Quality Improvement Strategy
2015-2018

Saving Lives, Improving Lives: The Safest Organisation in the NHS
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What are we Trying to Accomplish?

We aim to be the safest organisation in the NHS; we’ll accomplish this by putting the needs of our patients, their families and carers, first. In this third iteration of our Quality Improvement Strategy we will continue to relentlessly pursue giving our patients, families and carers safe, clean and personal care, every time.

As part of our Quality Improvement Strategy, we introduced and rolled out a wide range of patient safety initiatives to tackle issues such as cardiac arrests, falls, pressure ulcers and surgical site infections.

Nearly seven years later, we know our patients are benefitting greatly from this work. Since 2008 we have nearly eliminated MRSA blood stream infections, reduced *C. difficile* by 90%, cardiac arrests by 51%, and pressure ulcers by 70%.

Our mortality rates are in the best 10% nationally and the best outside of London and in addition fewer Salford Royal patients now die, if they are admitted over a weekend, due to the changes we have made to our services to ensure patients receive the same high quality care on a weekend as throughout the week.

We are particularly proud of the fact that our patients have rated us in the top 10% of all Trusts in the 2012 National Inpatient Survey and that our staff rated us the best acute Trust in the 2012 and 2013 National NHS Staff Survey.

Our staff working in the community have shown exemplary dedication to improving quality and safety and have implemented the Community Assessment and Accreditation System, safety huddles, and a programme of collaborative participation to achieve harm free care.

Acknowledging our successes, we know that achieving our ambitions will take unwavering focus. This new strategy refocuses and reinvigorates our ambition to be the safest Trust in the NHS.

What Have we Achieved so Far?

In 2008 we launched our ambition to become the safest organisation in the NHS through delivering safe, clean and personal care to every patient, every time. We were determined that we would lower our mortality rates and ensure that fewer patients experienced harm whilst in our care.

Over 7 years we have achieved:

- **No Preventable Deaths**
- **Continuously Seek Out and Reduce Patient Harm**
- **Achieve the Highest Level of Reliability for Clinical Care**
- **Deliver What Matters Most: Work in Partnerships with Patients, Carers and Families to Meet all Their Needs and Better Their Lives**
- **Deliver Innovative and Integrated Care Close to Home Which Supports and Improves Health, Wellbeing and Independent Living**

**AIM**

1. **No Preventable Deaths**
2. **Continuously Seek Out and Reduce Patient Harm**
3. **Achieve the Highest Level of Reliability for Clinical Care**
4. **Deliver What Matters Most: Work in Partnerships with Patients, Carers and Families to Meet all Their Needs and Better Their Lives**
5. **Deliver Innovative and Integrated Care Close to Home Which Supports and Improves Health, Wellbeing and Independent Living**

**Over 7 years we have achieved:**

- **10%** reduction in risk adjusted weekend mortality
- **100%** reduction in MRSA blood stream infections
- **90%** reduction in *Clostridium difficile* infections
- **51%** reduction in cardiac arrests
- **70%** reduction in pressure ulcers
- **8.7%** reduction in risk adjusted weekend mortality over 420 days without a MRSA blood stream infection
- **96%** of patients have VTE risk assessment completed over a Year without a serious incident in Theatres within the Division of Surgery
- **95%** maintained 95% compliance with evidence based Surgical Site Infections Bundle
- **95%** compliance with Salford Royal’s Dementia and Delirium Care Bundle
- **97.9%** of Salford Royal patients receive harm free care
- **90%** of Salford Royal patients rate their care as excellent or very good
- **Best Trust** nationally in the NHS Staff Survey 2013


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How was this Strategy Developed?

A small team of leaders was convened to review the Francis report and assess the Trust against the recommendations. Early on in these conversations, it became clear that what was really needed was a re-envisioned Quality Improvement Strategy.

After the Berwick Review was published, the Trust took the Berwick recommendations to the staff and used this as an opportunity to get views from the frontline on how to move Salford Royal’s vision forward of being the safest Trust in the NHS.

Called the ‘Berwick review sessions,’ senior leaders facilitated a series of one hour sessions to review the Berwick recommendations and ask staff what they think we need to do next to achieve our vision. The sessions focused on:

- The feedback from over 500 staff was collated and merged with the draft ideas discussed from the small team of senior leaders as well as trends and feedback from:
  - Patients, families and carers gleaned through engagement sessions on the Patient, Family, and Carer Strategy
  - Patient Surveys
  - Staff Surveys
  - Governance intelligence sources: complaints, incident reports, claims

Together, these sources gave us the direction for this, our third generation Quality Improvement Strategy.

### A PROMISE TO LEARN - A COMMITMENT TO ACT: IMPROVING THE SAFETY OF PATIENTS IN ENGLAND

- **The Patient Voice should be heard at every level of the service**
- **Quality First**
  - Safety
  - Above All
- **Measure, Transparency, Understand Variation**
- **Build Capability, Improvement Science, Networked Learning**
- **Leadership = Commitment, Visibility, Encouragement, Compassion**
- **Staffing Levels**

*Don Berwick, MD*
As measured by:

- Maintaining position in 10% of NHS organisations with the lowest risk adjusted mortality
- Serious untoward incidents that resulted in patient death
- Mortality reviews
- Dr. Foster mortality alerts

The number of preventable deaths in the NHS remains uncertain with estimates for England ranging from 840 to 40,000 per year. Estimating preventable deaths becomes complex when reviewing cases of patients with complex conditions and co-morbidities.

We are certain, however, through the mortality reviews we carry out on all patients who die whilst under our care, that not all patients receive all ideal aspects of care for their conditions in a timely manner. We use these mortality reviews to find defects in care that we can fix in service of pursuing our aim of having no preventable deaths.

Monitoring our risk adjusted mortality rate is one way to understand how we are doing on eliminating preventable deaths. Not every patient admitted to the hospital for a given condition has the same risk of death.

For example, an otherwise healthy 40 year old with pneumonia has a different risk of death than a 90 year old lifelong smoker. In order to account for these differences, we use a risk adjusted ratio that incorporates the characteristics of each patient.

If the Trust had a risk adjusted mortality of 100, that means that the number of patients who died is exactly as it would be expected taking into account the standardisation factors.

A risk adjusted mortality above 100 means more patients died than would be expected; one below 100 means that fewer than expected died. We currently have the lowest risk adjusted mortality outside of London and we aim to maintain our position in the best 10% of the NHS.
Harm is defined in many ways but a common belief is that harm is ‘unintended physical or emotional injury resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice) that requires additional monitoring, treatment or extended length of time under the care of a clinician’.

Healthcare acquired infections, medication errors, surgical infections, pressure sores and other complications are examples of harm which are commonplace. Despite the extraordinary hard work of healthcare professionals patients are harmed in health care every day.

The Berwick Report stated that “all in the NHS should understand that safety is a continually emerging property, and that the battle for safety is never “won”; rather, it is always in progress.” This is why we will approach harm reduction by working on strengthening our Trust wide and local learning systems and building capability in our staff to recognise and prevent harm in addition to addressing a suite of projects on specific harms.

As measured by:

- NHS Safety thermometer
- Never events
- Reduction in repeated cause serious incidents

It is widely acknowledged that aspects of health care do not perform as well as they should. Even when we know what the right thing to do is, often our systems are not designed to deliver all aspects of evidence based care to every patient, every time. Measuring how reliable our care is can help us to uncover the variation across our Trust and point to where improvement is needed.

Over the next 3 years, we will seek out and reduce our variation. Additionally, we will put specific focus on the conditions and pathways indicated above so that all patients receive the same high quality care 7 days a week.

As measured by:

- New Advancing Quality care bundles:
  - Chronic obstructive pulmonary disease
  - Diabetes
  - Acute kidney injury
  - Sepsis
  - Alcohol related liver disease
  - Hip fracture
- Structured ward rounds
- Weekend mortality
- Agreed staffing levels
- Reliable adherence to NICE guidance
The Institute for Healthcare Improvement encouraged us to shift the focus of our relationships with patients from 'what's the matter?' to 'what matters most to you?' Going forward we'll use this new paradigm to drive our improvement focus and service design.

As measured by:

- Reduced waiting - for appointments, medications, discharge, transport
- Patient surveys, particularly the questions:
  - I understood what the nurse/doctor was telling me
  - I was involved as much as I wanted to be in decisions about my care
  - Did we deliver what matters most to you?
- Acute: More ‘better than expected’ questions on the inpatient survey than any other acute Trust
- Outpatients: More ‘better than expected’ questions on the inpatient survey than any other Trust (this survey takes place every two years)
- Response to survey question: Do you feel your appointment today was worth the time?
- Community: Implement measurement strategy and improve year on year

Caring for patients, their families and carers, is just as important out of hospital as it is when they’re staying with us as an in-patient.

Community based teams such as district nurses, community allied health professions, and intermediate care teams provide high quality compassionate care closer to or in patient’s homes. It’s important that in and out of hospital care feel seamless for patients and is of a consistent high quality.

For the next 3 years we want to work with out of hospital staff to address their unique improvement ambitions including improving coordination of care and person centeredness.

- Testing and rollout of the Productive Community
- Patient Surveys in community settings
- Safety Thermometer in community settings
What changes can we make that will result in improvement?

In order to accomplish our ambitious aims we’ll need a far reaching plan to engage with staff on finding solutions right across the Trust. The following Driver Diagram summarises the areas of work we’ll tackle in the next three years while the following pages examine each primary driver and what projects will be needed for each.

Key additions to the strategy in this third iteration include:

› Seeking out variation in practice
› Using our skills in quality improvement to improve efficiency and flow
› Focusing on groups of staff and processes that haven’t had as much exposure to Quality Improvement in areas such as administrative teams, middle managers, allied health professionals, pathology, etc.

![Driver Diagram](image-url)
Primary Driver 1: Leadership and Culture

Work to continue from previous strategy:

› Board level leadership and attention to measuring and maintaining safe care
› Further development of the contribution framework and development of our ‘continuous improvement’ value
› Continue a programme of WalkRounds and ‘Work-Whites’ where senior leaders work alongside staff to better understand their day-to-day challenges

New Ideas:

› Develop internal capability in executing a safety culture survey and use throughout the organisation
› Focus on developing leadership, quality improvement, and flow management skills of clinical and non-clinical middle managers
› Work to understand the barriers to doctor involvement and commit to a step change in doctor engagement and leadership of quality initiatives
› Expand work on transparency with patients and families when things go wrong
› Improve frontline to board organisational communication
› Commit to understanding safe staffing levels and work towards reliable safe staffing

Salford Royal’s Leadership Model
Leaders at all levels in Salford Royal are crucial in creating an outstanding culture of care and compassion.

Clarity of Purpose
- Aims & values
- What, how much, when
- Assess & measure

Behaviours
- Hear patient voice & listen to staff
- Authenticity - signal generator
- Defer to expertise
- Adopt a coaching approach

Mindset
- Avoid simplifying complexity
- Openness & transparency
- Teamwork trumps hierarchy
Primary Driver 2: Our Community

Work to continue from previous strategy:

› Focus programme of WalkRounds on working with staff out of the hospital
› Continue integrated care programme and pathway development
› Continue working with out of hospital staff on improving governance systems, understanding patient harm, incident reporting and root cause analysis
› Microsystems coaching programme – continue offering community staff the opportunity to apply for a Microsystems coach and ring-fence slots solely for community teams
› Community teams to continue deep engagement with harm free care projects: falls, catheter associated UTI, and pressure ulcers

New Ideas:

› Make clear for community staff the resources available to them including the quality improvement team and governance teams
› Make clear for acute staff what resources are available in the community
› Develop new ways to engage with community staff recognising that their working patterns will be different to other staff groups
› Work on rolling out the Productive Community Module (releasing time to care) and Effective Meeting Skills
› Use a teamwork and culture survey with community staff
› Potential community project focus:
   › Handoffs
   › Discharge
   › Documentation
   › High risk medications
Work to continue from previous strategy:

- Continue patient, family and carer collaborative - a place where staff can come together to share and test ideas to be more person centred in the environments they work in
- Continue to embed our ‘Always Events’ in every interaction with our patients
- Listening and responding to our patients through events and surveys in all care settings
- Salford Real Time Coaching: After a session of observation, feedback is provided to clinicians on the interactions that they have with patients

New Ideas:

- Focus on Shared Decision Making with our patients, families, and carers
- Improved patient information such as the use of videos to describe conditions & procedures, medications and acclimatisation to care areas
- Use experience based design techniques and co-design services with patients
- Develop consultant level patient experience data for outpatients
- Develop a person centeredness training for staff
- Further develop self-care models
- Consider using patients on interview panels and within the existing governance structure

The four principles of person-centred care
**Primary Driver 4: Quality Improvement Capability Building**

The ability for the Trust to deliver on all aspects of this strategy depends on the ability of staff to engage with improvement techniques and our ability to measure progress. Therefore, supporting this strategy through measurement and capability building warrants its own primary driver.

**Work to continue from previous strategy:**
- Continue offering bespoke training for staff using the 90 minute modules, content includes: Model for Improvement, lean tools, managing an improvement project, reliability, human factors, patient safety, and measurement
- Offer the Clinical Quality Academy course annually
- Continue offering Microsystems coaching to 10 teams 6-monthly

**New Ideas:**
- Focus on developing improvement skills in trainees
- Focus on developing improvement skills in middle managers
- Further develop and offer human factors training
- Develop a Salford Royal patient centeredness training
- Develop skills in using quality improvement tools to work on efficiency and flow problems

**Primary Driver 4: Quality Improvement Measurement**

**Work to continue from previous strategy:**
- Continue developing frontline to board dashboard used in Prodecapo
- Continue using Statistical Process Control charts for all quality improvement projects to understand variation
- Continue to evolve the Board level quality improvement dashboard
- Continue to perform a review on 100% of deaths that occur in the hospital
- Continue using clinical audit as a tool for improvement

**New Ideas:**
- **Past harm:**
  - Measure past harm and develop new measures such as medication errors
  - Present disaggregated data at specialty, team, unit, and consultant level where possible
  - Implement a whole organisation culture and teamwork survey
- **Reliability:**
  - Develop systems to measure: COPD care, AKI, sepsis, structured ward rounds, 7 day working, safety at night, sepsis, safe staffing
  - Reliability at directorate level (care bundles, NICE guidance, etc.)
- **Sensitivity to operations:**
  - Develop measures and skills in real time capacity and demand management
  - Further develop capability in data analysis
  - Real time and prospective quality and safety data
Primary Driver 5: Learning Systems

While Salford Royal already has strong governance structures and processes in place, we think we can strengthen our systems of cross-organisational learning by better integrating quality improvement with the methods already used in governance to create an agile learning system.

For this reason, we have added this area as a new addition to the strategy.

New Ideas:

› Integrated governance; strengthening the connections between the way we handle and learn from incidents, risks, complaints and claims. Use QI methods where applicable to address the action plans generated.

› Develop mechanisms to better listen to staff

› Supporting staff when things go wrong

› Designing/clarifying local learning systems

› Shift learning system focus to - will care be safe in the future?

› Strengthen systems to ensure reliability to clinical standards (NICE, NCEPOD, etc.)

Primary Driver 6: Suite of Projects

Some of the previous suite of projects will continue with a clear hand-off into the organisation for Divisions to ensure standards are sustained.

The previous set of projects included:

### SAFE

- a) Reliable care for high volume conditions
- b) Harm Free Care Project
- c) Pressure Ulcers
- d) Delirium
- e) Readmissions
- f) VTE
- g) Falls
- h) Medication Safety

### CLEAN

- a) Surgical site infections
- b) Sepsis
- c) CA-UTI
- d) Productive series
- e) *Clostridium difficile*
- f) MRSA
- g) E-Coli

### PERSONAL

- a) Hospital Empowering Loved-ones & Patients (HELP)
- b) End of Life Care
- c) Nutrition
- d) Intentional Rounding
- e) 7-day Working
- f) Patient and Carer Centred Working

New Ideas:

› Outpatients Improvement

› Theatre culture and efficiency

› 7 day working

› Structured ward rounds

› Improving Flow, efficiency, discharge and administrative processes

› Clinical communication and handover

› Safety at night

› Missed diagnosis and/or Mis-diagnosis

› Advancing quality new focus areas:
  - Acute Kidney Injury
  - Chronic obstructive pulmonary disease
  - Alcohol related liver disease
  - Diabetes
  - Hip fracture
Project Framework

We intend to tackle our proposed projects by using appropriate quality improvement methods on a project by project basis. What is common to the success of all quality improvement approaches is that they require deep engagement and collaboration.

Subject matter experts will need to work with improvement experts to test and implement changes on the front line of care. If successful, systems will be redesigned from the bottom up using small tests of change.

In addition to the methods listed below, we’ll work on developing our skills with tools that work on addressing flow and capacity/demand management.

The Breakthrough Series Collaborative Model

The Breakthrough Series Collaborative (BTS) Model is a proven intervention in which frontline teams can learn from each other and from recognised experts around a focussed set of objectives.

It is a fast paced approach where teams are brought together for learning sessions and are taught by both subject matter and quality improvement experts. There is emphasis on learning from each other, the testing of small changes and the collection of data.

A BTS cycle typically takes 9-15 months to complete; in our experience more than one cycle may be required for a project to achieve its aims.

Clinical Microsystems

The Clinical Microsystems approach involves supporting teams to lead and manage their improvement work by focusing on the needs of their patients and strengthening their links within the organisation.

Teams are supported in identifying and addressing areas for improvement through the use of a framework for data collection and a set of specific tools and techniques.

The focus of the Clinical Microsystems approach is to ensure that the smallest replicable unit (for example a district nurse team or ward) within an organisation is performing optimally.

Lean Tools

Lean is a set of tools that assist in the identification and steady elimination of waste. As waste is eliminated quality improves while efficiency and cost are reduced.

The aim of lean is to improve efficiency whilst reducing costs. All of the stakeholders within a process or patient pathway are brought together and the current process is mapped out.

The group then work together to redesign the process into a “future state,” the process is tested and refined until it can be implemented.
Collaboration with Partners

This Strategy is intended to support the delivery of the objectives of the Service Development Strategy and should be read in conjunction. Additionally, there will be much collaboration and crossover with the Trust strategies for IM&T, Innovation, and Person Centeredness.

In order to achieve our ambitious aims, we’ll also need to collaborate with external partners.

Our partners include:

Salford Clinical Commissioning Group

Safeguarding and Quality

Sign up to SAFETY
LISTEN LEARN ACT

AQuA
Advancing Quality Alliance

Manchester Academic Health Science Centre

Strategy Governance and Delivery

The Executive Quality and Safety Committee will oversee the delivery of this strategy. In early 2015, the committee will debate and approve a timeline for the initiation and continuation of projects referenced in this strategy.

Each project, as it is begun, will deliver a detailed project initiation document that includes clear aims, measures, and a project level driver diagram to this committee for approval and monitoring.