To:	**Trust Board**
From:	Suzanne Hinchliffe
Date:	**20 DECEMBER 2012**
CQC regulation:	ALL

Title:	**Quality and Safety Commitment 2012 - 2015**

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Purpose of the Report:

- To share with members the final draft of the trust Quality and Safety Commitment 2012 – 2015 for approval
- To update members on the three task groups held to discuss the three key goals
- To update members on the identified key actions from the workshops and the next stage of engagement and monitoring

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

- The first draft of the Quality and Safety Commitment was shared with the Trust Board in November 2012 following which three workshops have been held with excellent attendance
- For each goal, key actions have been identified during 2013/2014 and 2014/2015 also supported by fundamental areas that are considered core to pursue
- Positive feedback has been received from commissioners and discussions are now being pursued as to how the Quality and Safety Commitment can be actively aligned to the 2013 Quality Schedule and CQUIN
- A wider engagement and communications plan is being developed ahead of the Quality and Safety Commitment launch which is expected to take place mid January 2013
- Further workshops are being held early January as part of the engagement process and will include patient representatives

Recommendations: To approve the Quality and Safety Commitment 2012 - 2015

Strategic Risk Register Linked to Quality and Patient Experience identified risk	**Performance KPIs year to date** Linked to Net Promoter and 4 Harms

Resource Implications (eg Financial, HR)
To be identified at January workshops

Assurance Implications N/A

Patient and Public Involvement (PPI) Implications – For active engagement

Equality Impact - Addressed

Information exempt from Disclosure N/A

Requirement for further review ? QAC/Trust Board Quarterly Basis

University Hospitals of Leicester NHS
NHS Trust

Quality & Safety Commitment

2013-2015

Foreword

Our aim at University Hospitals of Leicester is to put quality and safety at the centre of everything we do. As one of the largest teaching hospitals in England, this means providing high quality services for a diverse population of nearly one million people across Leicester, Leicestershire and Rutland.

Many of the services provided by our 10,000 staff across three hospital sites of Leicester General, Glenfield and Royal Infirmary hospitals are of high quality. We provide nationally and internationally renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders for approximately three million people. We have also made improvements in certain key areas (e.g. infection prevention).

There is still opportunity for further improvement in many areas. Our recent review of patient and staff opinions has identified key areas for us to focus on a. We are on a journey which will involve strong leadership and sustained commitment from each and every member of staff. Only by working together will we be able to achieve our aim.

This document summarises our quality commitment over the next 3 years to ensure that we provide 'Caring at its best'.

1 Our vision and values

1.1 Our Vision

In the next five years, we will become a successful Foundation Trust that is recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience.

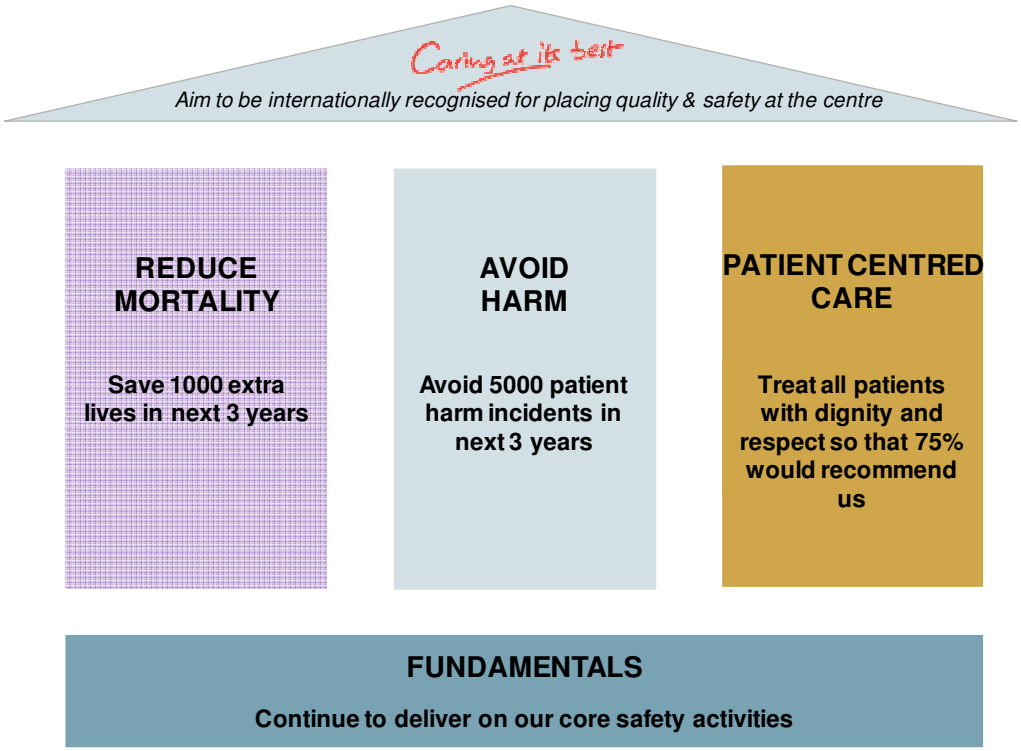
1.2 Our Values

Supporting our vision, are values and behaviours which we believe will enable us to place quality and safety at the heart of our hospitals and fulfil our purpose to provide 'Caring at its best'.

2 Our quality commitment

To deliver our vision of 'Caring at its best' we are laying out an ambitious quality commitment for UHL. Our priorities will be led through three over-arching strategic goals, each with a target to be delivered over the next 3 years. By 2015 we will aim to deliver a programme of quality improvements which will:

- Save 1000 extra lives
- Avoid 5000 harm events
- Provide patient centred care so that 75% of our patients would recommend us



We will particularly focus our efforts on a few targeted projects that are relevant to patients and staff, reflect local and national requirements and which we believe will have the largest impact on delivering against these commitments.

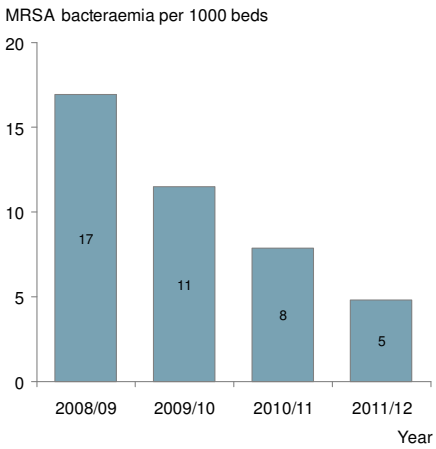
This will be supported by continuing focus on fundamental areas of quality that are ongoing and key for delivering our vision.

A central enabler of delivering against these goals will be improvement of our emergency pathway. This area has been identified as a key priority for improvement by the trust and is the focus of a project that will run in parallel with this commitment.

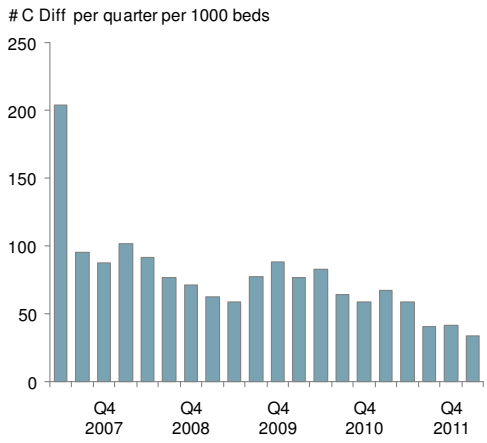
3 Why we believe we can deliver

Our quality commitment is ambitious and will take UHL to new levels of quality excellence. Our track-record shows we can achieve this through focus and commitment from all of us. We already have many areas of outstanding care, and over the last 4 years we have shown we can deliver in key areas of quality, such as infection prevention.

MRSA bacteraemia



C. Difficile toxin +ve



This commitment will be building on UHL's strengths; we will need to apply the same approach that has made us successful in the past to achieve this. In particular, a clear defined and appropriately resourced programme of quality improvement, and engagement of our frontline staff to deliver this programme.

4 Where are we now?

4.1 What do our patients tell us?

We gather feedback from patient surveys, NHS Choices, complaints and Net Promoter Scores. These highlight several areas where we are currently doing well, including several specialty areas and planned care.

"Everyone was helpful and friendly and the Doctors and Consultants all listened to me"

They also identify a number of areas of we can improve in order to positively affect their overall experience of care. In particular, improved information and decision making (particularly on discharge), improved efficiency of care processes (e.g. waiting times), understanding and care for people at end of life, patients with dementia and the older patient; hospital car-parking and food, and reducing unnecessary pain.

"I left in a state of confusion, not really understanding"

4.2 What do our staff tell us?

To inform the development of the Quality & Safety commitment we conducted web-surveys and focus groups with key front-line staff. Many clinical areas are seen as delivering high quality care for patients. In most specialities, our clinical outcomes are good and there are frontline led initiatives to reduce harm and improve patient experience (pressure ulcers, pathway re-design).

Furthermore, there has been significant improvement in incident reporting and learning from serious untoward incidents.

"We have demonstrated we can deliver quality improvements for our patients"

Clear opportunities for improvement were also identified. Quality priorities of the trust are not as clear as they need to be. In the past, there has not been sufficient commitment behind quality initiatives to ensure delivery. Additionally, greater emphasis needs to be placed on patient experience, and to address areas poorer clinical care.

"Roll-out of quality initiatives has been slow and variable ... there has been direction but not engagement"

5 How have we shaped our commitment?

Our commitment is being developed in consultation with our patients, staff and commissioners, as well as recognizing external requirements. It is based around what we believe are the most important priorities for UHL in order to save lives, avoid harm and deliver patient centred care. Two key steps have shaped our commitment to this point: identification of our goals, and defining focus areas. The next step will be to develop clear action plans in each focus area.

5.1 Identification of goals

An initial independent assessment and consultation process commenced in September with a web-survey sent out to key frontline staff, individual interviews with all board members, and key analyses of our performance. These findings were used to engage members of the Trust Board in a workshop dedicated to quality and safety in October. As a result of this workshop our three key goals were defined and circulated through-out the organisation.

5.2 Defining focus areas

To define focus areas within each goal, half-day quality workshops have been run with members of the Divisions and Clinical Business Units. Additionally, wider discussions with our commissioners, patient advisors and LINKS are taking place. This is essential to help ensure the plans we develop are robust and will achieve our goals. From these engagements we are identifying 2013 priorities; key fundamentals; and potential 2014-15 priorities for each goal.

2013 priorities: a small number of priority focus areas for 2013 have been identified for each goal within the commitment. These have been identified as the areas which offer the greatest opportunity to impact our targets within the next 12 months. These will be given additional focus and support to accelerate and ensure success.

Fundamentals: selected areas have been identified where we have an ongoing commitment to continue delivering excellent care or further improve services, but will not have a big impact on our target. These are of key importance and will continue to be pursued.

2014-15 priorities: we have identified other areas that will be prioritised in 2014-5, once we have delivered on 2013 priorities. These areas are also considered important, but may not be able to be fully delivered on in the next 12 months, or do not offer as big an opportunity as 2013 priorities. Over the next 12 months we will put in place any enablers required to ensure delivery on these priorities in 2014-15.

5.3 Next steps

Quality Action Groups, comprised of frontline staff and managerial support, were identified as part of the workshops. The next step will be for these groups to develop action plans for delivery against the 2013 priority focus areas.

This commitment will be reviewed on an annual basis alongside the trust Quality Account. As we deliver on priority areas in the commitment we will

want to refocus attention to others. This will ensure we focus on what matters most and deliver the best care for patients.

6 Goal 1: Save lives – save 1000 extra lives over the next 3 years

6.1 What is our target?

Overall, UHL is within normal range limits when compared against other NHS trusts for mortality using the two common standardised measures (SHMI and HSMR).

We believe there is the opportunity for UHL to achieve even better outcomes. We are setting our ambition higher by using the much tougher comparison of other acute teaching trust peers. We believe this is realistic, as we are already achieving this goal in several areas within the trust. We need to achieve these same levels of excellence in all areas.

Target

- *To save 1,000 extra lives over the next 3 years*

Stretch

- *To be in the top quartile of teaching hospital peers for mortality*

6.2 Where will we focus in 2013?

We have identified two priority focus areas for 2013, to drive accelerated improvement: respiratory pathway and out-of-hours. Peri-natal mortality, escalation processes and locum/agency staff will continue to be addressed as ongoing fundamentals.

2013 priorities	• **Out-of-hours (weekends and nights)** • **Respiratory pathway**
2014-15 priorities	• **Heart failure** • **Myocardial infarction** • **Other specialist care pathways** • **ITU/HDU provision**
Ongoing (funda-mentals)	• **Peri-natal mortality** • **Escalation processes** • **Locum/agency staff**

6.3 How will we measure?

We will use **Summary Hospital-level Mortality Indicator** (SHMI) to measure progress. SHMI is the recommended measure of mortality by both the National Quality Board and the first Francis Inquiry and will be used across the NHS.

SHMI is a hospital-level measure which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction takes in to account key information about the patient such as their age, diagnosis and co-morbidities and compares the patient to all patients with the same profile in English NHS Trusts. SHMI includes the number of patients who die in hospital and within 30 days post discharge. A SHMI of 100 means that the number of patient who died is as exactly as predicted based on the average outcome in other Trusts. A SHMI of below 100 means fewer patients died than predicted. A 1 point change in SHMI equates to ~39 patients at UHL. Our current SHMI is 105.

7 Goal 2: Reduce Harm – Avoid 5000 unintentional patient harm events in the next 3 years

7.1 What is our target?

We have made progress in reducing unintentional patient harm events over recent years. Infection prevention measures have been very successful, as described before. We have reduced serious untoward incidents, supported by our '5 critical safety actions' (CSAs) campaign. We are actively involved in the national programme to address the '4 harms' (falls, pressure ulcers, venous thrombo-embolisms, catheter-associated UTIs) with reductions in pressure ulcers in particular. Furthermore, there is a growing focus on harm events as indicated by the high levels of incident reporting.

There is opportunity to do better. Currently we are only mid-range in many areas when compared to our peers. We have the ambition to rise to the top

Target

- *Avoid 5000 patient harm incidents in next 3 years*

Stretch

- *To be in the top quartile of hospitals for priority areas (against national measures)*

quartile of Trusts for our high impact priority areas.

7.2 Where will we focus in 2013?

We have identified two priority focus areas for 2013, to drive accelerated improvement: 'falls' and 'senior review on wards with documented plans'. In addition, two further areas are still undergoing assessment for inclusion: specific medication errors, and ensuring results are acted on in outpatients. The '4 harms' (excluding falls) and Critical Safety Actions will continue to be addressed as ongoing fundamentals.

2013 priorities	• **Elderly and dementia care** • **Discharge processes & communication**
2014-15 priorities	• **Efficiency of care processes** – Improve access, waiting times, speed of appointments / referrals – Reduce / remove cancellations and outliers • **Environment and services** – e.g. improve car-parking, meals
Ongoing (funda-mentals)	• **Pain management** • **End of life care** • **Patient information and choices** – Staff availability – Staff attitudes and behaviour

7.3 How will we measure?

The trust currently uses multiple ways to measure harm. It actively encourages staff to report harm through incident reporting. The 'Safety Thermometer,' is used to assess the prevalence of the 4 harms on one day of every month. Infections are picked up through our microbiology laboratories. It will soon be possible to audit medication errors more easily with electronic prescribing, which is currently being rolled out.

The final decision on how to measure harm will be decided at the first meeting of the quality action group. It will be key to select measure(s) of identified focus areas that are reliable over time so that it is possible to track progress against our target.

8 Goal 3: Patient Centred Care – treat all patients with dignity and respect so that 75% would recommend us

8.1 What is our target?

Patient centred care should be core to everything we do at UHL; which is why it is identified as a key goal. We have some areas of excellence within the Trust, receiving very strong positive endorsement from patients. Additionally, a recent pilot intervention at UHL has demonstrated the potential to rapidly improve patient experience.

There is an opportunity to provide a better experience for many of our patients. UHL ranks low on likelihood of patients to recommend the hospital to family or friends when compared to peers. We have the ambition to rapidly improve this over the next 3 years so that we are in the top quartile of trusts in the East Midlands.

Target

- *75% of patients would recommend UHL to family or friends*

Stretch

- *To be in the top quartile of East Midlands Trusts for patient recommendations*

8.2 Where will we focus in 2013?

We have identified two priority focus areas for 2013, to drive accelerated improvement Elderly and dementia care, and discharge processes and communication. Pain management, end of life care and patient information and choices continue to be addressed as ongoing fundamentals. Our 2012-15 patient experience strategy will build on this and provide further detail, particularly on how this will be delivered.

2013 priorities	• **Falls** • **Senior review on wards and documented plans** • *Medication errors, not dependent on EPMA* • *Outpatient acting on results*
2014-15 priorities	• **Medication errors, dependent on EPMA** • **Catheter associated UTIs** • **Electronic handover**
Ongoing (funda-mentals)	• **Infection prevention** • **Pressure ulcers** • **VTE** • **Acting on results** • **Escalation (inc. EWS)** • **Handover**

8.3 How will we measure?

We will use information within the Net Promoter Score to assess our progress improving patient experience. Patients are asked " How likely is it that you would recommend this service to a friend or family?", scoring on a scale of 0-10. Those scoring between 0-6 are identified as detractors, between 7-8 are neutral, and between 9-10 are promoters. The Net Promoter Score is the difference between the percentage of users who would recommend our serves minus the percentage of those who would not. Our goal is to ensure that 75% of patients would recommend us (i.e. scoring 9-10). Our baseline score is 63%.

We will use other patient experience measures, such as qualitative feedback, patient recorded outcome measures to further inform continuous improvements in the quality of care received by patients.

9 Delivering our Commitment

The commitment laid out in this document is ambitious and will take UHL to new levels of excellence. Delivery of our commitment will depend on two key elements: a clear defined and appropriately resourced programme of quality improvement; and engagement of our frontline staff to deliver this programme.

9.1 Quality improvement programme

The Quality Action Groups will be accountable for the delivery of the quality improvement programme. They will develop clear action plans, with targets, milestones and assigned responsibilities. In addition, they will identify resource required to support delivery.

These action plans will be shared with the trust board. Following this they will be shared with our Divisional and Clinical Business Unit leads, and then with each member of staff, clearly explaining their role in the delivery of our quality commitment, and addressing potential issues and concerns.

There are three key requirements to help ensure success of this programme:

I. Capability development: All staff will need to be given the training and skills to deliver against the quality commitment, and the tools to apply continuous improvement techniques. It will be key to ensure training needs captured in the trust Organisational Development Plan 2012 – 2015.
II. Quality improvement (QI) infrastructure: Appropriate resource to support delivery will need to be in place. In particular, it will be essential to have advisory and coaching QI support for staff introducing change and improvement.
III. Actively managing for results: to build a culture of continuous quality improvement it will be important to ensure staff have personal objectives linked to quality and safety, and then to closely track progress, continually refining approach and holding to account.

9.2 Frontline staff engagement

Engagement of frontline staff support is key for delivering against our commitment. Projects will be delivered with a real focus on staff engagement, using their skill and expertise to inform and deliver our quality commitment. There are three steps to achieving this:

I. Initial engagement: It is important to engage staff in the case for change and the overall vision. This has already started and will be further reinforced in early 2013.
II. Mobilise: Action plans will be clearly explained to staff through cascaded communication events. It will be essential to have strong frontline leadership who can clearly address potential issues and concerns and explain the valuable role of each member of staff.
III. Continued commitment: It will be key to celebrate achievements and communicate ongoing progress through-out the organisation. Initial successes are particularly important to share and build momentum. We will build a system of awards and accreditation that support staff along the journey utilising current monthly newsletters, awards and

through celebrating our successes with our public. Over the next 3 years we will aim to engage over half our staff in a quality improvement project.

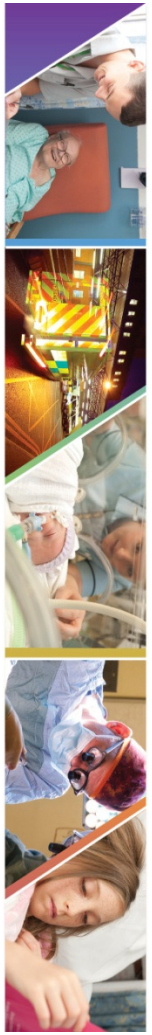
In addition to the focus on UHL staff, wider engagement will continue to be maintained with commissioners, patient advisors, LINKS and fellow health and social care colleagues, recognising the integral links with partner agencies and optimising opportunities for cross health economy working.

10 Return on investment

We strongly believe that delivering high quality services reduces costs over the medium term. This conviction is based on our experience with the infection prevention where patients with infections stayed in hospital much longer than average and therefore reducing the number of infections reduces length of stay and cost.

The Quality Improvement Strategy will require the Trust to invest in the work set out within this document. This will include direct investment in quality improvement resources, and in ring-fencing resources that might otherwise be considered for reduction. A detailed proposal of what will be required will be presented to the board over the coming months.

The quality and safety commitment laid out in this document is focused on the areas that will deliver the most value against our targets. We also expect this to deliver this to deliver the greatest financial value for our investment. Over the 3 years of this quality commitment we expect to see clear financial benefits from this investment. These will result from more straight-forward clinical course for patients both in hospital and following discharge, and from achievement of clinical quality incentives. We will measure and report these benefits.



Return on investment