Deteriorating patient driver diagram

What are we trying to achieve…	We need to ensure…	Delivered through…
To improve the early recognition of, and response to, adults experiencing deterioration in hospital, by March 2028 **Outcome measure:** Rate of Cardiopulmonary Resuscitation (CPR) *While CPR rate provides a high-level measure of impact, the measurement framework should be used alongside this for associated process and balancing measures to monitor whether changes are leading to improvement.*	A people-led approach to the planning and delivery of safe care	People, families, carers and staff are systematically listened to, and concerns are acted upon
		Reliable documentation of Treatment Escalation Planning
		People and professionals are equal partners in shared decision making
		Care and support is shaped to meet the needs of people
	Effective and inclusive communication	Clear and structured escalation pathways
		Communication tailored to individual needs and preferences
		People and teams feel safe and able to speak up
		Team communication and collaboration
	Leadership at all levels to support a culture of safety	Learning system for deterioration-related events to support continuous improvement
		Leadership is compassionate and inclusive
		Staff are supported, valued and enabled to learn and develop
		Clinical and care governance structures support safety
	Safe clinical and care processes for reliable recognition of deterioration and standardised structured response	Reliable and timely monitoring of vital signs using NEWS2 and clinical judgement
		Identification of people at risk of deterioration
		Access to senior clinical decision maker review
		Regular review and reassessment
		Safe staffing and resources to recognise and escalate acute deterioration

Primary driver

A people-led approach to the planning and delivery of safe care

People, families, carers and staff are systematically listened to, and concerns are acted upon	Patient, family and carer views of illness and concerns are consistently sought and recorded	Locally agreed process to support appropriate assessment and escalation in response to patient, family or carer concerns about deterioration	Implementation of a patient and family / carers activated rapid response system, for example Martha's Rule		
Reliable documentation of Treatment Escalation Planning	Implement structured, person-centred approaches to Treatment Escalation Planning discussions	Establish consistent local standards and processes for Treatment Escalation Planning documentation	Embed routine review and updating of Future Care Plans at key points of care	Improve access to and sharing of Future Care Planning documentation across care settings	
	Use digital tools, to support people in accessing and sharing care plans		Strengthen clinical decision making by integrating Future Care Planning and Treatment Escalation Planning into escalation pathways		
People and professionals are equal partners in shared decision making	Include 'what matters to you' in all processes to plan, deliver and review care	Introduce shared decision-making tools / templates to support consistent practice across teams	Involve those close to the person including care partners, families, and legally appointed representatives where appropriate	Embed a standardised process to engage specialist and community teams usually involved in the person's care	Provide accessible and quality decision making aids to support informed decision making
Care and support is shaped to meet the needs of people	Reconciliation of Electronic Key Information Summary (e-KIS) and Future Care Plan on admission	Process to understand and document a person's usual baseline, and presentation when unwell/deteriorating	Care planning includes clinicians, carers and teams who have expertise about a person's needs	Provide post-acute illness follow-up conversations with recovering patients, their family, and carers	Person-centred care planning reflects individual needs and preferences including cultural and religious considerations

Primary driver

Effective and inclusive communication

Clear and structured escalation pathways	Template for handovers to highlight high acuity patients at risk of deterioration	Local process to identify deteriorating patients within a clinical area and hospital wide, for example at safety huddles, and team briefs	Local process for safe transfer of care of deteriorating patients, including clear pre / post transfer responsibilities	Clear and accessible escalation guidance identifying the appropriate contact person for each shift to enable timely escalation	
	Shared understanding of team roles and responsibilities when a person deteriorates		Patient placement decisions informed by clinical condition and level of care		
Communication tailored to individual needs and preferences	Individual communication needs are identified, recorded and supported through appropriate communication adjustments and resources	Including future care plan and / or TEP in all communication between teams	Use of multidisciplinary structured ward rounds	Create a single place to record and view communication needs and preferences	
People and teams feel safe and able to speak up	Processes to promote a culture which supports staff and students to raise concerns	Process for managers at all levels to effectively recognise and respond to patient safety concerns	Patient, family and carers are included in handovers, and know how to raise any new concerns	Promotion of Speak Up advocates and ambassadors to encourage staff to raise concerns	Structured process for multidisciplinary hot and cold debriefs
Team communication and collaboration	Structured handovers within and between teams, for example use of SBARD	Local induction processes for all staff include introduction to Multi-disciplinary team (MDT) and local handover tools	Regular opportunities to pause, prioritise and adapt, for example unit safety huddle or safety pause		

Primary driver

Leadership at all levels to support a culture of safety

Learning system for deterioration-related events to support continuous improvement	Develop a reliable data collection process	Local process to share, and act on reliable data and learning between teams, hospitals, and boards	Explore existing processes to identify and share learning, for example MDT morbidity and mortality meetings	Learning and improvement forums to identify and share areas for improvement with staff, patients, and carers	Shared opportunities for improvement and collaborate on testing changes
Leadership is compassionate and inclusive	Visible and present leadership, for example leadership walk rounds	Access to clinical and improvement leadership time, for example deteriorating patient lead	Opportunity for senior leaders to review deteriorating patient related data and trends	Deteriorating patient improvement priorities align with organisational priorities	Improvement team includes clinical and QI expertise, for example resus and QI colleagues
Staff are supported, valued and enabled to learn and develop	Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing	Prioritise civility through communication and teamwork, for example use of TeamSTEPPS	Support job satisfaction through evidence-based interventions, for example Professional Identity Development Programme	Provide access to senior support and discussion for all staff, for example through clinical supervision	
	Education and induction include local processes for recognition and a structured response to deterioration		Delivery of education and simulation to support improvement in communication and technical skills		
Clinical and care governance structures support safety	Timely reporting and sharing of adverse events, successes and opportunities for improvement	Teams routinely collect, review and act on care assurance data, and contribute to local governance processes	Use of effective health and wellbeing conversations to identify and mitigate risks to wellbeing	Clinical governance processes include oversight of deteriorating patient data, improvement and priorities	

Primary driver

Safe clinical and care processes for reliable recognition of deterioration and standardised structured response

Reliable and timely monitoring of vital signs using NEWS2 and clinical judgement	Reliable process for timely recording of observations and NEWS2 scoring to support early identification of physical deterioration	Use of clinical judgement to identify physical deterioration	Assessment recognises variation in presentation, e.g. considerations of ethnicity in pulse oximetry, postural care needs	Use of 'Special Instructions' within NEWS2 to reflect individual physiological baseline
Identification of people at risk of deterioration	Proactive identification of presentations at higher risk of deterioration, for example, sepsis	Process to identify people with significant co-morbidities, frailty or complex care needs at higher risk of deterioration	Use assessment tools (for example, Clinical Frailty Scale, 4AT) to identify people whose deterioration may present atypically or without changes in NEWS2	Identify people on a deteriorating health trajectory with an advanced condition who may benefit from earlier care planning discussions, for example, use of SPICT tool
Access to senior clinical decision maker review	Local escalation processes enable early involvement of a senior clinical decision maker	Locally agreed process for high dependency / critical care review	First consultant review within 14 hours of hospital admission (or sooner if clinically indicated) and daily thereafter	
Regular review and reassessment	Documenting re-assessment criteria as part of the management plan, including who to contact and the time of the next planned reassessment	Each reassessment includes a review of working diagnosis and treatment goals	Patients, families, and carers are given advice to support identification of further deterioration using locally agreed communication method	
Safe staffing and resources to recognise and escalate acute deterioration	Process for real time staffing risk assessment, escalation and mitigation	Systems and processes are in place to monitor staffing risk and support timely escalation and decision making	Identification of people cared for out with parent speciality (for example, boarding patients)	Education and induction includes local processes for structured response to deterioration	System to identify and support staff working out with their usual area