Salford Royal NHS Foundation Trust (SRFT)
NHS Litigation Authority Claims Reduction Award Summary

1. Introduction

Salford Royal is committed to the national Sign up to Safety Campaign and will be connecting the campaign to our implementation of our Quality Improvement Strategy 2015-2018. The Sign up to Safety Campaign in collaboration with the NHSLA has provided the opportunity to apply for funding to be applied specifically to working on reduction in claims. SRFT's application was awarded £222,545.40 from the NHSLA and we will be using this to work on the reduction of incidents that may lead to claims in Spinal Surgery. This document summarises our project plan for claims reduction in Spinal Surgery. This plan should be read in conjunction with the Trust's Quality Improvement Strategy 2015-2018.

2. Area of Focus

SRFT has chosen to focus on improving multiple aspects of quality and safety in Spinal Surgery. Applying a comprehensive department level version of our quality improvement strategy, we want to reduce claims by half in this area.

Our claims are few in number and have very varied root causes. While the claims numbers are small we know that our number of defects is much higher. Some of these defects end up being complaints, some are reported incidents, and some are claims. In order to make an impact on our relatively few (but high value) claims we need to make a large impact on the overall number of defects occurring in Spines. Our approach is to work on reducing today's defects so they never become tomorrow's harm events or claims. In doing so, our improvement programme will be much wider than focusing on a single harm event or pathway and seeks to address safety, quality, teamwork, and culture across the speciality.

Highlights of our plan include:

2.1. Leadership and Culture

We will build skills in leadership for improvement in clinical and non-clinical management and build a culture of safety and continuous improvement within the team that undertaken spinal surgery. We aim to achieve this via numerous methods including enrolling a team in either the Clinical Quality Academy or Microsystems coaching (SRFT quality improvement experiential learning programmes), deploying the Safety Attitudes Questionnaire, training team members in the duty of candour and how to be transparent when patient harm occurs.

2.2. Person Centeredness

The experience that our patients have whilst under the care of our organisation is of utmost importance to us. We understand that many of our patients are often undergoing life

changing diagnoses and treatments and it is our ambition that we make that experience the best that it can possibly be. We are rated as one of the best organisations in the NHS by our patients for several aspects of our care but there is still much more that we can do.

Within this workstream we aim to improve patient involvement in their care and patient satisfaction. Staff will be trained in shared decision making and undergo Salford Real Time Coaching which is where a staff member trained to observe clinics and patient/clinician interactions will observe and provide coaching to the consultant on their approach.

2.3. Quality Improvement Capability and Measurement

One of the key features of an organisation that has a safety culture is that it has a workforce that is capable of delivering improvement. This is something that we have prioritised at the highest level. One of the core values of the Trust is that our employees practice continuous quality improvement. This means that our staff must respond well to change and embrace initiatives, be open to new ideas and encourage forward thinking, taking ownership for continuous learning and self-development.

We will work with the Spinal team to build a quality and safety dashboard providing measurement that reflects both local and national priorities. The team will consider if there are relevant bundles of care to be developed and measured for their patient population. Human factors training will be provided to enable teams to understand why defects and harm occur and develop methods of improving reliability.

2.4. Learning Systems

Seamlessly integrating governance and quality improvement from the perspective of a specialty is a challenge. We have numerous outlets for reporting defects and for improvement but they don't always work in a unified joined up way. For this driver we will seek to align these streams of work to optimise learning inside the specialty.

This work stream will include the development of shared knowledge between local governance systems, quality improvement and claims processes to enhance learning and speed of improvement. The teams will also work on ensuring reliability to clinical standards deployed through NICE guidance, clinical audit and our own Nursing Assessment and Accreditation System (NAAS).

2.5. Driver 5: Projects to Support

In order to achieve our aim a number of individual projects will need to be executed in addition to the streams of work listed above. The projects will help to develop safer systems for patients, for example the management of the deteriorating patient with sepsis, and recognising post-surgery complications. Some of the most important projects are improving clinical communication and handover (which is a theme noted in the majority of claims and serious incidents), deploying reliable ward rounds and exploring a homecare pathway for spinal patients.

3. Measures

The measurement strategy for this plan will cascade from the measurement plan in the Trust Quality Improvement Strategy and will include local measures to understand specialty level mortality, harm, person centeredness, and reliable care.

3.1. Mortality

- Specialty level risk adjusted mortality
- % completed mortality case reviews

- Consultant level scorecards (provided by Dr. Foster)

3.2. Harm
- NHS Safety Thermometer
- Days between never events and serious incidents
- Number of repeated root causes in serious incidents
- Safety culture survey results

3.3. Person Centeredness
- Inpatient survey results. Particularly to the questions: 'I was involved as much as I wanted to be in decisions about my care', 'I understood what the nurse/doctor was telling me,' and 'did we deliver what matters most to you?' [all measured daily on our Hospedia system]
- Outpatient survey results

3.4. Reliability
- Reliability to structure ward rounds
- Safe staffing levels for nursing (% shifts filled)

3.5. Additional process measures
- Days between claims received
- Number of consultants trained in transparency
- Number of staff trained in human factors

4. Aims

This comprehensive programme will be deployed over 3 years in order to complete all areas of work and achieve sustainable change.

We will aim ambitiously for:

- 0 health care acquired pressure ulcers
- 0 inappropriate catheters
- 95% appropriate VTE prophylaxis
- 0 unexpected cardiac arrests
- Greater than 95% of patients harm free (as measured by the NHS Safety Thermometer)
- 0 never events (several claims were also directly related to never events – wrong level laminectomies)
- At least a 50% reduction in serious incidents
- Redesign and implementation of a more robust learning system to bring together root causes of claims, incidents and complaints
- 95% reliable nurse safe staffing levels
- Increased patient experience survey results