Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD

25th July 2013

TITLE	**Quality, Safety and Risk Management Strategy Progress Report**
EXECUTIVE SUMMARY	This is the review of year 1 of the strategy. The paper reviews the eight deliverables, 12 tasks and 49 objectives to reveal the steady progress made. Whilst there are some deliverables off plan, the quality of the changes is resulting in transformational change in quality governance and improvement in the Trust. Year 2 is emerging as the year when capabilities will be developed in order to effectively execute the vision of quality safety and risk management. The Progress report was reviewed by IGAC at its meeting in July.
ASSURANCE (Risk) / IMPLICATIONS	With robust and inclusive quality governance and improvement processes, the Trust will achieve its objective to be one of the best health care organisations in the country delivering joined up care.
LINK TO STRATEGIC OBJECTIVE	The Strategy links to all Trust Strategic Objectives.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	This successful delivery of the strategy will see the quality and safety of services improve. This will be a positive outcome for patients and their family.
EQUALITY AND DIVERSITY ISSUES	None known
LEGAL ISSUES	None known
The Trust Board is asked to:	Review and obtain assurance of the year one progress with the strategy.
Submitted by:	Suzanne Rankin, Chief Nurse
Date:	18th July 2013
Decision:	For Approval

1. Introduction

The Trust began the new Quality, Safety and Risk Management strategy in May 2012 with a view to embed ownership of quality assurance, quality improvement and risk management at every level throughout the organisation.

This paper will report on the progress against the strategy implementation plan. Performance against the 8 deliverables, 12 tasks and 49 objectives will be reported against the plan of delivery. Year 1 of the strategy has been successful in defining and describing the vision. However, for effective delivery, year 2 of the strategy is emerging as the year when the Trust is focusing on building leadership capabilities in order to execute and implement the strategy.

2. Quality, Safety and Risk Management (QSRM) plan (See Appendix 1)

The QSRM plan is divided into the four domains of quality as described within the strategy.:

- **Strategy – Delivering the Trust's vision**: this will track the milestones that are required to approve the Trust's strategy and that they have been reached.

- **Capabilities – Implementing Quality, Safety and Risk Management Structure:** this measures the milestones that are required to re-define the quality-related Committee structure and assess the safety culture within the organisation.

- **Processes – Delivering High Performance Teams to deliver high Quality and Safer Care**: these key performance indicators measure the effectiveness of the Service lines within the organisation so that they are developed to deliver the quality assurance, quality improvement and risk management throughout the organisation.

- **Measurement – Measurement for Improvement – Improving Outcomes for Quality** : these will detail the key quality indicators that will act as evidence of the effectiveness of the strategy in the first year

Appendix 1 describes the details of the progress to date.

2.1. Progress

2.1.1. **Delivering the Trust's vision (Green rating)** – This deliverable was due in June 2012. There were two tasks and both were completed. One was related specifically to the merger with Epsom and therefore this task, although completed, no longer became relevant. All objectives within the tasks have been achieved.

2.1.2. **Implementing Quality, Safety and Risk Management Structure (Green rating)** – This deliverable was due in June 2013. There were two tasks: Redefining the Governance Committee Structure which was completed and Assessing the Safety Culture, which is still in progress and marginally off-plan. This task was turned into a 6-month research project and will be completed in September 2013.

2.1.3. **Delivering High Performance Teams to deliver high Quality and Safer Care (Amber rating)** – This deliverable was due to be delivered in December 2012. There are two tasks: 1) to define Service lines / Divisional Quality

Structure and 2) define service line leadership roles and training of senior management, Divisional Triumvirate and Clinical Specialty Leads. The leadership roles, although they have been defined in the Strategy require learning and development programmes for them to be effectively carried out. Team ASPH which was launched in autumn 2012 will be taken further with a more in-depth training package to build leadership capability amongst the senior clinicians in the organisation at clinical speciality level and above. This package was recently commissioned by the Trust from the Hay Group and the NHS Leadership Academy. The launch of this programme took place on 5th July 2013 and is currently being rolled out. Despite being off-plan this is in progress.

The Trust is currently furthering the devolvement of quality governance within the Clinical Division to ensure that "quality is everyone's business". The consultation for this organisational restructure will take from in August 2013.

2.1.4. **Measurement for Improvement – Improving Outcomes for Quality (Amber rating)** – This deliverable is due by September 2013. There are two tasks. Task one is to improve the methodology for quality performance tracking and validating. Out of the 13 objectives, four are still in progress of which two are off plan. The first objective which is off-plan is the implementation of a 24-hour Help line is now being scoped and implemented under the chairmanship of the Chief Nurse. The other objective is the instituting of the Clinical Day Programme. This was implemented in March 2013 and will be reviewed later this year.

The second task was to achieve the quality performance targets for 2012 /2013. Out of the original 20 indicators: two were discontinued, eight were achieved – ***green rated***, eight were not achieved – ***red rated***, two showed no materiel change – ***amber rated***.

2.2. Next phase

2.2.1. **Strategy – Delivering the Trust's vision** – *Repeat Vision*: Deliverable 5. Annual planning cycle which will be due in October 2013.

2.2.2. **Implementing Quality, Safety and Risk Management Structure** – *Process Development*: Deliverable 6. There is one task in progress, which is off plan and was due in January 2013. The development of the Quality and Safety Half (QUASH) Days relates to this deliverable and the recent review of the risk management structures.

2.2.3. **Delivering High Performance Teams to deliver high Quality and Safer Care** – *Capabilities – Delivering High Performance Teams to deliver high Quality and Safe Care*: Deliverable 7. This is on track due to be delivered in December 2013.

2.2.4. **Measurement for Improvement – Improving Outcomes for Quality** – *Measurement for Improvement*: Deliverable 8. Design KPIs for 14/15. This is on plan and due in December 2013.

3. Conclusion

The Trust's *Quality Safety and Risk Management Strategy* has led to a transformation in the way quality is governed, improved and managed in the Trust. Key deliverables around devolving quality governance and building leadership capabilities to improve quality is currently in train and set to define the success of year two of the Strategy.

Appendix 1

ID	Deliverable / Task / Objective / Measure	Description	Lead	End	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
1	**D**	**Deliver the Trust's Vision**		**Jun-12**										
1.1	*T*	*Approve Strategy*		*May-12*										
1.1.1	O	Submit Quality Safety and Risk Management Strategy to the Trust Executive Committee for approval.	SR / HC	May-12										
1.1.2	O	Disseminate copy of the Strategy to the Divisional General Manager, Heads of Nursing and Corporate Co-ordinators Group.	SR / HC	May-12										
1.2	*T*	*Communicate vision to Epsom Hospital*		*Jun-12*										
1.2.1	O	Begin communication of Strategy to Epsom Hospital.	SR / HC	Jun-12										
	M													
2	**D**	**Implement Quality Safety and Risk Management Structure**		**Jun-13**										
2.1	*T*	*Re-define Quality-related Committee Structure*		*Oct-12*										
2.1.1	O	Review governance structure with clear reporting lines between sub-committees of the Board, directorate management boards and other committees.	SR / HC	Jul-12										

2.1.2	O	Review terms of reference for the sub-committees and groups pertaining to quality, safety and risk management.	SR / HC	Jul-12		Complete									
2.1.3	O	Review timings and frequency of quality related boards, sub-committees of board, groups and Divisional meetings relating to quality, safety and risk management.	SR / HC	Jul-12											
2.1.4	O	Implementation of Datix Web	SR / HC	Oct-12				Complete							
2.2	*T*	*Assess the safety culture*		*Jun-13*											
2.2.1	O	Determine Baseline Measurement of Safety Culture using the Manchester Patient Safety Assessment.	SR / HC	Dec-12					This baseline measurement has commenced as a 6-month research project. To be completed in September 2013.						
2.2.2	O	Evaluate the positioning of Risk Scrutiny Committee as a sub-committee of the Integrated Governance and Assurance Committee.	SR / HC	Jun-13											Complete. Review reported to IGAC
	M														
3	**D**	**Delivering High Performance Teams to deliver high Quality and Safe Care**		**Dec-12**											
3.1	*T*	*Define Service lines / Division Quality structure*		*Jul-12*											

3.1.1	O	Prepare detailed guidance on the role of the Divisional Performance and Quality Review meetings, including agenda items, action plans and reporting to Quality Governance Committee.	SR / VB / HC / CB / DF / MI	Jul-12								Complete			
3.2	*T*	*Define service line leadership roles and training of Seniors management, Divisional Triumvirate and Clinical Specialty Leads*		*Dec-12*								Complete			
3.2.1	O	Provide training on risk management methodology and how to apply to Board, sub-committees of the Board, other committees and Trust Executive Committee.	SR / RB / HC	Dec-12				Complete							
3.2.2	O	Complete training programme for building capabilities of Divisional Triumvirate, Clinical specialty leads and Matrons on quality governance.	SR / RB / HC	Dec-12								Trust commissioned a training and development package to build capabilities across the clinical leadership in the organisation. Programme commenced July 2013.			
3.2.3	O	Patient Experience and Engagement Strategy.	SR / HC	Dec-12								Strategy consultation began in Dec 2012, strategy ratified by TEC in Jan 2013 and launched in May 2013.			
3.2.4	O	Lead and devolve internal CQC assessment and risk management processes and embed Health Assure for Provider Compliance Management.	SR / HC	Dec-12				Complete							

	M														
4	**D**	**Measurement for Improvement – Improving Outcomes quality**		**Sep-13**											
4.1	*T*	*Improve methodology for quality performance tracking validating*		*Sep-13*											
4.1.1	O	Co-produce the Quality and Safety Half (QuASH) days with developed KPIs for Divisions, specialties and wards.	SR / DF/ MI / HC	Jun-12				QuASH terms of reference agreed							
4.1.2	O	Evaluate and determine external benchmarking support required.	DF/HC	Ongoing								Clinical Outcomes Steering Group still in operation. TORs to be reviewed and remit extended to include Mortality Reviews and feed into Quality Improvement Discussions.			
4.1.3	O	Launch Leading Improvements in Patient Safety Programme.	SR/MW	May-12											
4.1.4	O	Implement Improvement initiatives.	SR / DF / MI / HC	May-13								Initiatives implemented and presented regularly to Chief Exec's LIPS Surgery			
4.1.5	O	Promote and embed the use of Risk Predictor Tools across Trust (March 2013).	SR / HC	Mar-13							Completed – Quality, Experience, Workforce & Safety (QEWS) dashboard completed and discussed monthly at IGAC and performance review meetings				
4.1.6	O	A 24 hr. "Help-Line" – "If you are concerned about the care you or a relative is receiving and don't feel able to speak to the ward or medical team call: XXXX".	SR / HC	Mar-13							Working group with senior nursing staff, senior clinical representative commenced May 2013, chaired by Chief Nurse. Implementation due by December 2013.				
4.1.7	O	Patient Diaries following re-design based on pilot feedback.	SR / HC	Jun-12											
4.1.8	O	Mystery Shopper Programme	SR / HC	Sep-13								Currently being designed – commercial partnership formed with a provider of the service.			

4.1.9	O	Implement Dr Foster patient level activity tracker and adapt for staff feedback.	DF / HC	May-12											
4.1.10	O	Introduce ~~Dr Foster~~ CHKS patient experience data and adapt for both staff and patient feedback.	SR / HC	Dec-12							Data sets produced on a monthly basis as part of QEWS dashboard to be fed back to speciality teams.				
4.1.11	O	A shared approach and build engagement with the Doctors Advancing Patient Safety (DAPS) doctors to co-produce patient safety projects.	SR / HC	May-12											
4.1.12	O	Implement Clinical Days Programme	SR / HC	Jun-12							Implementation of programme started in March 2013. Central coordination reduced and to be reviewed in September 2013.				
4.1.13	O	Set up Divisional Improvement Teams to deliver LIPS	MW	Aug-13											

4.2	*T*	*Improve outcomes*		*Apr-13*										
ID	**Deliverable / Task / Objective / Measure**	**Description**	**Lead**	**End**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
4.2.1	O	20% reduction in Pressure Ulcers	SR / HC	Apr-13	14	10	14	12	18	21	11	YTD +56		
		10% reduction in readmission rate (elective)	SR / DF / MI / HC	Apr-13	3.4%	2.8%	2.8%	3.2%	2.5%	2.5%	3.2%	YTD 3.2%		
4.2.2	O	10% reduction in readmission rate (emergency)	SR / DF / MI / HC	Apr-13	14.%	13.9%	13.4%	12.%	13.3%	16.6%	14.8%	YTD 13.6		
4.2.3	O	10% reduction in death in hospitals	SR / DF / MI / HC	Apr-13	1.61%	1.7%	1.8%	1.9%	1.64%	1.61%	2.06%	YTD 1.68%		
4.2.4	O	Crude mortality (excluding readmissions = < 1.6)	SR / DF / MI / HC	Apr-13	1.61%	1.7%n	1.8%	1.9%	1.64%	1.61%	2.06%	YTD 1.68%		
4.2.5	O	Improved Net Promoter Scores (65) / Friends and Family test from Dec 12	SR / DF / MI / HC	Apr-13	64	64	58	64.4	72	60	72	ACT 69		
4.2.6	O	Level 3 NHSLA and CNST	SR / DF / MI / HC	Apr-13										
4.2.7	O	10% reduction in complaints in key thematic areas; communication and shared decisions making	SR / DF / MI / HC	Apr-13										
4.2.8	O	PALS conversion rate < 7%	SR / DF / MI / HC	Apr-13	1.5%	1%	6%	2.3%	1.3%	4%	10%	ACT 2%		
4.2.9	O	Complaint performance > 95%	SR / DF / MI / HC	Apr-13	77%	82%	92%	89%	86%	80%	79%	ACT 89%		
4.2.10	O	Improved National Patient Survey Results	SR / DF/ MI / HC	Apr-13							Stayed the same with significant improvement in 5 indicators			
4.2.11	O	Summary Hospital-level Mortality Indicator (SHMI) < 100	SR / DF/ MI / HC	Apr-13	66	60	62	62	57	54	68	YTD 60		

4.2.12	O	10% reduction HSMR or < 100	SR / DF/ MI / HC	Apr-13	No longer using Dr Foster										
4.2.13	O	Mortality UTI as Primary Diagnosis (SHMI < 100%)	SR / DF/ MI / HC	Apr-13											
4.2.14	O	VTE (hospital acquired with PE or DVT < = 14)	SR / DF/ MI / HC	Apr-13	4	4	2	2	3	2	0	YTD 24			
4.2.15	O	Serious Incidents Requiring Investigation (SIRI < = 50)	SR / DF/ MI / HC	Apr-13	6	9	4	4	4	6	7	YTD 71			
4.2.16	O	SIRI Grade 2 (proortion of total SIRI 0.0%)	SR / DF/ MI / HC	Apr-13	15.6%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	10%			
4.2.17	O	Falls (Total number < = 462)	SR / DF/ MI / HC	Apr-13	42	41	49	69	81	58	82	YTD 766			
4.2.18	O	Falls Rate - resulting in significant injury	SR / DF/ MI / HC	Apr-13		2	1	1	1	2	3	YTD 18			
4.2.19	O	Average Bed Occupancy (inc escalation = 92%)	SR / DF/ MI / HC	Apr-13	93.6%	85.4%	89.1%	87.1%	84.6%	91.1%	91.1%	YTD 88.6%			
4.2.20	O	Patient Moves (ward changes < = 3)	SR / DF/ MI / HC	Apr-13	6.7%	7.5%	7.4%	7.2%	7.0%	8.0%	7.0%	7.4%			
4.2.21	O	Formal complaints total number < 500 in 12/13	SR / DF/ MI / HC	Apr-13	28	46	50	27	49	47	50	485			

5	**D**	**Vision – annual planning cycle**		**Oct-12**											
5.1	*T*	*Integrate quality objectives into strategic and annual planning objectives, aligned to Strategic Objective one.*		*Oct-12*							Complete				
5.1.1	O	Design Quality, Safety and Risk Management Strategic planning process.		*Oct-12*							Complete				
	M														
6	**D**	**Process development**		**Jan-13**											
6.1	*T*	*Support Divisions in developing their Divisional level dashboard for QuASH days.*	*SR/DF/MI/HC*	*Jan-13*											*June: Guidance developed and being rolled out.*
	M														
7	**D**	**Capabilities – Delivering High Performance Teams to deliver high Quality and Safe Care**		**Dec-13**											
7.1	*T*	*Buddying with hospitals internationally.*	SR / HC	*Dec-13*											
	M														
8	**D**	**Measurement for Improvement – Improving Outcomes quality**		**Dec-13**											
8.1	*T*	*Design further KPIs for next year*	*SR/DF/MI/HC*	*Dec-13*											