SUMMARY REPORT			
TRUST BOARD		**1 March 2018**	**Agenda Number: 08**
Title of Report	**Quality Improvement Programme update**		
Accountable Officer	Kate Shields, Deputy Chief Executive		
Author(s)	Kate Shields, Deputy Chief Executive		
Purpose of Report	The purpose of the report is to provide the Trust Board with an update on the Trust's Quality Improvement Programme through the oversight of the Quality Improvement Delivery Board.		
Recommendation	The Trust Board are recommended to: • Receive the update report		
Consultation Undertaken to Date	Update presented at Quality Improvement Delivery Board and QAC		
Signed off by Executive Owner	Kate Shields, Deputy CEE	21.02.18	
Reviewed by Executive Team	Quality Improvement Delivery Board	13.02.18	
Reviewed by Board Committee (where applicable)	Quality Assurance Committee	27.02.18	
Reviewed by Trust Board (where applicable)	Trust Board	01.03.18	
Date(s) at which previously discussed by Trust Board / Committee	The Quality Assurance Committee and Trust Board receive a routine update report.		
Next Steps	Trust Board to continue to receive routine updates		

Executive Summary

The Trust have embarked on a Quality Improvement Programme to support progress against the CQC 6 priorities and the Section 29a Warning Notice as well as providing a sustained approach to Quality Improvement moving forward against 3 priority Workstreams: Safety Culture, Strong Governance and Tackling Patient Delays.

The update will outline:

- A summary of Programme progress to date and the proposed next steps
- A 6 Key Priority summary
- The Section 29A Dashboard
- An update summary on the Strong Governance Workstream
- The Approach to maintaining a sustainable approach to Quality Improvement

Quality Improvement Plan - Executive Summary

The Quality plan and associate programme of work has moved past the start up phase and is well into delivery. We recognised last month that we had leadership and delivery capacity deficits across the programme. We have now ensured that all project infrastructure and leadership is in place and that all energy can be focused on delivery. We have spent time ensuring that we have a robust and auditable programme governance, which ensures that reported quality improvement stands up to objective measurement and challenge.

We have supported the Tackling Patient Delays Workstream with specific project delivery around access to surgical services. Our focus has been to work with clinical colleagues to identify the mechanisms by which we can immediately increase our ability to deliver Orthopaedic and GI elective services.

We have seen encouraging indicators of success with a positive external review undertaken in Cardiology by Royal College of Physicians.

Part of the work of the programme is to ensure we have a sustainable approach to quality, which allows us to learn and apply lessons across clinical services and have planned ways of the continued oversight of quality. For example we have designed a methodology for the conduct of harm and risk reviews based on the work undertaken with Cardiology and Ophthalmology. This enables us to have a systematic approach to apply to other services where backlog issues have the potential to cause harm or compromise quality. This is an example of how we intend to transition areas of concern from the Section 29A notice into the Quality Delivery Plan for onward dissemination of good practice. (Please see slide 10 for the longer term approach to Quality Improvement – The approach to Quality methodology will be presented during the March Board).

Area	Key Updates
6 Key Priorities	• Work is ongoing to define exactly how we demonstrate progress against the 6 Priorities and progress made to date and planned next steps will be presented at the IDM / Quality Oversight Meeting scheduled for 28/02/18
Section 29A	• The Section 29A Dashboard has been refreshed for January and all Workstreams are engaging to understand where improvement and action can be taken to address all Red and Amber recorded metrics
Quality Improvement Programme	• Clear trajectory and phasing of governance improvement (Slide 8) • All Workstream Governance initiated and reporting underway

Immediate Next Steps

- Options appraisal of the immediate steps to manage elective capacity (02/03/18)
- Reporting against agreed level 1 Quality Plan KPIs from 28/02/18
- Cross workstream interdependency mapping (Tom to confirm date)

6 Key Priorities

Priority 1: Robust structure and governance in place to support delivery of CQC actions, specifically timely access to cardiology and ophthalmology, and safe, high quality maternity care

- Please refer to Section 29A Dashboard

Priority 2: Winter pressures managed successfully

- Please refer to Winter Dashboard

Priority 3: Substantive appointment of Medical Director

- Complete

Priority 4: Broader engagement programme in place and starting to deliver

- Please refer to Executive Summary for Programme Update

Priority 5: Criteria for lifting Section 29A Notices will be met

- Please refer to Section 29A Dashboard

Priority 6: Medical Leadership Development Programme in place

- Being delivered through the Culture and Leadership Workstream in the Quality Programme

Section 29A KPI Performance Dashboard – Jan 2018

Safety Culture			Strong Governance	Tackling Patient Delays					Culture & Leadership	Other
Maternity Services		**Staffing & Skill levels**	**Serious Incidents**	**Cardiology**	**Surgical Services**	**Ophthalmology**	**Fracture Clinic Waiting Room**	**Patient Flow in Critical Care Unit**	**Grievances**	**Patient Records**
Emergency Incidents in the community ↓	Registered Nurse/Midwife with HDU per shift ↓	Vacancy rate (all staff) ↓	20 working days to investigate & close incidents ↑	Urgent outpatient waits ↑	Theatre brief & Debrief compliance ↑	Co efficient Risk Score ↑	All interim estates work completed ↑	RCA transfers that exceed the 1hr rule ↑	Time to complete grievances ↑	Compliance with Policy to monitor information & records ↑
SWAST – Purple rated calls (8mins) ↑	Numbers trained ↓	Turnover ↑	24Hr Divisional Clinical Review from potential SI ↑	Routine outpatient waits ↓	WHO Surgical Safety Checklist compliance ↑	Size of Follow Up pending waiting list ↑	Paeds booked first hour - % of appointments before 10am ↑	Delayed Discharges >24hrs ↓		
SWAST – Red rated calls (14mins) ↓	No. of incidents or post op infections ↓	Retention rate ↓	48Hr decision on SI classification / reported on STEIS ↑	Patients past their to be seen by date ↓	Scheduling policy to be developed ↑	Past to be seen by date ↓		Out of Hours discharges ↑		
SWAST – Green rated calls (4hrs) ↓	No. of delays reported ↓	Retirees ↑	72Hr Report Divisional Response ↓	longer than 1 month wait past seen by date ↓		New OP wait – urgent average ↑				
Incidents relating to deteriorating patients ↓		Skills competency compliance ↓	40 working days Draft Report to Governance ↓	Echocardiogram ↓		New OP wait – routine average ↓				
Compliance with documentation standards (MEOW) ↓		Registered nurse (Child) in ED 24/7 ↓	60 working days Final Report to Commissioners ↓	Event analysis ↓		Delay related SI's – reported harm ↓				
Compliance with documentation standards (all) ↓			Evidence Duty of Candour completed ↓							

Key:

⇧ Positive change

⇩ Negative change

Red = 15 Amber = 9 Green = 22	Improved = 21 Worsened = 16 Unchanged = 9

Section 29A KPIs in detail (1 of 5)

The Section 29A following data has been provided via the Performance team on the 19/02/18

	Topic	Ref	KPI	Target	Baseline	December	January	SRO Comment and Narrative for Action taken to improve situation
Safety & Culture	Maternity Services	1	No adverse incidents related to emergencies in the community	0	0	0	0	
		2	SWAST response within standards set for maternity purple rated calls (8mins)	90%	0	57%	100%	• Discussed at QIDB (13/02/18) that this is not a RCH standard and requires discussion
		3	SWAST response within standards set for maternity red rated calls (14mins)	90%	100%	81.80%	50%	• Discussed at QIDB (13/02/18) that this is not a RCH standard and requires discussion
		4	SWAST response within standards set for maternity green rated calls (4hrs)	90%	89.5%	100%	100%	
		5	No. of incidents relating to recognition of deteriorating patients	0	0	0	0	
		6	Compliance with documentation standards (MEOWS)	95%		99%	99%	
		7	Compliance with documentation standards (All)	85%	67%	74.1%	78%	• Audit commenced to understand next steps
		8	1 Registered Nurse/Registered Midwife with HDU formal qualification per shift 24/7	100%	87%	99%	88%	• Training underway to ensure by Mid March there will be someone on every shift to address this
		9	Numbers trained	5.63 WTE	5.2 WTE	7.2 WTE	4.2WTE	• Training underway to ensure by Mid March there will be someone on every shift to address this
		10	No. of incidents or post op infections	0	0	0	0	
		11	No. of delays reported	0	N/A	0	0	

	Topic	Ref	KPI	Target	Baseline	December	January	SRO Comment and Narrative for Action taken to improve situation
Safety & Culture	Staffing & Skill Levels	12	Vacancy rate (all staff)	8%	10.30%	11%	11.7%	• Active recruitment to all vacancies • Development of international recruitment plan • Development of clinical fellows programme • Proactive consultant recruitment • Improving proactive workforce planning • Developing divisional workforce plans with focused resourcing plan
		13	Turnover	10%	10.80%	10.10%	10.2%	
		14	Retention rate	88%	87.6%	86.8%	86.7%	• Cultural piece with address this • Professional networks set up such as CNS and HCAs for example to increased feeling of solidarity
		15	Retirees	2%	1.80%	2.10%	2.0%	
		16	Skills competency compliance	95%	85.20%	87.45%	86.35%	• Collected requirement and audit completed. Next steps to place on eRoster
		17	2 Registered Nurse (Child) in ED 24/7	95%	33%	97%	98.30%	

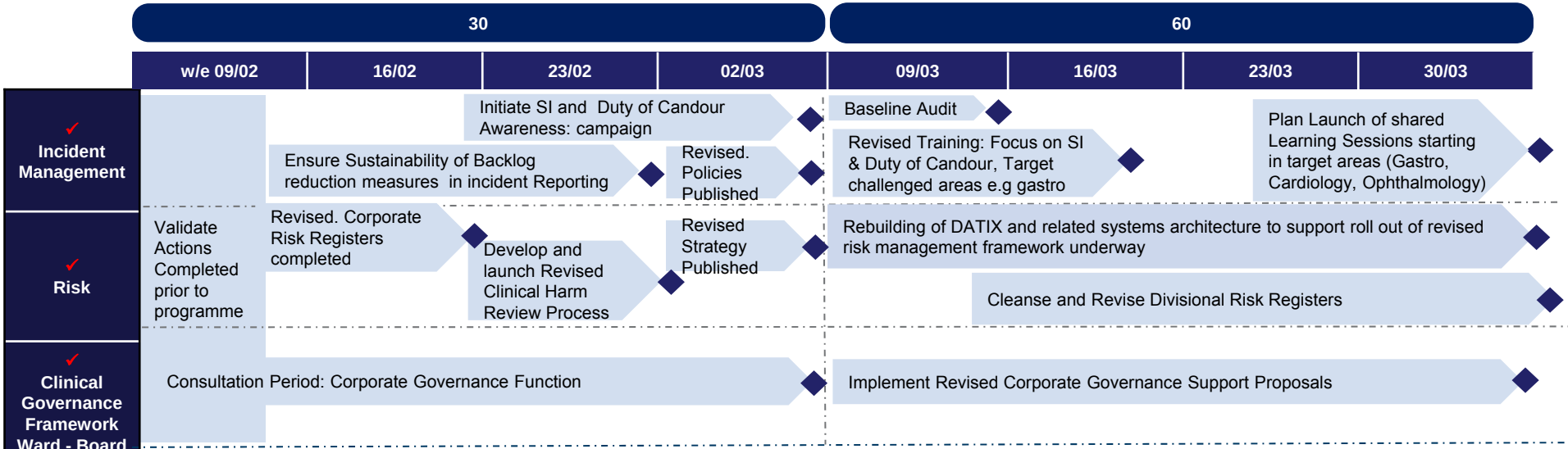
	Topic	Ref	KPI	Target	Baseline	December	January	SRO Comment and Narrative for Action taken to improve situation
Strong Governance	Serious Incidents	18	20 Working Days to investigate and close incidents	95%	TBC	54%	59%	• Revised SI SOP to be published (01/03/18) to include: ► New process with improved and clear reporting times, scheduled reminders and support from specialists for the achievement of all targets ► Additional and Improved Investigator training is under development ► The SI review panel will receive all 60 day reports at day 30 ► SI Panel to receive "pipeline" view of all SIs to hold divisions accountable for progress against internal targets from day 1 of identifying an SI
		19	24 Hour Divisional Clinical Review from identification of potential SI	80%	N/A	33%	61%	
		20	48 Hours Decision on SI classification/reported on STEIS	80%	TBC	21%	92%	
		21	72 Hour Report Divisional Response	80%	TBC	20%	0%	
		22	40 Working Days Draft Report to Governance	80%	N/A	100%	77%	
		23	60 Working Days Final report to Commissioners	80%	TBC	100%	88%	
		24	Evidence Duty of Candour completed.	100%	N/A	0%	0%	• The project will: correct the metric calculation to identify our DoC Datix recorded compliance • A brief retrospective review will be undertaken to establish our actual compliance base, to then be reported proactively from Feb data. This will inform the development of an improvement trajectory to full compliance
Tackling Patient Delays	Cardiology	25	Urgent outpatient waits	92% of patients on waiting list with an average wait within 4 weeks	3.31 weeks (Aug 2017)	3.58 weeks	2.73 weeks	
		26	Routine outpatient waits	92% of patients on waiting list with an average wait within 7 weeks	7.31 weeks (Aug 2017)	6.71 weeks	7.28 weeks	• The increase in average wait for routine is linked with sub speciality reviews for new outpatients. Consultants who work in the sub speciality areas are being targeted to release capacity
		27	Patients past their to be seen by date	400 (Dec)	575	433	460	
		28	Patient waiting longer than 1 month "past seen by date"	0	455	304	439	• The increase relates to consultant capacity. A redistribution of capacity was required to maintain wards and lab cover due to a departure of a locum. There will be full consultant establishment in March which will increase overall capacity for elective work
		29	Echocardiogram	98% within 6 weeks	86% (Aug 2017)	99.51%	98.28%	• Performance continues to achieve national target
		30	Event analysis	95% analysed within 6 weeks	12 weeks	100%	100%	

	Topic	Ref	KPI	Target	Baseline	December	January	SRO Comment and Narrative for Action taken to improve situation
Tackling Patient Delays	Surgical Services	31	Theatre Brief and Debrief Compliance	95%	69%	75.73%	85.93%	• A comprehensive process has been implemented to ensure the process is evidenced. Improvements expected as the process becomes fully embedded
		32	WHO Surgical Safety Checklist Compliance	100%	98%	99.60%	99.80%	• Exceptions have been investigated and process reviewed to ensure we meet the target
		33	Scheduling Policy to be developed	KPI 1 - Policy to be approved by January 18 KPI 2 - Policy to be implemented by February 18	No Policy	Draft Policy ratified (Dec); Final to be ratified in Jan.	Policy ratified in January	
	Ophthalmology	34	Co Efficient Risk Score	95% <2	96.5%	97.5%	98.02%	
		35	Size of Follow Up pending waiting list	7955 (Apr 2017)	July 2017 list size was 8227	7740	7950	
		36	Past to be seen by date	1248 (Apr 2017)	1270	1296	1496	• To improve these metrics, additional capacity is being built in to right size the service. This will be evidenced through an internal modelling size exercise. The increase in January is due to an exponential increase in demand
		37	New OP wait - urgent average	2.64 weeks	2.86 weeks	2.91	2.28	
		38	New OP wait - routine average	3.31 weeks	2.91 weeks	3.86	3.23	• High performance will be maintained
		39	Delay related SIs – reported harm	0	4	0	0	
	Patient Flow in Critical Care Unit	40	RCA transfers that exceed the 1hr rule	0	New measure	N/A	0	
		41	Delayed Discharges >24hrs	16	31	12	12	• Performance being maintained despite high acuity
		42	Out of Hours discharges	5	10.75	10	9	• Continuing to expedite discharges in day time hours. The high acuity month has necessitated later discharges

	Topic	Ref	KPI	Target	Baseline	December	January	SRO Comment and Narrative for Action taken to improve situation
Tackling Patient Delays	Fracture Clinic Waiting Room	43	All interim estates work completed.	Q4 for all work	List of estates work.	Unknown until Q4 2017/18	Work in progress	
		44	Paediatrics booked first hour of clinic - % of paediatric appointments before 10am.	80%	40.6%	72.2%	81.10%	
Culture & Leadership	Grievances	45	Time to complete grievances	8 weeks	18 weeks	13 weeks	9 weeks	• The grievance policy has been reviewed and will be implemented subject to the ongoing consultation. External investigators have been used to speed up processes. This action is on track
Other	Patient Records	46	Compliance with Policy to monitor information and records	95%	55%	86%	88%	

Strong Governance: 30 - 60 Day Priority Plan

Key: Duration of Task | Planned Milestone | ✓ Section 29A Priority Area



Weekly Wins

Weeks 1-2

- ✓ Workstream Scope, Objectives and KPIs (ToR) have been agreed
- ✓ Corporate Governance Function Consultation Launched
- ✓ Project lead, PIDs and Project Plan in place for priority areas
- ✓ SI backlog Deep Dive
- ✓ Revised SI and Duty of Candour Policies and Processes drafted for Ratification
- ✓ Revised Risk Strategy drafted for Approval
- ✓ Communications Plan and Materials for Duty of Candour and Serious Incidents Awareness

Weeks 2-4

- ► Launch Print, Digital and Face to Face Awareness campaign for Serious Incidents and Duty of Candour
- ► Sustainable Measures in place to complete all SI investigations by 60 days and ensure there is appropriate management and closing of action plans.
- ► Publish revised Policies and Procedures for Serious Incidents and Duty of Candour
- ► Publish the revised Risk Strategy
- ► Clinical Harm Review Methodology agreed and new reporting process started by Divisions
- ► Accurate pipeline of all SIs agreed

Weeks 4-6

- ► Case note audit of Duty of Candour compliance
- ► Revised and Targeted Training on SI/Duty of Candour and Risk Management commenced
- ► Map of new Datix Architecture to improve risk reporting and management agreed
- ► Begin Cleanse of Divisional registers to input into upgraded Datix
- ► New SI case Investigators in training
- ► Update on SI improvement trajectory agreed with Division

Weeks 6-8 to weeks

- ► Engagement with Divisions to develop shared learning sessions
- ► Communications and dates for shared learning sessions in place
- ► Completed Datix Upgrade
- ► Improved Divisional SI reporting position

Weeks 9-10

- ► Completed Risk register Cleanse

Developing and maintaining a sustainable approach to Quality Improvement

- Quality improvement has a role in improving all aspects of quality. This includes not only safety but effectiveness and the experience of care. We know that improving quality of care is complex and takes time to achieve. Analysis of major improvements in the NHS over the past 30 years shows that progress is typically made through a series of small steps rather than giant leaps forward. The nature of change management means it often takes time to demonstrate impact, and that even the most successful efforts will face obstacles, not least the unpredicted demand facing provider services in the NHS, Alderwick 2015.

- The structure of our Quality Plan has been to bring immediate focus on the most urgent patient safety and quality issues facing RCHT. We have supported projects to design their interventions around 30 day PDSA cycles and reporting structures to enable us to have better transparency of what has been delivered and what we can expect in the next month.

- We are committed to ensuring that our programme governance adds new capability in scrutinising our performance. We have continued work to achieve in; ensuring robust data capture, data sources and flow of information that provide a consistent version of performance across the Trust.

- We acknowledge that we have more work to do to ensure that Divisional and Speciality governance will provide a systematic approach to quality, with a clinically and operationally led approach as close to the patient as possible. This will be a key mechanism by which we ensure standards are achieved, there are clear mechanisms for investigating and taking actions on sub-standard performance, driving continuous improvement, and identifying and managing risks to quality of care. Key to this, is our complementary work around culture, leadership and engagement.

- We are now seeing specific improvements and signs of quality improvement across the work streams. This is being effectively identified through our structured monitoring and reporting mechanisms via the Quality Improvement Delivery Board. The Board will oversee our compliance against the Section 29A CQC and importantly act as the conduit as how we transition learning across the wider organisation. An example of this is how we have taken our approach in undertaking harm reviews, developed an organisational approach and are now planning on applying to other specialities.

- The development of the Quality Hub will be the key strategic driver around quality improvement. This will be the mechanism by which we identify, share and ensure delivery of best-practice.