Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
24th June 2010

TITLE	**Ashford and St Peter's Hospitals Quality Strategy**
EXECUTIVE SUMMARY	The Quality Strategy forms a central corporate document for the Trust. This provides a structure for monitoring quality against National standards and gives a focus to the delivery of this Key Strategic Objective. This strategy has been shared with the members of the Trust Executive Committee and comments have been received.
BOARD ASSURANCE (Risk) / IMPLICATIONS	None identified
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The Quality Strategy explains how we as an organisation demonstrate a programme of continued quality improvement for our services and gives assurance to the public and our commissioners.
EQUALITY AND DIVERSITY ISSUES	ASPH's Quality Strategy supports that our services are accessible to all our population regardless of their disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	None identified
The Trust Board is asked to:	Note the final layout of the report
Submitted by:	Dr. Mike Baxter Medical Director
Date:	24th June 2010
Decision:	For Approving

Ashford and St. Peter's Hospitals NHS
NHS Trust

DRAFT QUALITY STRATEGY (June 2010)

1.0 INTRODUCTION AND PURPOSE

This document serves as an overview and summary of the importance of service quality in the Modern NHS.

It explains why the delivery of high quality services, together with the ability to demonstrate a program of continuous service improvement, is seen as the most important indicators of a successful health care organisation. It also shows why the clear demonstration of a quality focus is an absolute prerequisite for any organisation aspiring to be a foundation organisation.

The document explains the complex system of financial incentives and penalties based on quality targets that are used at National, SHA and PCT levels to exert influences on the commissioning, and therefore viability and sustainability, of services. It is through this pressure on commissioning that acute trusts are encouraged (but effectively mandated) to ensure they provide high quality services.

This strategy paper describes how the Trust has embraced and embedded the philosophy of quality as the essential determining core of its strategy. ASPH has clearly, and unequivocally, positioned quality as the primary strategic objective of the organisation and it is the major focus of 2 of the 6 core work stream programs in the organisation.

The strategic document also describes the detailed definition of quality which has been adopted by the Trust (outcome, safety and experience), sets a primary objective for each of these categories and describes 4-5 focused key deliverables for each area. This will provide the Trust with a clear focus for the quality agenda.

This strategy will also provide structured objectives enabling the whole Trust to review, map and monitor progress that is being made on the delivery of the quality agenda.

1.1 SUMMARY STATEMENT

- The quality strategy forms a central document for the Trust.
- It sets the national context for the quality agenda.
- It describes the rationale for the Trust's focus on quality and the Trust's commitment to the quality agenda.
- The strategy provides a structure for monitoring and reporting quality in the organisation.
- The setting of key deliverables defines the important quality focus for the organisation.
- The recognition of the key objectives provides measures by which the progress and success of the organisation can be objectively assessed and reported.

2.0 BACKGROUND

The ASPH NHS Trust's declared vision is, **to be one of the best trusts in the country.**

The Trust has identified 4 key strategic objectives to deliver this vision:

1. To achieve the highest possible quality standards for our patients, meeting and exceeding their expectations, in terms of outcome, safety and experience
2. To recruit, retain and develop a high performing workforce to deliver high quality care and the wider strategy of the Trust.
3. To deliver the Trust's clinical strategy; redefining our market position to better meet the needs of patients and commissioners, and increasing market penetration.
4. To improve the productivity and efficiency of the Trust in a financially sustainable manner, within an effective governance framework.

The clinical strategy is composed of 4 key elements and the first of these relates to the delivery of high quality services.

The four strategic objectives of the Trust will be delivered through 6 programmes of work:

1. Improving the patient experience programme
2. Leadership development programme
3. Workforce redesign programme
4. Implementing the clinical strategy programme
5. Improving quality and productivity programme
6. Building stronger clinical directorates programme

In defining quality, the Trust has adopted the definition, as described in "high quality of health for all", that quality reflects equally; clinical outcome, safety and patient experience.

It is clear that Quality is the primary focus of Program 1 and a large element of Program 2 and is clearly a central element of the Trust's primary strategic objective and essential to the delivery of Trust's vision statement.

The primary position of quality in the modern NHS is re-emphasised in the national operating framework and accompanying document "Good to Great " where an emphasis is placed on the quality of services and the concept of "best tariffs" is introduced.

Best Tariff outlines that payment for certain defined services will be withheld or capped if certain levels of "quality" are not delivered. This best tariff currently applies to stroke care, cataract surgery, cholecystectomy and hip replacements. It is envisage that this policy will be rolled out to cover additional care pathways.

This document also makes reference to a financial incentive being placed on the Trust to specifically deliver an improvement in the patient experience. It is suggested that up to 30% of the Trust's total income may be under review in response to the inpatient survey scheduled for July 2010.

The South East Coast Strategic Health Authority (SEC SHA) has also commissioned a major quality initiative entitled "Enhanced Quality". This is a prospective intervention study designed to improve the clinical outcome for patients presenting to the acute Trust with community acquired pneumonia, acute myocardial infarction, congestive cardiac failure, or

receiving hip and knee surgery. These projects also carry financial incentives and penalties related to achievement of enhanced levels of service quality and improved outcomes.

Furthermore, via NHS Surrey, there is monthly review (with financial implications) of a number of quality measures (CQUINS) which include rate of readmission, 36 hr emergency hip fracture surgery rates, VTE prophylaxis rates, stroke care, elective, caesarean section rate and WHO stop/check compliance in theatre.

Recognising the definition of quality, it is clear that in the Trust, the activities of Program 1 and 2 should be directed to delivering the quality objectives. The purpose of this paper is to provide an over view strategy delineating priorities to enable work undertaken in these 2 separate work programs within the Trust.

3.0 SPH QUALITY STRATEGY PRIORITIES

3.1 IMPROVMENT OF CLINICAL OUTCOMES

This objective requires demonstration of a change in clinical service provision delivering a measurable improvement in patient outcome.

The Trust has used the National and SEC SHA targets in setting out outcome objectives.

OVERALL METRIC: Reduction in Trust's Crude Mortality rate and SMR

3.1.1 OBJECTIVE: **Improve the treatment pathway and clinical outcome for patients with Pneumonia**

ACTION:

- Implement the enhanced quality program for community acquired pneumonia (CAP).
- Reduce the incidence and improve the outcome of hospital acquired pneumonia (HAP) by avoidance of postural and aspiration pneumonia, early detection of HAP and instigation of clear treatment pathways.
- Ensure there is applied crossover of learning from the "best Practice" care bundles defined by CAP program

MEASURE:

- Compliance with the enhanced quality programs.
- Compliant with all CQUIN requirements.
- Reduction in the Trust's SMR and Crude Mortality rate for community acquired and hospital acquired pneumonia by 20%.
- Position the Trust as having the lowest mortality in SEC (currently 3rd).
- Monitor and demonstrate a reduction in rates of HAI in Trust Mortality reviews

3.1.2 OBJECTIVE: **Deliver all emergency hip fracture surgery within 36 hrs**.

ACTION:

- Implement changes in patient pathway, surgical preoperative care, trauma list prioritisation and theatre capacity:

MEASURE:

- To deliver and exceed the 85% target.
- Demonstrate a 30% reduction in length of stay and a 15% reduction in mortality for patients with fractured neck of femur

3.1.3 OBJECTIVE: **To reduce mortality from Clostridium Difficile.**

ACTION:

- Reduce the number of cases of C.Diff.
- Use of early identification of cases of C.Diff and instigation of aggressive treatment in line with the Trust's treatment protocols.

MEASURES:

- 30% reduction in number cases of C. Diff (2010 target 26) and a 25% reduction in mortality from C.Diff if contracted.

This would amount to a reduction of 15 cases of C.Diff and 10 deaths in the year.

3.1.4 OBJECTIVE: **To reduce the rate of readmission of patients following discharge from the Trust**.

ACTION:

- Multiple inputs which include protocols for discharge. Recognising and mitigating for the risk factors for readmission such as social isolation, unsupported nursing homes and multiple prior admission.
- This will include work being undertaken in the Transformation Program 2 focusing on nursing homes and patients with multiple admissions.

MEASURES:

- 25% reduction in readmission rate. 50% reduction in patients admitted from and discharged to a nursing home. Reduction by 25% in LOS of patients admitted from nursing homes. 50% reduction in admissions from patients previously admitted more than 4 times in the last 12 months.

3.1.5 OBJECTIVE: **To reduce mortality and morbidity from STROKE.**

ACTION:

- Implement stroke best practice representation.
- Use of 24/7 thrombolysis intervention.
- Contribute to the Stroke Network and Transformation Program 3 which is working on the stroke pathway across health care boundaries.
- Ensure all patients with stroke are cared for in the designated acute stroke unit and receive specialist rehabilitation.

MEASURES:

- A 60% increase in the number of patients receiving Thrombolysis. Demonstration that this is a 24/7 service by analysis of activity data.
- Reduction in stroke mortality by 20%. Reduction in residual disability by 50%. 100% of stroke patients will receive their care in a designated stroke unit and rehabilitation unit.

Reduction in length of stay in the acute sector by 20%.

3.2. SAFETY: TO REDUCE AVOIDABLE HARM

OVERAL METRIC: To reduce by 20% the Trust's SARI (summated adverse report index) by reducing the number of adverse events, which result in avoidable harm, which lead to either an incident report or SUIs.

3.2.1 OBJECTIVE: **To increase to 100% compliance with VTE prophylaxis.**

ACTION:

- To measure VTE compliance on a weekly basis, and police under performance.
- To ensure there are no ward transfers or acceptance of patients in theatre without VTE forms being completed.
- Use of "integrated" prescription form which has been designed to facilitate VTE process.
- Monitoring of VTE compliance on Directorate dashboard and in monthly performance reports.

MEASURES:

- Compliance with VTE which will be reported to TEC and monitored via CQUIN by the PCT.
- Measure rates of DVT and post admission PE as a direct measure of effectiveness of VTE intervention.
- A reduction in Trust mortality from these diagnostic categories by 20%.

3.2.2 OBJECTIVE: **To deliver 100% compliance with a high quality WHO stop surgical check list.**

ACTION:

- To continue to monitor and report WHO stop list compliance. Continue to empower clinical champions. Direct action on under performance.

MEASURE:

- Direct audit of activity.
- 50% reduction in the number of cases of unexpected return to theatre.
- Elimination (100%) of Never Events.
- Reduction by 75% in theatre related SUIs.

3.2.3 OBJECTIVE: **To reduce incidence of Hospital Acquired Infection.**

ACTION:

- To continue to monitor MRSA and C. Diff infection rates.
- To monitor hospital acquired respiratory infections, particularly aspiration and postural chest infections.
- To reinforce all hygiene code advice, high impact interventions and line care policies.
- Increase training and enforce competency training. Hold individual practitioners to account for any policy errors.

MEASURES:

- Rates of MRSA and C.Diff infections. Reduction in hospital related chest infection reports. Reduction in mortality related to these diagnostic categories by 50%.

3.2.4 OBJECTIVE: **Reduce the rate of drug related errors in the Trust.**

ACTION:

- To implement the new adult in patient drug chart. Continue to monitor medicine prescribing including start stop dates, IV to oral switch rates and compliance with Trust prescribing protocols. Update hospital formulary, make available electronically and implement restrictions.
- Competency training at Trust induction.

- Direct action for persistent under performance.

MEASURES:

- Completion of revision of Hospital formulary. Continued reporting of all drug errors directly to Directorate, monitor actions to mitigate through the monthly performance meetings and CGC.

- 100% use of gentamicin calculator

- Reduction in all drug errors by 50% and elimination of all mortality related to drug errors.

3.2.5 OBJECTIVE: **To reduce the number of falls and adverse outcomes related to falls in the Trust.**

ACTIONS:

- Implement the learning from the study on Chaucer ward, which demonstrated an effective strategy for reducing falls to all wards in the Trust.

- Use of the new orthogeriatric service to strengthen risk assessment and falls avoidance strategies in the Trust.

- Use of predictive risk interventions to prevent further falls and reduce the number of admissions to the Trust with fractured neck of femur.

MEASURES:

- To demonstrate a reduction in rate of falls in the Trust. Reduction in adverse outcomes from falls within the Trust. Demonstrate reduction in admissions of patients with fractured neck of femur.

3.3 IMPROVING THE PATIENT EXPERIENCE

OVERALL METRIC: INCREASE TO 98%, THE % OF PATIENTS WHO WOULD RECOMMEND THE TRUST TO FAMILY AND FRIENDS

3.3.1 OBJECTIVE: **To implement and sustain, the top 10 high impact intervention for improving the patient experience (see patient survey strategy)**

ACTIONS:

- Roll out of program for high intensity impacts (see separate attachment)

MEASURES:

- Improvements in the patient comment cards collected in July.

- Improvement in national inpatient survey results, to be reported in September.

Specific Objective:

- No results in the bottom 20% of questions, a doubling of the number of answers within the top 20%.
- Increase to 98% the positive response to the question "would you recommend ASPH to your friends and family"
- Reduction in the number of PALS contacts by 20% and of formal complaints by 30%.

3.3.2 OBJECTIVE: **To agree, embed and police the newly agreed organisational behaviours.**

ACTIONS:

- 100% of staff signed up to the pledge on behaviours.
- The active support of agreed and acceptable behaviour and a zero tolerance of all unacceptable behaviour.
- Honesty conversations to be held with challenged colleagues.
- Customer service training to be provided at the Trust on a regular and ongoing basis.
- All recruitment adverts to be clear and explicit about the Trust's commitment to these values. Values and behaviours to be stressed at all new staff induction by CEO or MD.

MEASURES:

- Improvement in patient experience metrics with particular reference to staff attitude and empathy.
- A reduction in complaints related to communication and attitude by 80%.
- A clear cultural focus on patients first and personal responsibility

3.3.3 OBJECTIVE: **To review all complaints and PALS contacts to ensure themes are identified, learning is shared and practise is changed to improve the patient experience.**

ACTIONS:

- Co-ordinate incident reports and PALS contact
- Clear identification themes and personnel involved where appropriate
- Draw conclusions and actions based on this analysis
- Shared with Board and directorate

MEASURES:

- Change in practise – assured by audit and beneficial re-affect on SARI

3.3.4 OBJECTIVE: **The use of Experienced Based Development (EBD) to inform staff directly of their contribution to the patient experience and to use EBD as a primary driver in all new service design and reconfiguration.**

ACTIONS:

- To personally continue to champion EBD.
- Arrange training sessions in the technique, and its use, via the Institute of Innovation
- Appoint 3 EBD facilitators to introduce and use the technique in the Trust. Proposed start date end of JUNE 2010.
- Use this technique to feed back to staff about their perceived performance, and the patient focus of current services.
- Use EBD in all new service design and have it as a standing True north Metric in all EQUIP projects.

MEASURES:

- Effective gathering and sharing of patient stories.
- Change in staff perception, empathy and patient focus performance with clear engagement in pieces of work to improve patient experience and act on information provided.
- Impact of EBD on patient pathway design. An improvement in patient satisfaction scores on feedback metrics.

3.3.5 OBJECTIVE: **To engage with patients, relatives and the community to build a sense of joint ownership and partnership in the Trust and the services provided.**

ACTIONS:

- To ensure patient representation at all major committees in the Trust. Strengthen and support the patient speciality groups within the Trust.
- To improve the communication with the community and the Trust's membership, proactively sharing achievements and areas requiring and receiving special attention.
- Ensuring that all patients are aware of the importance of completing the national patient survey and submitting it if requested.

- Jointly determine a strategy for meaningful working with the FT membership and governors to improve community engagement, trust and loyalty.

- Establish a regular quarterly public meeting and bi monthly communication (hard copy and electronic) to share the Trust news.

- Be receptive to community suggestions and questions.

- Create an electronic suggestion and comment board for patient and public use.

- Have in place a clear membership and governors' strategy to improve engagement.

- Build positive relationships with the local press.

- Regular CEO, Chair and MD press briefings.

MEASURES:

- Patient representation in place.

- Establish a metric for accessing patient perception of engagement and ownership in the Trust.

- Reduction in bad news stories reported in local press.

- Improvement in the patient satisfaction survey.

- Increase in the number of positive press coverage and reduction in the negative press reporting.

4.0 RESPONSIBILITIES AND REPORTING MECHANISMS

Executive responsibility for these targets will be shared by the Chief Nurse and MD.

Responsibility for delivery of these targets will lie with the directorates and held directly by the clinical director and the directorate matrons.

Progress on the key objectives will become the core of the quality report which is presented at the monthly Board meeting.

Data will also be reviewed on a monthly basis at the Trust Executive Committee (TEC)

The individual directorates' performance against these quality metrics will be reported at the monthly directorate performance meeting.

The directorates will report performance against the key quality objectives at the Clinical Governance Committee on a 6 monthly basis

Directorate key quality performance which is reported at CGC will be reported to IGAC which reports directly to the Board.

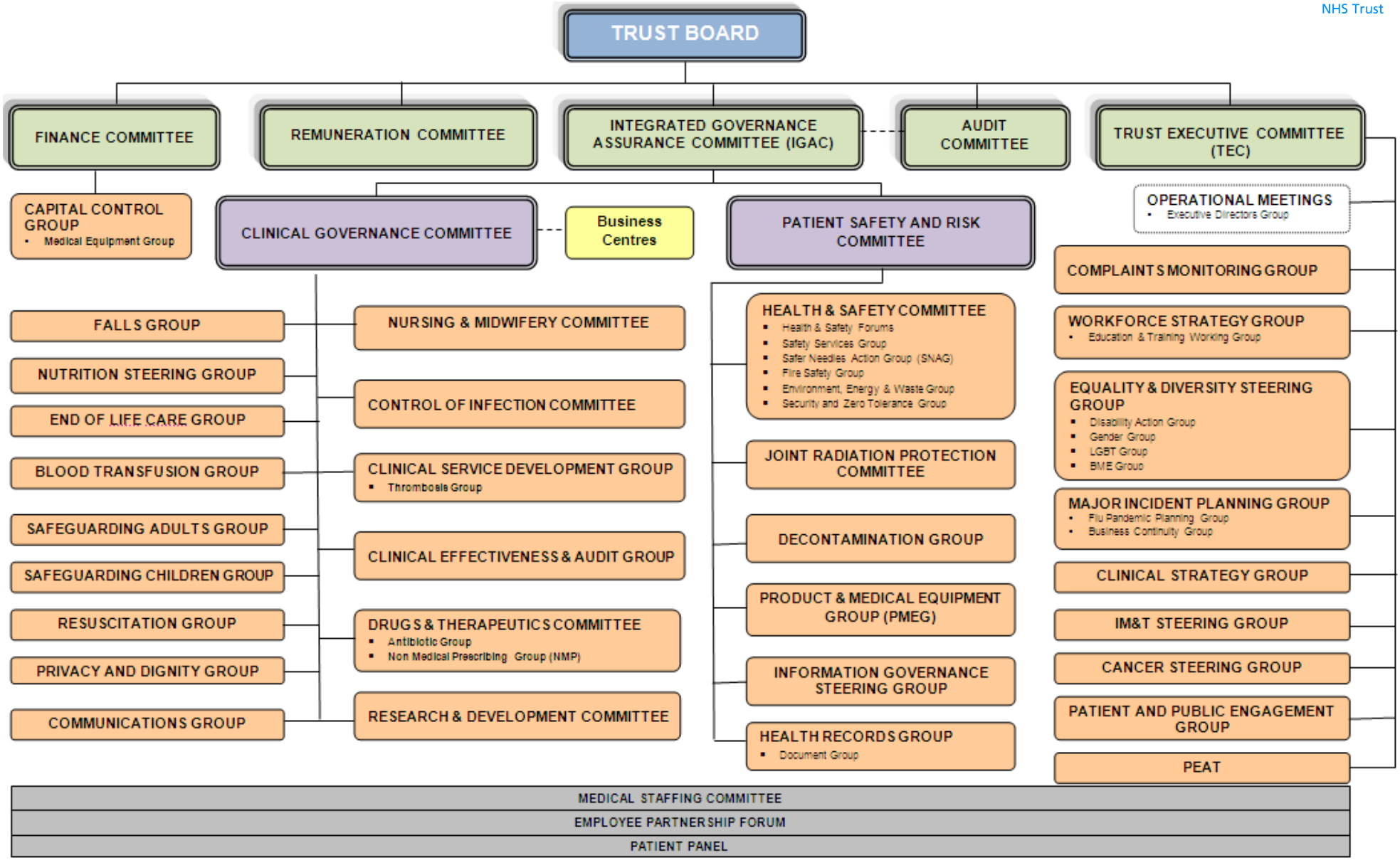
Any significant concerns will be brought directly to the Board by the MD's Quality Report.

Performance against the key quality will be the central theme of the annual Quality Accounts presented to the Board and shared with the governors, membership and general public.

Performance against National, Monitor, SHA and PCT (CQUIN) targets will also be reported via the appropriate mechanisms.

Appendix 1

Ashford and St. Peter's Hospitals NHS
NHS Trust



Patients first • Personal responsibility • Passion for excellence • Pride in our team

Appendix 2

Ashford and St. Peter's Hospitals NHS
NHS Trust

JOB DESCRIPTION

Job Title	Clinical Governance Manager, Medical Business Centre
Band:	7
Hours:	37.5
Responsible to:	Clinical Governance Lead
Accountable to:	Head of Nursing/BCM
Professionally Accountable to:	Trust Clinical Governance Lead
Responsible for:	N/A
Base:	Cross Site Working
Criminal Records Bureau Disclosure	Yes Standard

DRAFT

Job summary

Work with the BCM Medicine and Business Centre Clinical Governance Lead to help deliver the Trust's clinical governance agenda throughout the Business Centre.

Co-ordinate clinical and non-clinical risk management activities across the Business Centre.

Take the lead role in preparing for CNST accreditation within the Business Centre.