the action the Trust will take to ensure staff attitudes and behaviours, and consequently the Trust’s organisational culture, combine to reinforce each other and constantly promote and enhance the quality of the care provided by each of the Trust’s services.

No system can be 100% failsafe. The presence of such a culture will reduce the likelihood of failures but also ensure that where failures occur and we fall short of the standard of care we expect to provide, this is quickly identified and remedial action is taken promptly to safeguard our patients and deliver rapid improvements. We strive to be an organisation that not only learns when things go wrong but actively seeks potential risk to prevent harm.

1 Five year forward view (Oct 2014)
We will maximise the benefits of our integrated status to prevent harm and promote wellbeing.

This strategy outlines how the Trust ensures that when failure is encountered, not only is it rectified, but failure is investigated and examined so that its root causes can be identified, lessons learned, and action taken to prevent similar failures from recurring. This strategy also explains how lessons learned are shared across the Trust, so that relevant best practice can be adapted and implemented across the organisation.

Underpinning this culture will be a set of quality objectives and deliverables which will enhance the quality of service provided by the Trust.

- All staff across Buckinghamshire Healthcare Trust are responsible and accountable for the quality of services they provide to our patients. All staff will comply with identified quality standards and requirements as set out in national, professional or Trust policies, procedures and guidelines.

- All staff are responsible for ensuring that they maintain their professional competencies, skills and knowledge. All staff must satisfy any professional training and development requirements that are required either by the Trust or any external professional bodies.

- All staff will report on Datix any patient safety incident they witness. Patient safety incidents are events or circumstances that could have resulted, or did result in unnecessary harm or damage such as physical or mental injury. The Trust Board is committed to ensuring the organisation learns from incidents and near misses. The Board understands that Management cannot act to reduce the risk of similar incidents recurring if it is not informed of them. The Trust Board recognises that staff must feel that they can safely report incidents without fear of blame or retribution. The Board is committed to fostering such an environment that supports learning by maintaining a positive culture that does not blame staff who report incidents or seek reprisals against incident reporters. All staff can therefore be assured that they will not be blamed for the incidents they report, and that management will take incident reports seriously and investigate them in order to identify their root causes and take appropriate action.

- Where staff become aware of something that raises serious concerns about unlawful conduct, misconduct, financial malpractice, fraud or dangers to public, staff, patients or the environment, they should formally raise these serious concerns in line with the procedure outlined in the Raising Concerns at Work (Whistle blowing) Policy. These concerns will be formally investigated and responded to in line with the process stipulated in this policy. When staff raise concerns in line with the Raising Concerns at Work (Whistle blowing) Policy, they are protected from workplace reprisals by the Public Interest Disclosure Act (1998).

The people strategy will support individuals to ensure they have adequate support, encouragement and training to fulfil their responsibilities outlined above.
3. What is ‘quality’?

The Health and Social Care Act 2012 enshrined Lord Darzi’s definition of quality into legislation. Quality is comprised of three dimensions; clinical effectiveness, safety and patient experience.

**Clinical effectiveness** – high quality healthcare is care that is delivered in accordance with the best and most up to date evidence as to what is clinically effective in improving patients’ health outcomes.

**Safety** – high quality healthcare also has to be safe in so much as it must be delivered in such a way as to avoid all avoidable harm through the management of risks to the patient’s health.

**Patient experience** – high quality healthcare also gives individual patients and their carers a positive experience of receiving and recovering from their care. Such care must be delivered in accordance with what the patient wants or needs, and with compassion, dignity and respect.

4. Embedding Quality into the annual business planning cycle

The Trust’s business planning cycle ensures that quality is considered alongside financial matters in the development of the Trust’s annual business plan at the end of each financial year. This ensures that quality considerations are treated as equally important as financial considerations. Internal and external quality drivers such as the NHS Operating Framework, national quality requirements contained with the Standard Acute Contract, and CQUINs combine with locally determined quality requirements such as service developments within the local health economy as well as locally negotiated quality requirements and CQUINs. These quality drivers interact with local and national financial concerns such as changes to the tariff and locally agreed QIPP schemes to shape and inform the development of the Trust’s annual business plan.

This process ensures that the culture of the organisation remains focused on quality and the delivery of several quality outputs that are integral to the Trust’s annual business plan. These include:

1. Corporate objectives underpinned by key quality deliverables and milestone for inclusion in the Board Assurance Framework
2. The identification of specific quality objectives, key performance indicators, and the minimum accepted standards of quality for inclusion in the Quality Accounts and each Division’s annual business plan and internal Performance Contract
3. Signed SLA contract with the Trust’s Commissioners identifying the national quality requirements and CQUINs as well as the locally negotiated quality requirements and CQUINs.
4. Joint QIPP plans (including objectives, milestones and metrics) to be implemented by the Trust in conjunction with the Commissioners in order to improve the quality of services provided by the NHS across the local health economy.
5. We will drive quality through our integrated status to keep people well and at home wherever possible.

4.1 Accounting for quality at Buckinghamshire Healthcare Trust

In order to assure the public and our commissioners that Buckinghamshire Healthcare Trust provides high quality healthcare, we will publish an annual Quality Account to detail the Trust’s achievement against the quality objectives. This will help patients make informed choices about where they receive their care and in doing so they will be able to hold the Trust Board to account for the quality of care we provide.
The Trust Board will involve patients and commissioners in the development of the annual Quality Accounts. This process will include the evaluation of the existing quality objectives and the development of new quality objectives for inclusion in the quality accounts and the coming financial year. The Trust Board will also review this quality strategy annually alongside the development of the quality accounts. This will enable the quality objectives and metrics for coming years to be constantly refreshed in order to stretch the Trust and in so doing enable it to realise the ambition to compete on quality with the leading healthcare providers.

4.2 Capacity and capability to improve

5.2.1 Approach to quality improvement
Our approach to quality improvement is based on the Institute of Healthcare Improvement Model for Improvement. We will embed the use of this model through our collaborative programme which develops change packages for implementation across the organisation and in our rapid improvement projects.

In 2015/16 we will run
- Spread phase of the deteriorating patient collaborative
- Initial phase of a falls and a discharge collaborative

The People Strategy describes how we will develop the organisation into a great place to work where
- We will attract and retain high calibre people
- Everyone understands their role and is engaged in delivering our vision and living our values
- Every member of staff receives the performance coaching, support, feedback, and appreciation they need to give their best.
- We consistently deliver safe and compassionate care, every time.

Through our in house training programmes we will train 500 staff a year on the Model for Improvement to ensure that we are building sustainable capacity and capability to improve.

4.2.2 Academic Health Sciences Network
The Oxford Academic Health Science Network brings together the NHS, universities, business, patients and the public to promote best health for our population and prosperity for our region.

It facilitates the breaking down of traditional organisational boundaries and building stronger relationships between industries, scientific and academic communities – coupled with better knowledge exchange – will bring lasting benefits as best practice is spread quickly and widely across the NHS.

As members of the Network we are engaged in the following work streams to reduce:
- Pressure ulcers
- Falls
- High risk medication errors

4.2.3 Sign Up to safety
Sign Up to safety is a national campaign to reduce avoidable harm by half and save 6000 lives over the next three years. BHT has committed to make its contribution by pledging to
• **Put safety first** by reducing avoidable harm from falls, pressure ulcers and medication errors and by improving our response to deteriorating patients.

• **Continually learn** by spreading quality improvement skills through our breakthrough collaboratives; implementing evidence based care bundles; sharing learning from incidents across the organisation; using patient feedback to address concerns and celebrate success.

• **Honesty** by informing patients and carers when we get things wrong and involve them in all stages of our investigations; apologising when we do not get things right and support staff in being open and honest.

• **Collaborate** by including all partners in care in our service improvements, engaging with patients, the public and our staff on the future shape of our services for example our strategy for Wycombe Hospital, sharing learning with our commissioners.

• **Support** by developing strong clinical governance systems in our Divisions; ensuring staff have access to timely information to inform their decisions; training staff to carry out good investigations when we get things wrong; celebrating success at all levels of the organisation.

Through signing up to the campaign our business case was successful in securing £526,000 from the NHS Litigation Authority to support our falls reduction work.

### 5.0 Our five year goals

*National patient safety priorities*

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<th>Measurement</th>
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<td><strong>Other major sources of death and severe harm</strong></td>
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Our five year goals to be achieved by 2020:-

*All specialities will have a CQC rating of at least good or outstanding.*
Maximise our integrated status to improve outcomes and experience for patients

Reducing Mortality

- We will have a rolling sustained HSMR of below 98.8
- We will have reduced the number of people admitted to hospital within the last 24 hours of life
- We will have increased the number of patients who die in their place of choice
- We will have implemented a care bundle approach for agreed conditions to ensure that all patients receive all elements of best practice

Reducing harm

- We will have zero never events
- There will be zero avoidable cares of C Difficile or MRSA
- At least 95% of patients cared for by the Trust will have harm free care as measured by the safety thermometer against pressure ulcers, falls, VTE or catheter acquired infections
- There will be zero harm resulting from medication errors

Patient experience

- All patients will report that they are partners in their care.
- Patients will recommend our services to their friends and family

Patient engagement

- We will build on the successful engagement initiatives 2014/2015 which have helped shape and improve services
- We will continue work in partnership with patients and co design new models of care

6.0 Quality Objectives 2015/16

The Trust Board has agreed three strategic priorities in relation to quality

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These were first described in the 2013-2015 Quality Strategy and remain priorities for the Trust.

6.1 Priority 1 Reducing mortality

Quality Improvement Strategy/ BHTS027/Version 2.0 & Issue No 1
Final
May 2015
In 2013 Buckinghamshire Healthcare Trust was identified as one of the trusts which had a higher than expected mortality, as measured by the HSMR, for three consecutive years. A challenging Quality Improvement Plan was put in place and delivered and as a result the HSMR was been within the expected range. Despite this assurance the Board wish to reduce the mortality further as a measure of the quality of care for our patients’. A proactive approach where we seek understanding in any variation and continually strive for improvement.

6.1.1. Care Bundles
Developing Care bundles are a means of ensuring that every patient gets the same standard of care every time. The principle is to define the evidence based pathway of care as a series of steps, preferably with time scales attached.
In 2014/15 we introduced three care bundles along the urgent care pathway – sepsis, acute kidney injury and community acquired pneumonia.
In 2015/16 Sepsis and Acute Kidney Injury are part of the national CQUINs.

Acute Kidney Injury (AKI)
This CQUIN aims to improve the follow up and recovery of individuals who have sustained AKI, reducing the risk of readmission, re-establishing medication for other long term conditions and improving follow up of episodes of AKI to reduce the long term cardiovascular risk.

Sepsis
The Sepsis CQUIN required all appropriate patients to be screened for sepsis and ensure antibiotics are administered within an hour for all those who have suspected severe sepsis, red Flag Sepsis or septic shock.
During 2015/16 we will be working to improve our performance against these measures.

6.1.2 Deteriorating patient
In addition to the interventions aimed at improving the level of Harm Free Care as measured on the Safety Thermometer, the Trust is committed to achieving the elimination of all avoidable cardiac arrests (i.e. excluding those occurring in critical care areas). The Deteriorating Patient Collaborative focuses on the identification of deteriorating patients, appropriate referral and timely management in order to prevent cardiac arrests. This project will also oversee the introduction of treatment escalation plans to identify patients who would not benefit from resuscitation attempts, so that ceilings of care can be established in order to, where suitable, provide compassion and safeguard patient dignity.

The Trust’s performance against each of the Deteriorating Patient KPIs are reviewed at the Mortality Reduction Group and reported to the Quality and Safety Group on a monthly basis.

6.1.3 Mortality reviews
One of the ways of reducing mortality is to screen each death for whether it was expected or not and then for each unexpected death do a clinical review to identify any sub-optimal care. Actions can them be identified to ensure such care does not recur.

In 2014/15 we have been carrying out mortality reviews. However our goal is to reach a state where all deaths are reviewed within three months of the death occurring. More importantly learning from the reviews will inform the mortality reduction strategy.
In addition we will work to link the process of sharing learning with our Serious Incident process to ensure the lessons are linked and shared widely.

6.1.4 **Proactively analysing information**

The quality of information on mortality in hospitals is improving with access to rolling 12 month HSMRs, monthly HSMRs, CUSUM charts etc.

We are committed to monitoring our mortality monthly, identifying areas where we could do better and carrying out clinical reviews of these areas.

6.1.5 **Improving the recording of our patients risk factors**

Key to identification of patients who have had sub-optimal care is the accurate recording of co-morbidities and expectations of care. In addition the transfer of this information to primary care makes the ongoing treatment of the patient safer and reduces the risk of readmission.

We are committed to improving the recording of co-morbidities; identifying all patients at the end of life within 24 hours of admission; fully implementing electronic discharge to communicate this information to GPs.

6.2 **Priority 2 - Reducing harm**

Hospital care in the UK is associated with approximately 10% incidence of avoidable harm resulting in requiring further monitoring, treatment or care and very occasionally, even patient deaths. The Safety Thermometer is used nationally to benchmark harm caused to patients in terms of hospital acquired pressure ulcers, venous thrombo-embolism (VTE), catheter associated urinary tract infections and falls. The metric that is used to benchmark quality performance is the percentages of patients who do not suffer any of these harm events and thereby receive ‘harm free care’. National performance is currently approximately 93%. Buckinghamshire Healthcare Trust is committed to achieving a harm free care rate of at least 95% from the end of 2015/16 onwards.

It is unacceptable that any patient who chooses to receive care from Buckinghamshire Healthcare Trust should be harmed in any way. One of our quality priorities therefore is to aspire to eliminate incidence of avoidable harm and injury to our patients and to ensure there is a continual reduction in harm suffered by our patients.

As part of our commitment to Sign Up to Safety the Trust has published a Safety Improvement Plan.

6.2.1 **Hospital Acquired Pressure Ulcers**

In 2014/15 the Trust launched a 2 year Pressure Ulcer Reduction programme to reduce the number of grade 3 and grade 4 healthcare acquired pressure ulcers by 50%. We have a zero tolerance approach to avoidable healthcare acquired pressure ulcers supported by a skin care bundle (SSKIN), training and competency assessments. All pressure ulcer incidents will continue to be reported to the Patient safety Group (PSG) so that Trust wide performance against the trajectory can be monitored. All healthcare acquired grade 3 and grade 4 pressure ulcers will continue to be routinely subject to root cause analysis investigations in order to learn from them and to determine whether they meet the European Pressure Ulcer Advisory Panel’s definition of a preventable pressure ulcer.

6.2.2 **Venous Thrombi-embolism (VTE)**
The Trust is committed to eliminating preventable hospital acquired VTEs (Deep Vein Thrombosis and Pulmonary Embolism). In order to support the achievement of this ambition;

1. A minimum of 95% of all admitted patients will undergo a VTE risk assessment and where necessary receive the appropriate prophylaxis.
2. 100% of patients who develop a new VTE will undergo a root cause analysis.

6.2.3 **Patient Falls**

In addition to the Trust’s efforts to reduce the level of harm caused by falls as measured by the Safety Thermometer, the Trust has launched a falls collaborative with the focus of reducing harm from falls in hospital. The Falls Steering Group will continue working on reducing the harm from falls, building on our past improvements, most notably on the implementation of the Fall Safe care bundle on wards 1&2. Our ambition is to reduce falls per 1000 bed days by 25% from the 2014/15 baseline.

In 2015 we were awarded £526,000 from the NHSLA as part of the Sign up to Safety Campaign to support us in making environmental changes which would reduce the incidence of falls.

In the community we will build on the launch of a new community Falls and Bone Health service which aims to empower patients to reduce their risk of harm through falls by providing assessment, treatment, exercise programmes and activities of daily living advice.

The Trust is a member of the Oxford Academic Health Sciences Network on falls.

6.2.4 **Medication errors**

Medications are the most common intervention in healthcare but are also most commonly associated with adverse events in hospitalised patients. At least 20% of all harm is associated with medication errors. High alert medications are more likely to be associated with harm than other medications as they cause harm more commonly, the harm they produce is likely to be more serious and they have the highest risk of causing injury even when used correctly. Medications responsible for the majority of harm are insulin, anticoagulants, opiates and sedatives.

The aim in 2015/16 is to increase reporting of medication errors. There is evidence nationally that not all medication errors are reported to Trust safety teams, however without the recording of errors we will not have a full picture of the risks and the improvements we need to make.

The second aim is to decrease harm by focussing on high risk medicines. These include Insulin, warfarin, low molecular weight heparins, narcotics and sedatives.

The US Department of Health and Human Services\(^2\) published a guide to reducing harm from high-alert medications. They identified the following harm reduction strategies:

- Awareness and education
- Standardised care processes
- Errors at transition of care
- Decision support
- Smart use of technology

\(^2\) Implementation guide to reducing harm from high-alert medications [www.hret-hen.org](http://www.hret-hen.org)
The Medication Error Reduction Group will review each high risk medication and devise an appropriate action plan.

The Trust is a member of the Oxford Academic Health Sciences Network on medication errors.

6.2.5 Safeguarding children and adults

We will continue to ensure that we protect children and adults from harm working in partnership with other healthcare providers, social services and the police. The safeguarding assurance framework will monitor our effectiveness and external peer reviews of our safeguarding practice and processes will identify best practice and areas for improvement.

6.2.6 Children’s health and well being

Support in the early years will be a key focus working with our health visitors and children’s community services. National key performance indicators will monitor our improvement journey and drive best practice.

6.2.7 Monitoring quality performance

The implementation of the Quality Strategy to reduce harm caused by VTE, medication errors, falls and pressure ulcers will be monitored by the Patient Safety Group which meets monthly and reports to the Quality Committee.

The performance and effectiveness of the VTE, medication errors, falls and pressure ulcer work streams at increasing the percentage of patients who receive harm free care will be measured by way of the Trust’s Safety Thermometer performance and the agreed KPIs incorporated into the Quality Dashboard. Safety Thermometer data is collected monthly and is reported to the Trust Board through the Quality Report. The Trust’s Safety Thermometer performance is benchmarked nationally on the NTDA Quality Dashboard will be reported to the Quality Committee for triangulation with the monthly Patient Safety Group reports for more detailed scrutiny.

6.2.8 Incident Reporting and learning

Central to the Trust achieving the aspiration to continually reduce harm is its ability to analyse and learn from its mistakes so that the risk of harm can be reduced in the future. In order to do this it is essential the Trust has a strong incident reporting and learning culture. Therefore, the Trust aspires to exceed the national median for incidents reported per 100 admissions by March 2014, and subsequently aspires to remain at the top quartile of medium acute trusts.

In order to achieve this, the Trust Board will promote a culture that encourages incident reporting and does not blame or pursue reprisals against members of staff who report incidents.

The Trust is committed to delivering a continual reduction in patient harm. The Trust aspires to deliver a continual reduction in the proportion of patient safety incidents that result in death, permanent severe or moderate harm, in comparison to the proportion of incidents that are near misses, result in no or minor harm. In order to ensure that a high incident reporting rate is indicative of a strong incident reporting culture, rather than a deterioration in the quality of our services, the level of harm caused by our incidents will be reviewed against national benchmarks. Where the Trust appears as an outlier and we are reporting a higher percentage of incidents that result in moderate, severe or catastrophic harm, this will be investigated by the Quality Committee and remedial action plans implemented and monitored.
The timeliness of incident investigations is crucial to being able to take meaningful action to reduce the risk of harm to future patients. Furthermore when managers act swiftly in response to incident reports, it demonstrates to staff that incident reports are important and taken seriously as opportunities to learn and improve. By the end of 2015/16 the Trust aspires to meet the national median for average length of time taken to investigate incidents and upload them to the NRLS.

The Trust will also promote feedback from investigations to incident reporters by integrating this process into the performance management framework and increasing attention and scrutiny of this process. The Trust will continue to develop effective mechanisms for communicating lessons learnt from incident investigations to frontline staff.

Performance against these incident reporting objectives will be monitored at the Quality Committee when the bi-annual NRLS Feedback Report is reviewed.

6.2.9 Patients participating in their own safety
A key element of safety coming out of the Francis Report is that organisations should work to empower patients to be partners in their own safety. Buckinghamshire Healthcare Trust is committed to this principle. Each of our Reducing Harm work streams will have clearly identified actions to support patients in managing their own safety. In addition we will work closely with the Sign Up to Safety campaign work stream to ensure best practice is implemented.

7. Great patient experience and engagement
In order to improve the patient experience, the Trust will aim to enhance the culture of the organisation by re-focusing attention on identifying and responding to our patient’s needs and desires. To support this ambition, the Trust will also endeavour to improve communication between the Trust and our patients, their careers and their families so that we are better able to tailor the care we provide to the individual needs of our patients.

The executive lead for patient experience is the Chief Nurse.

The NHS Mandate sets out an ambition for the NHS in England that the experiences people have of our health and care services become amongst the best in the world. In 2015/16 we will develop a patient experience and engagement strategy that will communicate to our staff and patients how we will deliver our contribution to this ambition. Improving our experiences of care: Our Shared Understanding and Ambition was published by the National Quality Board in 2015 and describes how patient experience can be understood in two ways:

- What the person experiences when they receive treatment or care
- How that made them feel

It begins at the first contact with a service and carries through to the last.

We believe that a great patient experience is important for the way it makes people feel but also because evidence shows it improves outcomes, ensures we are delivering value for money. A focus on patient experience encourages staff to engage with patients, making them active partners in their care. The implementation of the Trust’s 2015/16 Patient Experience Strategy will be overseen by the Deputy Director of Nursing and reported to the Quality Committee for monitoring on behalf of the Trust Board.

The Trust’s corporate performance with regards to responding to complaints will be reported quarterly to the Trust’s Quality Committee. Furthermore individual Division formal complaint response performance will be monitored on a monthly basis at the Division Performance Meetings.

The principal metrics for measuring the impact and effectiveness of these improvements on the patient experience will be the Friends and Family Test. The Trust expects that the
combined impact of the 2013/14 Patient Experience Strategy will increase participation in the Friends and Family Test as well as increase the proportion of patients who say they are ‘extremely likely’ to recommend either our wards or A&E department to a friend or family member if they needed similar care or treatment. This figure will be routinely reported to the Trust Board so they can be assured that the 2015/16 Patient Experience Strategy is actually translating into genuine improvements as felt by our patients across the Trust.

The Trust will also review the findings of the 2015/16 national inpatient, outpatient and cancer surveys in order to assure itself of the efficacy of the Patient Experience Strategy. Where survey results can be triangulated to identify specific problems with the patient experience, further action will be taken in response to address any disappointing patient survey results.

**Patient Engagement**

The extensive patient engagement initiatives of 204/15 will continue to shape and inform future service provision. Listening events, co design of new models of care and a well represented and powerful patient experience group will ensure patient engagement and involvement is central to our improvement journey.

7.1 **Communication**

Capturing and acting on the opinions and experiences of our patients is critical to ensuring our patients constantly receive a positive experience. We have engaged our patients in helping to shape several services through the ‘Listening to our patient’s voice’ initiative, using this opportunity to improve communication with our patients, their carers and their families so that our services can be more responsive to their needs, preferences and ideas.

In order to achieve this ambition, the Trust has in place the Patient Advice and Liaison Service which provides patients with the ability to submit questions, concerns, complaints or problems regarding our services.

The Trust has a Patient Information Group in order to help craft the Trust’s communications with our patients as well as assist in the design of patient information leaflets and local public health information campaigns.

The Trust’s Volunteer Strategy will see the number of volunteers at the Trust increase. These volunteers provide vital support to the Trust and greatly enhance the patient experience by meeting and greeting patients, assisting with directing patients and their families to the right ward and department, and where appropriate, assisting patients with eating and drinking as well as keeping them company and supporting them during their stay with us.

Central to the success of these initiatives will be the engagement and involvement of our patients in their evaluation and future quality initiatives. To this end, the Trust hopes to increase patient engagement and involvement by holding a number of targeted community events that will target a comprehensive range of the communities that use our services, with particular efforts made to engage with local hard to reach and vulnerable groups.

The Trust will ensure patients who wish to complain about the care they have received are supported to do so. Our PALS service will support patients who have informal complaints that the Trust should be able to act on and resolve immediately. Those patients whose complaints are more complicated will be supported to submit formal complaints for thorough investigation and formal response from the Chief Executive.

We know from feedback that 85% of our complainants feel that the response to their complaint addresses the matters raised. However only 61% of patients were satisfied with the response they received.
During 2014/15 we worked with our buddy trust Salford Royal NHS Foundation Trust to review our process and identify steps to improve it. In 2015/16 we will deliver the steps identified to improve the response and of equal importance the quality of the response.

7.2 Service Improvement Initiatives

7.2.1 Care plans
In 2014/15 we ensured that all of our services were using care plans to organise are for individual patients. In 2015/16 we will build on this work to ensure that care plans reflect the individual, their needs and how they wish those to be met. We will also review care planning in our short stay areas and develop documentation specifically designed to support those patients.

7.2.2 End of life
Five new Priorities for Care have replaced the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. The new approach recognises that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life.

The new Priorities for Care mean that:

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected.
- Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

The aim is to promote a stronger culture of compassion in the NHS and social care – one that puts people and their families at the centre of decisions about their treatment and care.

We have reviewed our end of life pathway and worked with patients and staff to develop new ways of working which reflect these priorities.
In 2015/16 we will roll out care plans and treatment escalation plans to ensure the patient is involved at all stages of decision making.

7.2.3 Children’s outpatients
The majority of children seen in an outpatient setting are seen in paediatric outpatients or in paediatric clinics in an adult setting. However an audit in February 2015 identified that a number of children are seen in adult clinics across the Trust. In 2015/16 we will assess those clinics against the Your Welcome standards and put in place actions plans as appropriate to improve the experience of these children.

7.3.4 Safe discharge

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The introduction of the SAFER patient flow care bundle across all adult wards will improve patient flow and prevent any unnecessary waiting for patients. The ultimate aim is to improve the patients’ journey and experience when they are admitted to one of our hospitals.

The initiatives summarised below are in addition to key service transformation programmes: reforming urgent care, reforming elective care and reforming integrated care.

7.3 Culture for Quality Improvement
With the increasing complexity of modern health care, high quality care is less a product of one to one patient/clinician interactions and more the outcome of multiple decisions and interventions across many care settings and teams.

Building foundations for improvement states that it is no longer enough for clinicians to be equipped with specialist clinical knowledge: they also have to have the knowledge and skills necessary to improve the quality of care and to work safely and effectively as part of a team. We are committed to building a critical mass of staff able to understand and use formal quality improvement methodology and tools. In 2015/16 we will train 500 staff in quality improvement methodology.

Of equal importance is the continued development of a learning culture. During 2014/15 staff reported that they felt more confident is raising issues when care was not as good as it could be. However our staff survey showed that we have still some way to go before we are among the top 20% in the country.

In 2015/16 we will continue our clinical leadership initiatives including executive walkabouts, Quality and Safety Peer Review programme, and clinical days for senior clinical managers. In addition we will continue the development of a nursing leadership framework.

We will continue the Board development programme to ensure that Board members have the skills and knowledge to ensure delivery of the quality agenda. As an integrated hospital and community trust we will develop our quality dashboards to allow transparency both at service level and across integrated pathways.

8. Quality Governance

8.1 Trust Board
Quality is central to the Trust Board agenda. Each month the Trust Board reviews a Quality Report and an Integrated Performance Report. This outlines the Trust’s performance against the quality indicators above aligned to national quality KPIs as well as locally negotiated and internally generated quality indicators. Of particular importance is the HSMR which gives an indication of whether the mortality ratio of the Trust is as expected, higher than expected or lower than expected when compared to the national baseline. This quality report is reported alongside other performance reports including financial and workforce so that quality performance can be triangulated and considered alongside other relevant corporate information.

Each quarter the Trust Board will review the Board Assurance Framework. This will include any significant risks to quality and outline the controls in place to manage the risks and the assurances that evidence the efficacy of those controls. Where there are gaps in control or assurance, these are identified along with details of action plan to close any such gaps in control or assurance. This will enable the Non-executive Directors to hold the Executive Directors to account for the management of risks to quality across the Trust.
At the end of the year, the Trust Board will review the Trust’s performance against each of its quality objectives prior to this being included in the Quality Accounts and Annual Report for the year. Underpinning this Quality strategy is a delivery programme in the form of the Quality Improvement Plan with deliverables and measures for 2015/16. (See appendix 1).

8.2 **Quality Committee**

The Trust Board is supported by the Quality Committee which is chaired by a non-executive director and enables more robust scrutiny of the Trust’s quality performance. The committee will meet bi-monthly and the non-executive director chair of the committee provides a formal report to Trust Board to assure the Board of the effectiveness of the committee.

The Quality Committee will review the corporate risk register to ensure that risks to the delivery of this strategy and the provision of high quality services are identified and robustly managed. Where risk assessments arising from quality improvement initiatives or proposed QIPP plans identify early warning indicators that point to a deterioration in the quality of services provided, these early warnings will be monitored at the Quality Committee. Where such early warning indicators demonstrate the need for remedial action, the implementation of such remedial action plans to restore high quality services will be monitored at the Quality Committee.

The Quality Committee will also monitor the Trust’s plans for mitigating risks to quality associated with financial and operational initiatives (such as major service changes or cost improvement plans) whilst ensuring the standards of clinical care are maintained.

The Quality Committee will oversee the development and implementation of the Quality Strategy, associated policies and action plans. The Quality Committee will also seek assurance on the Trust’s arrangements for engaging patients, staff and other key stakeholders on quality.

8.3 **Divisions**

Beneath the Trust Board level, quality performance is an integral component of the Trust’s Performance Management Framework. This ensures transparency and that accountability for achievement of quality objectives is maintained throughout the organisation up to the Trust Board.

Each Division has committed to deliver locally defined quality objectives which are stipulated on the Divisional Business Plans. Each of these objectives are aligned to national policy or local patient needs and requirements. For each of these quality objectives there is a trajectory and performance against this trajectory is monitored and formally reported at the monthly Division Performance meetings.

The Division Performance reports feed in to the Trust Board Integrated Performance Report which is reviewed at Trust Board.

Risks to quality will be managed in line with the process stipulated in the Corporate Risk Management Strategy. Local risks to quality will be captured on the Division risk registers and the Division Management Teams’ reviews and implementation of risk reduction action plans will be monitored by the Director of Finance and Performance at the monthly Division Performance Meetings.

In addition, for additional quality assurance, the Quality Committee reviews the Trust’s NTDA Quality Dashboard which benchmarks the Trust’s performance against a broad spectrum of quality indicators and compares this to national performance levels.

8.4 **Quality performance data quality and information governance**

From 2015/16 the Trust will continue with the implementation of the Information Governance Strategy including the delivery of the replacement Patient Administration System (PAS) and
maintain progress towards the roll out of a Trust-wide Electronic Patient Records (EPR) system.

The Trust Board will assure itself that the data and information it uses to inform decisions relating to quality is robust and valid. In order to achieve this, the Trust Board will commission regular ward and departmental visits for the Trust’s Governors so they can meet with patients and staff in order to assess the quality of care as experienced by our frontline staff and our patients. This will ensure that the Board is assured that the measures of quality that are routinely reported to the Board accurately reflect the quality of care as delivered to our patients.

The Trust Board will review how quality indicators are collected, checked and reported so that the Board is assured of each of the six dimensions of data quality for the quality metrics and performance indicators.

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<th>The six dimensions of data quality</th>
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Each year at least two of the quality metrics used by the Trust will be subject to external audit in order to provide external assurance to the Trust Board that the selected quality indicators are robust and reliable. The findings of this external audit will be reported in the Trust’s Quality Accounts.

8.5 Working with partners to enhance quality across the local health economy

The Trust recognises that it does not operate in isolation and works as part of a wider health economy that seeks to effectively and efficiently meet the healthcare needs of the local population. Continued focus on strengthening relationships with social care and the voluntary sector will be crucial to success. In order to do this, each year the Trust will agree a series of increasingly demanding quality objectives with its commissioners. This will ensure that continuous improvements in quality are made that are tailored to meet the changing needs of our patients and responsive to their experiences of the care they have received.

8.6 Local quality objectives governance

Each of the local quality objectives agreed with the Commissioners has been aligned with the Trust’s Performance Management Framework. This enables the Trust Executive to scrutinise
the achievement of each of these local objectives via the monthly Division Performance Meeting. Each of these objectives has been integrated into the Qlikview Performance Management Dashboards. This will ensure that robust monitoring of the delivery of these objectives is in place so that clear accountability can be maintained.

Furthermore, the Trust’s Commissioners will review the achievement of each local quality objective in order to ensure that the Trust has delivered each quality objective. Where the Commissioners are not satisfied that an agreed objective has been delivered, an action plan will be agreed between the Trust and the Commissioners in order to ensure the achievement of the quality objective. This external review process will occur at the Trust’s monthly Clinical Quality Review Meeting with the Commissioners.

8.7 CQUINS Governance

The Trust will provide the Commissioners with draft performance figures for delivery against each of the national and locally agreed CQUINs in line with the schedule outlined in the Standard Contract. These figures will be reviewed and agreed by both the Trust and Commissioners and formally reported to the Clinical Quality Review Meeting between the Trust and the Commissioners. Where the Trust meets the CQUINs requirements, CQUIN payments will be made to the Trust in line with the proportions and schedule outlined in the contract. If the Trust fails to deliver against any of the CQUINs, the proportion of CQUINs monies identified in the contract will be withheld from the Trust.

Once agreed with the Commissioners, performance against the CQUINs will also be reported to the Trust Board on a quarterly basis.

9. Dissemination and Implementation

The Quality Strategy will be proactively promoted and launched to ensure there is widespread awareness and staff engagement with it. The strategy will be cascaded to front line staff so they are informed of:

- The quality focused organisational culture that the Trust Board seeks to enhance in the coming years, and the roles and responsibilities for staff, managers and executives to support this.
- The quality aspirations and specific objectives that the Trust will deliver to further enhance the quality of services across the Trust in the coming years.

The Quality Strategy will be published on the Trust’s website following its approval by Trust Board so that it can be accessed by our patients and the public. In addition the Quality Strategy will be shared with our Commissioners to evidence how we expect to achieve the objectives we set out in our Quality Accounts.

The implementation of the Quality Strategy each year will also be accompanied with an internal communication campaign so that all staff are aware of it, the key messages concerning quality and our objectives for this financial year. The Strategy itself will also be made available in the Trust Policy and Documents section of the Intranet.

Each of the Trust’s priority quality objectives will have individual action plans with identified leads and key milestones identified. The implementation of these action plans will be reported and monitored in line with the governance arrangements specified for each individual set of quality objectives as outlined in section 6.7 Quality Governance.

10 Process for Monitoring Compliance and Effectiveness

The Trust’s achievement of the quality objectives outlined in the Quality Strategy will be formally reported to the Trust Board at the end of each financial year and this will subsequently be included in our annual Quality Accounts and the Trust’s Annual Report.

Performance against these quality objectives will also inform the choice of quality objectives and metrics for the following year.
The annual quality key deliverables and metrics will be formally reviewed and approved each year in order to refresh the performance management framework and include the new quality objectives for the coming financial year.

11 References


Appendix 1

Duties

*The Board*

- The Trust Board is collectively responsible and accountable for the quality of the services provided to patients by the Trust and for ensuring that the risks to quality are proactively managed.

- The Trust Board is collectively responsible and accountable for the culture of the organisation and for ensuring that the views and experiences of patients and staff are taken into consideration in shaping the decision making of the Trust.

- The Trust Board will foster a sense of ambition across the Trust, in order to give staff the confidence to achieve excellence and high quality care as well as recognise, highlight and respond to whenever the Trust fails to deliver on this ambition.

- The Trust Board is responsible for ensuring that the Trust works with its partners and stakeholders across the local health economy to deliver a quality strategy that is aligned to meeting the needs of local patients and other stakeholders.

*Non-executive Directors*

- Non-executive Directors are accountable for scrutinising the services provided by the Trust and assuring themselves of the quality. They should challenge the assurances received from the Executive Directors.

- In order to make an informed decision about the quality of services provided by the Trust, where Non-executive Directors do not have sufficient information, or information that is sufficiently robust, this must be brought to the attention of the Executive Directors who will furnish them with such information prior to such decisions being taken.

- Non-executive Directors must ensure that their scrutiny of quality performance is at least as robust as their scrutiny of the financial stewardship of the Trust.

*Executive Directors/ Trust Management Committee*

- The Executive Directors are responsible for promoting a culture that focuses attention on quality of care and continuous improvement of that quality, giving it parity with the importance of financial performance.
Executive Directors will lead by example and conduct themselves in accordance with the behaviours that are to be promoted across the Trust, namely, striving for continuous improvements in quality and a willingness to seek out and act in response to poor quality.

Executive Directors are responsible for the achievement of the Trust’s Quality objectives and for maintaining robust quality governance that provides assurance to the Board.

Executive Directors are responsible for holding management to account for the delivery of high quality services across the Trust. Where management fails in this respect, Executive Directors are responsible for ensuring robust remedial actions are identified, agreed and implemented within appropriate timeframes.

Executive Directors are responsible for providing an environment and the resources that enable management to ensure that all staff receive suitable education and training opportunities so they can maintain professional competencies and keep up-to-date with best practice.

Executive Directors are responsible for ensuring that all Service Improvement initiatives and QIPP schemes are risk assessed to ensure that risks to quality are identified and effectively managed so that quality is not compromised by any new business proposal. Where possible, these risk assessments will include the identification of early warning quality indicators that would quickly and safely identify any negative impact on quality caused by QIPP plans or service improvement initiatives.

Executive Directors are responsible for furnishing the Non-executive Directors with robust information that accurately reflects the quality of services provided by the Trust.

Clinical Leaders and Managers (E.G. Divisional Chairs, SDU Leads, Leads Nurses, Matrons and Ward Sisters, General and Service Managers)

Clinical leaders and leaders of clinical services are responsible for ensuring effective quality governance from the front line to the Board. Our leaders are also responsible for ensuring that the culture in their part of the Trust supports and rewards the right values and behaviours amongst their staff in order to support the provision of high quality care and that where high quality care is not being provided, this is recognised, reported and quickly acted upon.

Clinical leaders are responsible for ensuring the delivery of high quality services in their areas. They are also responsible for the identification, assessment and management of risks to quality in their areas. Such risks must be formally assessed and managed in line with the process stipulated in the Corporate Risk Management Strategy.

Clinical leaders are responsible for risk assessing any proposed service improvement initiatives or QIPP plans to ensure that any risks to quality are identified and rigorously assessed in order to enable such risks to be effectively managed. Where possible, these risk assessments will include early warning indicators that identify any negative impacts on the quality of services.
Clinical leaders are responsible for ensuring that staff under their management are provided with suitable education and training opportunities so that they can maintain their professional competencies and remain up-to-date with best practice.

Clinical Leaders are responsible for investigating incidents that are reported to them and for providing feedback to incident reporters outlining the root causes and action taken in response to incident reports using the lessons learned platforms to communicate such actions.

All staff

All staff are responsible for ensuring safe, high quality and responsive care for patients through their own behaviour and action.

All staff across Buckinghamshire Healthcare Trust are responsible and accountable for the quality of services they provide to our patients. All staff will comply with identified quality standards and requirements as set out in national, professional or Trust policies, procedures and guidelines.

All staff are responsible for ensuring that they maintain their professional competencies, skills and knowledge. All staff must satisfy any professional training and development requirements that are required either by the Trust or any external professional bodies.

All staff will report on Datix any patient safety incident they witness. Patient safety incidents are events or circumstances that could have resulted, or did result in unnecessary harm or damage such as physical or mental injury. The Trust Board is committed to ensuring the organisation learns from incidents and near misses. The Board understands that Management cannot act to reduce the risk of similar incidents recurring if it is not informed of them. The Trust Board recognises that staff must feel that they can safely report incidents without fear of blame or retribution. The Board is committed to fostering such an environment that supports learning by maintaining a positive culture that does not blame staff who report incidents or seek reprisals against incident reporters. All staff can therefore be assured that they will not be blamed for the incidents they report, and that management will take incident reports seriously and investigate them in order to identify their root causes and take appropriate action.

Where staff become aware of something that raises serious concerns about unlawful conduct, misconduct, financial malpractice, fraud or dangers to public, staff, patients or the environment, they should formally raise these serious concerns in line with the procedure outlined in the Raising Concerns at Work (Whistle blowing) Policy. These concerns will be formally investigated and responded to in line with the process stipulated in this policy. When staff raise concerns in line with the Raising Concerns at Work (Whistle blowing) Policy, they are protected from workplace reprisals by the Public Interest Disclosure Act (1998).

Supporting and developing staff

The people strategy will support individuals to ensure they have adequate support, encouragement and training to fulfil their responsibilities outlined above.

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