Salford Royal NHS
NHS Foundation Trust

University Teaching Hospital

Quality Improvement Strategy 2008 – 2011

safe ● clean ● personal

Contents

Appendices

What are we trying to accomplish?

We aim to reduce hospital mortality rates (HSMR) to the lowest in the NHS and reduce avoidable harm by 50% within 3 years. This document describes how we will achieve our goal.

We will deliver a programme of quality improvement projects which will help staff make changes to provide safe, clean and personal care to every patient, every time.

We will focus our efforts on a targeted portfolio of projects which we believe will have a significant impact on harm and mortality. These projects are described in the document, as are the dashboard of measures we will use to determine the success of the programme of projects.

We predict that this programme of work will help us to achieve unprecedented clinical quality over the next three years which will include:

Key goals

- 1000 lives saved
- 10,000 harmful events avoided

Additional benefits

- Infection rates reduced by 70%
- Patient and staff satisfaction scores in top 20% of NHS
- Average length of stay reduced by 20%
- Re-admission rate reduced by 30%
- A 3% increase in efficiency

The quality strategy builds on our strengths and complements our governance and safety infrastructure. This strategy takes us into unchartered territory. We will need to learn and embed a range of quality methods at all levels within the organisation. Our clinicians and managers will have to demonstrate an unrelenting determination to stick to this agenda despite internal and external challenges. We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day. Emphasis will be placed on understanding our systems in greater detail, working towards excellence in clinical systems, engaging all our employees in improvement, using small tests of change to build momentum and learning from mistakes.

Hospital standardised mortality rate (HSMR)

We have collected data to investigate our hospital standardised mortality rate. Our preliminary data suggests that whilst our system is improving (as demonstrated by figure 1) there is capacity for further improvement.

HSMR compares an organisation's actual number of deaths with their expected (or predicted) number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency, and the length of stay. Standardisation of the ratio allows valid comparison between different hospitals serving different communities. If the Trust has an HSMR 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 HSMR above 100 means more patients died than would be expected; one below 100 means that fewer than expected died.

The five year average HSMR for Salford Royal between 2002 and 2006 was 99. During the last six months of 2007 the HSMR fell to 83. This now means that we are saving 17% more lives than our expected level.

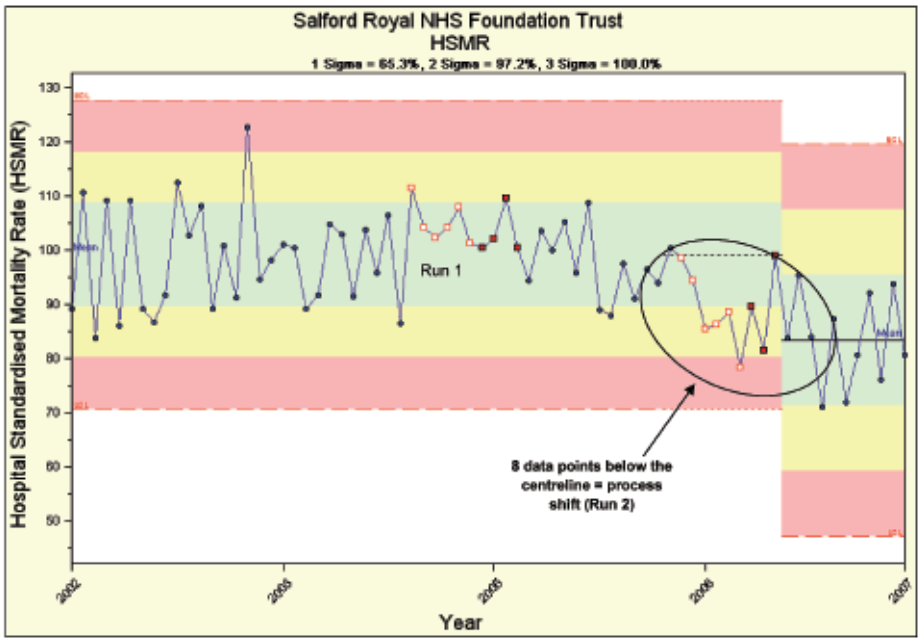


Figure 1: *A control chart of the monthly HSMR (vertical axis) and time (2002-7) captured by the Dr Foster performance measurement system. The green, yellow and pink shaded areas represent one, two and three sigma (variation) respectively. The open red squares indicate a shift in process (a run of 8 consecutive data points either above (run 1) or below the centreline (run 2). Control limits are re-calculated after the shift to mark the new process.*

QUALITY MATTERS

Can we save lives?

We understand that a small number of patients die in hospital. Each year we would expect approximately 1000 deaths (dependent on total patients admitted). The table below shows that year on year we have actually experienced fewer deaths than would have been predicted given the type of patients we treat. In 2007 we achieved unprecedented performance in that we had 200 fewer deaths than predicted.

In 1991 the Harvard Medical Practice study was published, in which 30,000 randomly selected patients in New York state hospitals were studied. 3.7% had injuries from adverse medical care and in 13.6% of cases this led to death. **The authors concluded that 50% of these deaths were preventable**.

These findings concurred with similar studies in the UK, Canada, New Zealand and Australia. In 2000 the Institute of Medicine (IOM) published its landmark report 'To Err is Human' in which it concluded that about **10% of hospital deaths were due to preventable adverse medical care events,** identifying iatrogenic harm as the third commonest cause of death in the developed world.

UK hospitals in the top decile of performance have achieved a HSMR as low as 75. This strategy will target avoidable harm and deaths and will see our lives saved achievement reach a level comparable with the best in the UK.

The data in table 1 are the actual number of hospital deaths per year at Salford Royal from 1999 to the present – the lives saved estimate is a simple subtraction of actual minus predicted deaths which gives the lives saved over a given period (in this case one calendar year).

As a rough guide, every 10 point reduction from a HSMR of 100 is just over 100 lives saved.

Limitations of HSMR methodology: The HSMR methodology examines a basket of 56 diagnosis groups, which represents 80% of hospital deaths. This means that our estimates of effect will be more conservative using this methodology.

Period	Deaths	Predicted	HSMR	Lives saved
1999	1097	1184.0	92.65	**87**
2000	1107	1164.7	95.05	**57**
2001	1163	1228.4	94.68	**65**
2002	1302	1326.1	98.18	**24**
2003	1317	1332.2	98.86	**15**
2004	1215	1202.5	101.4	**-12**
2005	1181	1185.3	99.64	**4**
2006	1139	1262.1	90.25	**123**
2007	1151	1358.1	84.75	**207**

Table 1: *Shows the actual number of deaths, the predicted and the HSMR (actual / predicted *100). The lives saved per year are calculated in the lives saved column.*

Estimate of impact

Given a 5 point per year improvement from the current level of 85 over a 3 year period the estimate for lives saved would be 750.

Setting an aim to save 1000 lives would be a reasonable stretch goal.

	HSMR	lives
2008	**80**	**200**
2009	**75**	**250**
2010	**70**	**300**
Total		**750**

Table 2: *Shows the predicted HSMR from a baseline of 84 (2007) with a 5 point reduction year on year over three years.*

First do no harm…

The Hippocratic Oath provides the basis of the fundamental principle for healthcare. Patients assume that their hospital is a safe place. It is our duty and responsibility to protect them from harm. Salford Royal is committed to provide services which are safe, clean and personal.

What do we mean by harm?

Hospital 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 hospitals everyday. Fortunately catastrophic events are rare but we must acknowledge that unintentionally a significant number of our patients experience some harm.

Harm is defined in many ways but a common belief is that harm is 'unintended 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 stay in hospital'.

Simply, this is suboptimal care which reaches the patient either because of something we shouldn't have done or we didn't do something that we should have done.

Measuring harm

Traditional efforts to detect harm have focused on voluntary reporting and tracking of 'adverse events'. However, research has shown that only 10 to 20 percent of errors are reported through adverse event reporting systems and, of those, 90 to 95 percent cause no harm to patients. Hospitals need a more effective way to identify events that do cause harm to patients, in order to select and test changes to reduce harm.

The Trust has therefore decided to use the Institute for Healthcare Improvement (IHI) Global Trigger Tool to accurately identify harmful events. This tool is used by clinical auditors to review a randomly selected set of patients' records. The review identifies 'triggers' or clues as to whether an adverse (sub optimal) event has occurred and whether this actually caused the patient any harm. Harmful events are then categorised as to the extent of harm.

Can we reduce harm?

We have been examining 20 randomly selected clinical records per month using the Institute for Healthcare Improvement (IHI) Global Trigger Tool (GTT) to provide a baseline adverse event rate.

Harm per 1,000 bed days	38.4
Total number of bed days / 1000 (2006/07 – Dr Foster)	277.721
Total Harm in 2006/07	10,664
20% Saving in 2008/09	2133
35% Saving in 2009/10	3733
50% Saving in 2010/11	5332
Total Harm Avoided in 3 Years	**11,198**

Table 3: *The table above shows the average harm per 1000 bed days from our baseline measure (August – October 2007) at 38.4.*

The total number of harms in 2006-7 can be extrapolated by dividing the total number of bed days (277,721) by 1000 and multiplying this figure by 38.4. We can estimate a 'total number of harms' for this year and use this figure as a baseline from which to estimate possible harms in future years. If we assume that 20, 35 and 50% of harms will be reduced in years 1-3 respectively then it is possible to estimate the impact of the quality improvement programme on harm to produce a 'total harms avoided' figure of 11,198.

Setting an aim to reduce the total number of harms by 10,000 would be a reasonable goal.

Other indicators and dashboards

Board dashboard	
Clinical outcomes	HSMR Harm Infection Re-admission
Satisfaction	Patient Staff
Resource utilisation	Length of stay

Table 4: Board dashboard contents

Level 1 – Corporate Indicators: Each month the board will review data on clinical outcomes, satisfaction and resource utilisation. The data will also be reviewed electronically using the board level scorecard in prodacapo. This information will also be cascaded to the clinical directorates and wards. The group will discuss how the QI strategy is impacting on the data in particular with regard to shifts, trends and special cause variation.

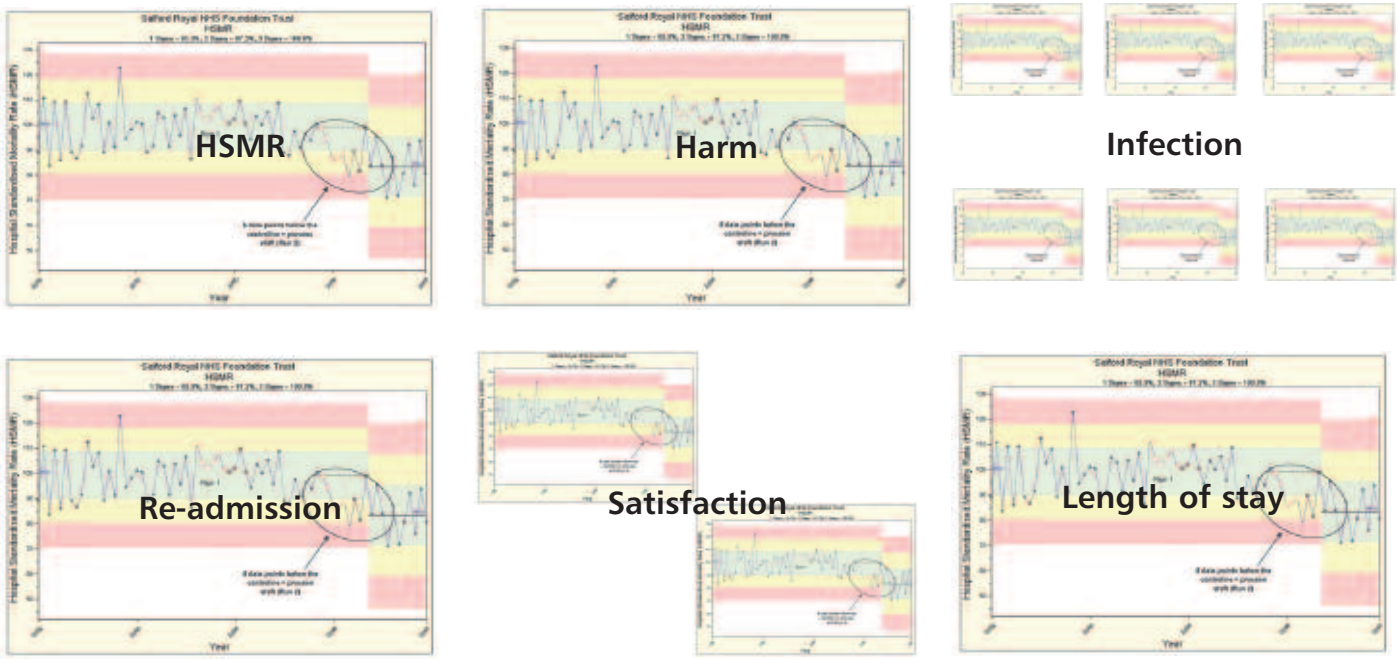


Figure 2: An illustration of the dashboard set up (using run charts) and using demonstration data (see figure 3 for details of infection surveillance).

Level 2 – Project Measures: Each project will have its own set of measures and milestones. These will be described in the project initiation document and progress against these measures will be reviewed by the Board of Directors on a pre-scheduled programme.

Level 3 – Other Measures: There will be centralised reporting of important quality initiatives which do not fall directly into the quality strategy portfolio of projects such as ventilator acquired pneumonia.

Understanding what will drive change

The improvements we are seeking will not happen by themselves. The Board of Directors has agreed that the improvements need to be managed through an understanding of what will drive and influence change. We have used a driver diagram to conceptualize the programme and determine its components and its organisational impact. This diagram helps to identify connections and interdependencies of what will drive and influence change.

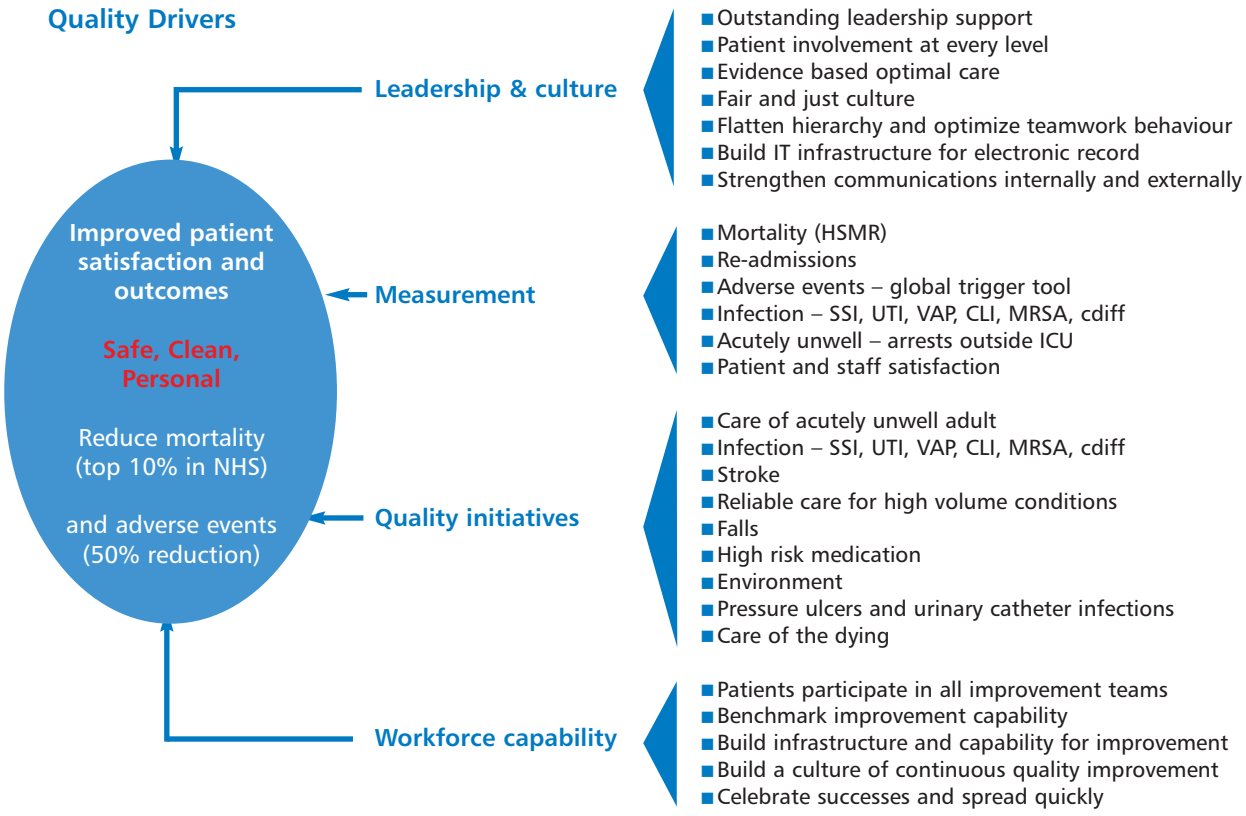


Figure 3: *Illustrates the four interdependent system components that we predict will drive the change required to support the programmed activity of projects and the activity which will be required to support the system components are bracketed.*

Reporting and organisational structure

The Trust Board will oversee delivery of the strategy. It will devote the first part of its monthly meeting to the QI strategy. During this part of the meeting the Board of Directors will be joined by the Associate Director of Governance; Associate Director of Quality Improvement; Associate Medical Directors and the Deputy Director of Nursing & Governance. The Board will oversee quality work within directorates and across the organization. It will provide the strategic direction for quality and safety and they will provide support to general managers, clinicians, project leads, project managers and quality improvement leads from the Quality Improvement Directorate.

Delivering the strategy: A programme of projects

The delivery of our strategy will be through programme management of a series of projects. The programme is designed to contribute to our aim to provide 'safe, clean and personal' care. We have now identified the projects in each area. This will focus our work as we move forwards. We have 'phased' them to indicate an order of delivery. A traffic light system has been used to illustrate projects that are in phase 1 (green), phase 2 (amber), phase 3 (red)

Safe

1. Acutely unwell adult
2. Reliable care:
   - Acute myocardial infarction
   - Heart failure
   - Hip & knee replacement
   - Community acquired pneumonia
3. Stroke
4. Falls
5. High risk medications
6. Pressure ulcers

Clean

1. Reduction of infection:
   - Clostridium difficile
   - Central and periperal line
   - Surgical site infection
   - Urinary catheter infection
   - Ventilator acquired pneumonia
2. Environment
   - Toilets and bathrooms

Personal

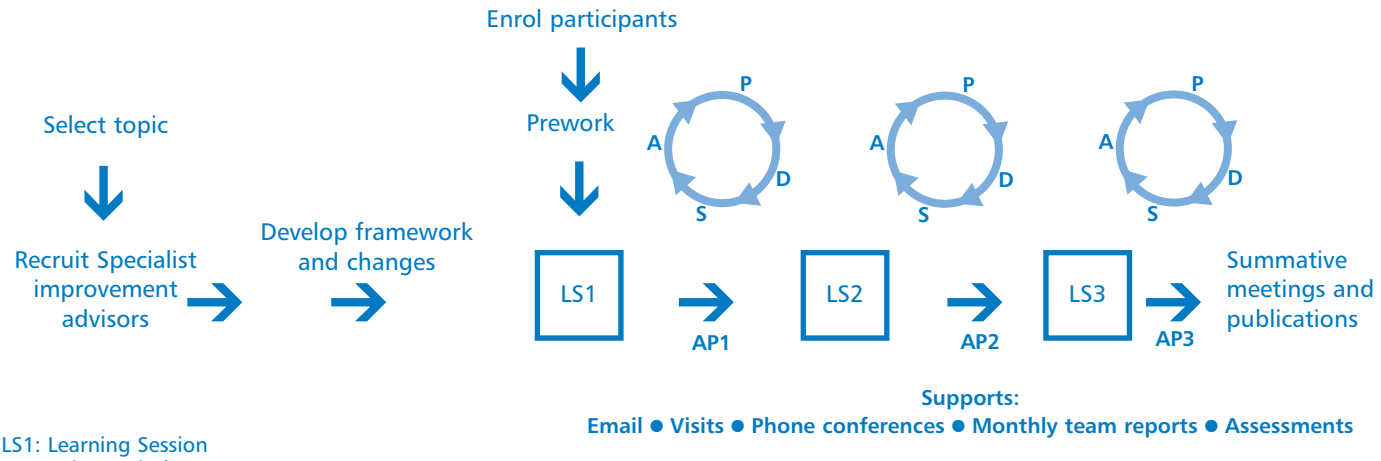
1. Staff engagement and awareness – QI launches
2. Safe, clean and personal every time 'SCAPE Ward'
3. Patients engage in re-design
4. Care of dying

Project framework

We intend to run system wide programmes of work for complex improvements which involve many stakeholders and several microsystems. This will form the mainstay of the work of the QI directorate over the next 3 years.

We will use the Institute for Healthcare Improvement's Breakthrough Series Collaborative Model (BTS) to provide a chassis for improvement efforts. The breakthrough series collaborative (BTS) model is a proven intervention in which wards and departments can learn from each other and from recognized experts around a focussed set of objectives. The key to success is engagement, alignment and collaboration. Subject matter experts work with improvement experts who help organisations select, test and implement changes on the front line of care. Systems are redesigned from the bottom up using small tests of change.

A BTS collaborative provides a framework to optimise the likelihood of success for improvement teams. It works best when there is a deficit in quality which can be identified by teams as 'unacceptable' and where there are pockets of excellence which can be used for learning. Critical success factors include leadership support; patients at the helm; a clear aim; focus on measurement; an agreed time frame and clinical engagement. Teams commit to working together over a fixed period and attend three 2 day learning sessions. In-between learning sessions there are 'action periods' where teams test changes. Learning sessions provide instruction in the theory and practice of improvement and feedback to senior leaders, focusing the organisation's learning. Each team reports on their methods and results, lessons learned and provide social support and encouragement for making further changes. During the intervening action periods participating teams have direct access to specialist improvement advisors and one another via an extranet home page, regular conference calls, online dialogue, frequent written updates and supportive ward visits.



LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Figure 4: *illustrates the BTS framework – specialist improvement advisors are selected and attend an expert meeting to develop the framework.*

Phase 1 projects

Timeline 2008 – 2009	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A
QI Launches																				
Cdiff				LS						S										
Hip & Knee	P	EM	PID	LS	LS	LS			S											
Acutely unwell	EM	PID		LS		LS			LS				S							
Stroke	P	P	EM	PID					LS			LS				LS			S	
Reliable	P	P	P	P	EM	PID			LS			LS			LS				S	HO
C & P Lines					P	P	P	EM	PID		LS			LS		LS		S	HO	
Environ				P	P	EM	PID			LS			LS		LS		S	HO		
Falls				P	P	P	EM	PID		LS		LS		LS		S	HO			
High Risk Meds				P	P	P	P	EM	PID		LS		LS		LS			S	HO	

Key: P = Prep; EM = Expert meeting; PID = project initiation document; LS = Learning session; S= Summit (scale up) Hand offs will start at third LS for each project.

Project infrastructure

Projects will be managed by project managers who will be allocated to work with expert specialist improvement advisors to plan and carry out the programmes. Projects are scheduled according to the framework of the BTS model and may last 6-18 months dependent on complexity and content. Each project will have an accompanying scale up and spread strategy. Each project will determine the best means for effective patient involvement. This may include a patient focus group and use of Trust membership.

1. **Preparation** – during the preparation phase the project champion will be identified by the Board. They will work with the project manager to identify specialist improvement advisors and organise the expert meeting and timeline. Information will be gathered and a best practice framework developed by a small team. Pre-work will commence on measurement, data collection and materials. The project initiation document will be completed in draft format.

2. **Expert meeting** – the expert meeting is convened to bring together subject matter experts who have skills and experience to complement each other and who are passionate about improvement. They agree the content of the programme and the project plan in the project initiation document.

3. **Project initiation document** – this is a detailed description of the background, aim, measures, changes and timescales. It will be presented to the board prior to commencement of the project and will be used to determine whether the project is running to schedule.

4. **Learning session** – see project framework (page 11).

5. **Summit / scale up** – the summit is an opportunity for teams not in the innovation community to learn about the changes tested in the collaborative. The spread strategy, which will be developed by specialist improvement advisors and commence during the innovation period, will be formerly discussed and presented.

Return on investment

Our long term financial planning has identified that the Trust has to deliver savings of £6 million per annum per year for the next three years. We are convinced that delivering high quality services reduces costs. This conviction is based on our experience with the clostridium difficile collaborative which clearly showed that patients with infections stayed in hospital three times longer than average and therefore reducing the number of infections, reduces length of stay and cost.

It is important that we are able to identify the financial benefits that will accrue from the work undertaken in each of the projects. This will rely on being able to measure the financial impact of the initiatives and compare income and costs of service at the individual project level before and after quality improvement activity. We will call this 'return on investment' and this must be demonstrated and measured within each project.

The Quality Improvement Strategy will require the Trust to invest in the work set out within this document and it is anticipated that this will be approximately £1 million per annum. However, the programme of activities will be a main contributor to the delivery of overall organisational efficiency through its improvement programmes and therefore contribute to the achievement of the required savings each year.

Marketing and communications

We believe that a cornerstone of the success of our strategy is a shared vision for what we want to be in the future. Preparatory work will need to focus on building a common vocabulary for everyone in the organisation. It is important that we provide staff with a clear understanding of the need for change whilst recognising that everyone in the organisation is doing their best and that their contribution is valued.

To start this process we have held a series of consultation events for 800 randomly selected employees of the Trust during January, February and March 2008 which served several functions; first it allowed us to articulate our strategic direction; second it began to articulate the problems we face; third it began to develop a common language for quality and fourth, and most importantly it allowed us to begin to harvest staff opinion about our new direction. We will go through a similar process with our service users and membership during 2008.

A series of curricula will be developed for all staff which will include a session on quality improvement at induction and a comprehensive website with tools and resources. Over the start-up three years we will aim to engage over 70% of staff in a quality improvement project as our programme scales up and spreads across the organisation.

Figure 5: *An example of a quality matters newsletter for stroke services.*

Figure 6: *An example of a certificate of achievement presented to a ward team participating in the cdiff collaborative.*

We anticipate building capability for improvement around a structured programme of accreditation (e.g. bronze, silver and gold). Frontline teams and project participants will be encouraged to achieve bronze / silver whilst project leads will complete the gold accreditation. Secondees into the QI directorate will be expected to complete the full accreditation via fast track to gold accreditation and will return to their clinical areas to lead quality improvement. There will be an ongoing senior management and leadership development programme in QI methods which will include the Board of Directors.

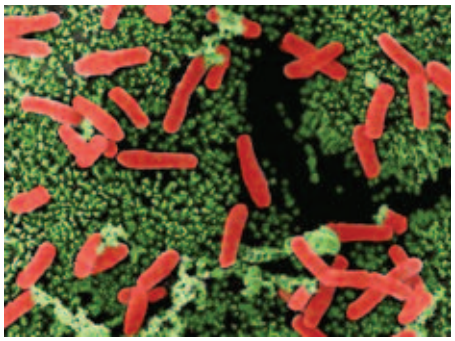
Quality Improvement Leads in the QI directorate will all be trained as Improvement Advisors and be encouraged to pursue personal development in priority areas for the directorate and organisation more broadly. A programme of in-service training will be developed and run by the QI directorate.

We will work with the communications department to develop a corporate template for QI information under the theme of 'Quality Matters'. Each project plan will have its own communications plan. We will develop materials that can be used to reduce variability in the system and support the strategy as it evolves. Our focus will be on identifying and sharing best practice and celebrating success (figure 5).

We will build a system of accreditation, awards and personal achievement which support staff along the journey. For example, we are keen that every ward should have a notice board to highlight important infection control issues. We are keen to support this activity with a core template, monthly updates and certificates of achievement similar to the one displayed in figure 6.

Appendix 1: Compendium of phase 1 projects

Clostridium difficile (cdiff)



The aim of the c diff collaborative is: To reduce the incidence of c diff on the elderly care wards by 50% within one year.

Why? The cdiff collaborative was the first test of whether an internal breakthrough series collaborative (BTS) could drive unprecedented improvements in the control of infection. In March 2007, we had the 4th highest incidence in the North West and our numbers were rising.

Who? Executive lead: Elaine Inglesby. Project lead: Consultant Nurse in Infection Control. Teams: Multiprofessional teams were invited to participate in an informational day. Attendees were present from domestic services, house keeping, portering, nursing, pharmacy, rehabilitation and medicine. Wards L2, L3, L4, L6 & L8 volunteered to pull together a multiprofessional group to participate in the collaborative. Two other groups were also formed to test changes in antibiotic prescribing and transfers of patients.

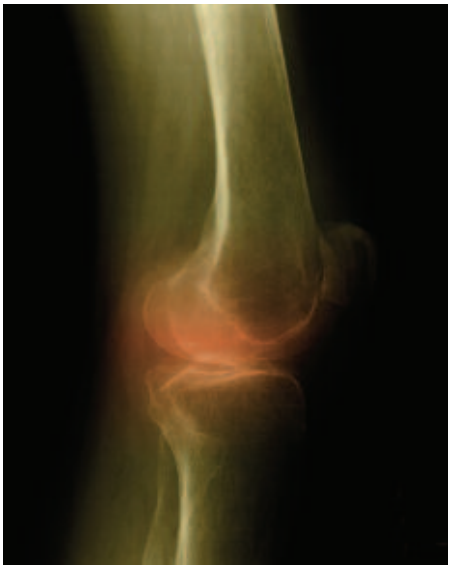
When? Commence March 2007 - end October 2008.

Outputs: 1.Change package for reduction of cdiff to share with the rest of the organization. 2. Project summary document for publication. 3. Conference papers. 4. Increased capability for improvement in the innovation community. 5. Cost benefits.

Scale up & spread: The QI directorate is currently working with teams to hold the gains and scale up improvements to the rest of the hospital. The handover commenced in February and will conclude in November 2008.

Safe, clean & personal goals: This collaborative delivers a phase ONE goal under the CLEAN portfolio of strategic QI objectives.

Hip & knee



The aim of the hip & knee collaborative is:
1. To shorten the patient journey for elective H&K to less than 18 weeks for 95% of patients.
2. To improve patient and staff satisfaction to the top decile within one year.

Why? The government agenda to achieve an 18 week pathway for all patients by 2008 requires services to run efficiently and respond rapidly. In order to meet the challenges of the 18 week project services need to redesign their processes which have historically been provided in a waiting culture. Service redesign offers the opportunity to improve the quality of the patient journey and increase satisfaction. Furthermore the introduction of the CATs service for orthopaedics means that our service has to meet and exceed the services provided within the private sector in terms of cost and quality.

Who? Executive lead: Stephen Waldek. Project lead: Assistant director of operations. A steering group has been set up and will comprise: Orthopeadic surgeon; service manager; ADNS; rehab services manager; stores & supplies; clerical & admin.

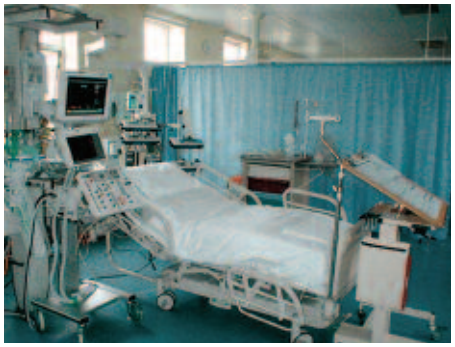
When? The initial part of this project will focus on the pre operative pathway. **The prework** has already commenced and an **expert meeting** was arranged for **March 2008**. The collaborative will follow the BTS model with teams from booking; out-patients, prehabilitation & pre-op and one ward.

The collaborative will commence in April 2008. This session will be 4 days and will use a modified template which will include in-depth review of existing services (process mapping), LEAN and re-design which will occur within the context of the learning session. Teams will leave LS1 with tests of change. The collaborative will last **6 months – end September 2008.**

Scale up & spread: The QI directorate will work with teams from September – November 2008 to continue to build satisfaction.

Safe, clean & personal goals: This collaborative delivers phase ONE goal under the PERSONAL portfolio. It also delivers SAFE objectives– surgical site infection. Shortening the pathway for patients with H&K should reduce pre-op hospitalization which is known to be associated with increased morbidity & mortality.

Care of the acutely unwell adult



The aim of the acutely unwell adult collaborative is:
To reduce cardiac arrest calls outside units by 50% within one year.

Why? Local data indicates that since the inception of the adverse incident database there have been 29 reported incidents which have identified sub optimal care contributing to patients' deaths and 100 incidents reported around unexpected deterioration. There are approximately 365 cardiac arrests annually with a survival rate of approximately 10 -15% .

Who? Executive lead: Elaine Inglesby. Project lead: Nurse Consultant in Critical Care. A project steering group has been formed and named 'care of the acutely unwell adult project team' and report to the critical care steering group. 12 wards have been invited to participate in phase 1.

When? Pre-work for this project started in November 2007. The expert meeting was held in January 2008. The collaborative will commence in April 2008.The duration will be one year end March 2009.

Outputs: 1. Change package for reduction of arrest calls outside units to share with the organization. 2. Project summary document for publication. 3. Conference papers. 4. Increased capability for improvement in the innovation community. 5. Cost benefits. 6. Rapid response appropriate to organizational need.

Scale up & spread: The QI directorate will work with teams to hold the gains and scale up improvements to the rest of the hospital. The hand off will commence in September 2008 and conclude in February 2009.

Safe, clean & personal goals: This collaborative delivers a phase ONE goal under the SAFE portfolio of strategic QI objectives.

Stroke

The aim of the stroke collaborative is:
To reduce stroke HSMR by 30% by adherence to 3 process indicators: CT brain scan, swallow screen and antiplatelet

Why? We have bid to be the comprehensive stroke centre for Greater Manchester. We need to demonstrate that we can improve our sentinel audit score from 81 to 95 by April 2008 and lead quality improvement efforts across the conurbation.

The aim of this collaborative will be to reduce stroke HSMR by 30% by 95% adherence to 3 process indicators: CT brain scan, swallow screen and antiplatelet within 24 hours.

Who? Executive Lead: Tony Whitfield. Project lead: Stroke Specialist Nurse and AHP lead for stroke services. We will invite 10 partner organisations across the SHA to participate in this collaborative. It has been funded externally by The Health Foundation and will have an advisory specialist improvement advisors, dedicated project lead and a project manager. It will run in close collaboration with the Cardiac Network.

When? The preparatory work for this collaborative began in January 2008, pre-work commenced in March and the first learning set will be in September 2008. The collaborative will last for two years. Year one will be 10 innovation teams, year two will be an additional 10 teams who will join the original teams.

Outputs: 1. Market placement as Salford Royal as the leader for stroke quality improvement. 2. Project summary document for publication. 3. Conference papers. 4. Increased capability for improvement in the stroke innovation community. 5. Cost benefits.

Safe, clean and personal goals: This collaborative delivers a phase ONE goal under the SAFE portfolio of strategic QI objectives.

Reliable care

The aim of the reliable care collaborative is:
To achieve 95% compliance to key process measures for heart failure, acute myocardial infarction, community acquired pneumonia and hip & knee within one year.

Why? The goal of the quality strategy is to reduce hospital standardised mortality to the best in the country. To this end we have decided to focus on those conditions where the volume of patients is high, mortality is significant and the evidence to support what is 'optimal' is clear. This programme will focus on delivering reliable care for patients with acute myocardial infarction (AMI) heart failure (HF), hip and knee (H&K) replacement and community acquired pneumonia (CAP). **Advancing Quality:** We are also participating in the pay for quality initiative commissioned by the strategic health authority. Selection of the clinical conditions maps onto this portfolio of work.

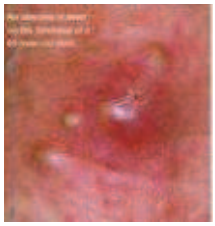
Who? Executive lead: David Dalton. Project lead: Clinical effectiveness lead. Clinical leads have been identified for each condition and the work will commence initially on the heart care unit, the elderly care and in the A&E department.

When? PRE-work (Dec 07-June 08). The scale and reach of the conditions requires a reliable electronic pathway which will automatically abstract real time data. Preparatory work is underway to agree pathways within each area, develop iSOFT infrastructure to support the pathways to support data abstraction by EPR. The collaborative will commence in September 2008.

Scale up and spread: The QI directorate will work with teams from March - September 2009 to hold the gains, scale up improvements to the rest of the hospital and handoff to governance and operational management. The handover will commence in March and conclude in September 2009.

Safe, clean and personal goals: This collaborative delivers a phase ONE goal under the SAFE portfolio of strategic QI objectives for HF, AMI & H&K. It also delivers on CLEAN objectives – CAP.

Central & peripheral line



The aim of the C&P line infection collaborative is:
To reduce the incidence of line infections by 50% within one year.

Why? We are committed to a quality strategy which will reduce the incidence of infection by 70% within 3 years. Local data suggests that infection of central and peripheral lines is still a significant contributor to our MRSA bacteraemia cases. We are committed to systematically reducing these cases by reducing the overall incidence of line infection.

Who? Executive lead: Elaine Inglesby. Project lead: Consultant Nurse in Infection Control. Teams: Multiprofessional teams will be invited to participate in an informational day. Attendees will include ambulance services, A&E, ECDU, theatres, phlebotomists, renal unit.

When? Commence November 2008 for six months ending in April 2009.

Outputs: 1. Change package for reduction of line infections to share with the rest of the organisation. 2. Project summary document for publication. 3. Conference papers. 4. Increased capability for improvement in the innovation community. 5. Cost benefits 6. Reduction in MRSA bacteraemia.

Scale up and spread: The QI directorate will work with the innovation teams to hold the gains and scale up improvements to the rest of the hospital by July 2009.

Safe, clean and personal goals: This collaborative delivers a phase ONE goal under the CLEAN portfolio of strategic QI objectives.

Environment

The aim of the environment collaborative is:
To improve satisfaction with bathrooms such that patients and staff rate the condition of bathrooms as good or excellent within one year.

Why? The aim of this collaborative is to work with teams to optimise the environment. This collaborative will engage clinical and non-clinical staff in improving the usability and acceptability of toilets and bathrooms such that by the end of the study patients and staff will rate the toilets and bathrooms in the highest decile of satisfaction.

This work will underpin the other work on infection control, falls and patient engagement.

Who? Executive lead: Simon Neville. Project lead: General manager, facilities. This programme will be led by the facilities directorate but will involve clinical staff, patients and other users of our buildings.

Initially we will work with the PEAT team to build an aim, goal and project plan.

When? The pre-work for this project has already started. Development of the quality improvement plan will commence in July 2008. The collaborative will start in October 2008 and run for 6 months. Six innovation teams will be nominated to participate in this innovation phase.

Falls

The aim of the falls collaborative is:
To reduce the incidence of falls by 50% within one year.

Why? Originally a phase 3 priority it has become clear that despite Trust protocols and risk assessments, the number of falls is unacceptably high. The harm from falls within our system is difficult to calculate but the adverse event reporting system has identified at least three incidents within the last year where falls have resulted in serious harm to the patient. The aim of this collaborative will be to develop new ideas for implementation of best practice, re-designing systems and working practices to reduce falls by 50% in one year.

Who? Executive lead: Elaine Inglesby. Project lead: Deputy director of nursing and the associate director of governance. Six wards will be identified to be involved in the pilot.

When? Pre-work has already been started to revise the protocols and purchase necessary equipment. A project team has been established and the pre work for the collaborative is underway. The first learning session will start in October 2008 and last for 6 months.

High risk medication

The aim of the high risk medications collaborative is:
To reduce medication errors related to opiates and anticoagulants by 50% within one year.

Why? Medication errors account for a significant portion of the harm that exists in healthcare.

Medications such as anticoagulants and opiates are known to place patients at particularly high risk.

We will focus on the administration and use of these two high risk medications. We will build systems which will allow us to assure the highest standard of prescribing, reconciliation, administration and follow-up.

Who? Executive lead: Stephen Waldek. Project lead: Director of pharmacy. We will work with the medicines management group to design data collection tools, capture baseline data and build a project plan and measurement system.

We anticipate participation from out-patient departments, PCT colleagues, haematology, pharmacy, orthopaedics and A&E.

When? A significant amount of pre-work is required to prepare the system for this collaborative. We anticipate this will take place between April and July 2008.

Learning session 1 is scheduled for November 2008.

Appendix 2:
What is quality healthcare?

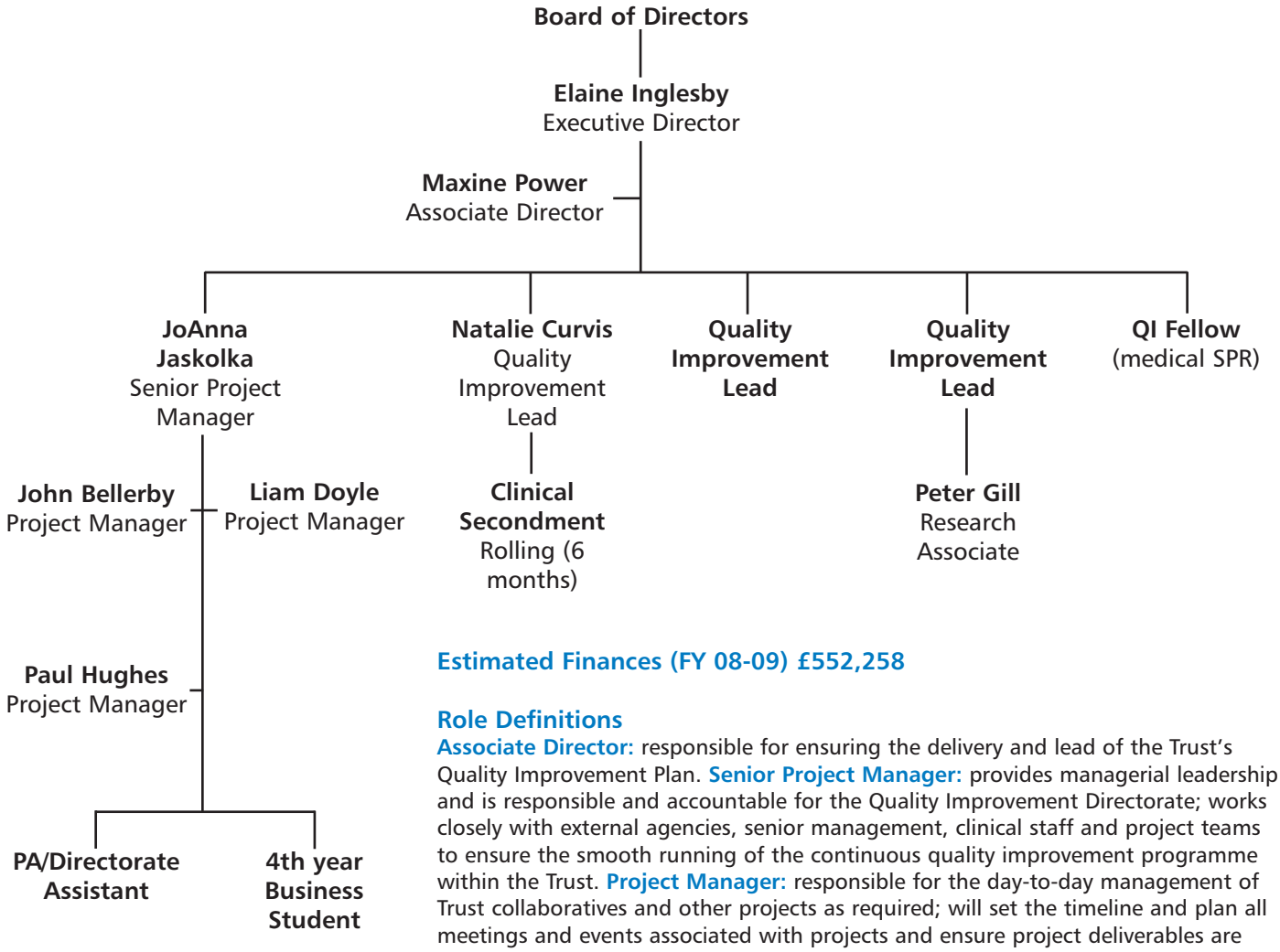
There are many definitions of quality in use. Most originate from the framework set out by the Institute of Medicine in 1999 when they described the 'domains' of quality as safe, effective, patient centred, timely, equitable and efficient.

Some broad descriptions of 'what this means' are given as illustrations in the table below

Safe	avoiding injury from care that is intended to help e.g. medication, surgery, medical equipment, falls, pressure sores.
Effective	avoiding under use or over use of services e.g. unnecessary tests or investigations, adherence to guidelines.
Patient-centred	providing respectful, responsive individualised care e.g. partnering with patients to design and re-design care pathways, improve estate and lead change.
Timely	reducing waits and harmful delays in care, including ensuring safe transitions into and out of the hospital system.
Equitable	providing equal care regardless of personal characteristics, gender, ethnicity, geographic location, and socio-economic status.
Efficient	providing care that best uses available resources for optimal benefit and focuses on eliminating waste such as unnecessary movement of patients or staff.

Appendix 3: The Quality Improvement Directorate

Organisational structure



Estimated Finances (FY 08-09) £552,258

Role Definitions

Associate Director: responsible for ensuring the delivery and lead of the Trust's Quality Improvement Plan. **Senior Project Manager:** provides managerial leadership and is responsible and accountable for the Quality Improvement Directorate; works closely with external agencies, senior management, clinical staff and project teams to ensure the smooth running of the continuous quality improvement programme within the Trust. **Project Manager:** responsible for the day-to-day management of Trust collaboratives and other projects as required; will set the timeline and plan all meetings and events associated with projects and ensure project deliverables are met in a timeline manner. **Quality Improvement Lead:** expected to work with teams to define and develop programmes of quality improvement work, including teaching quality improvement methods. An expert resource to advise on the aims, scope, timescale, milestones and success of projects; contributes to setting organisational priorities for improvement and being a key contributor to building capability for quality improvement methodology across the Trust. **QI Fellow:** a position for a medical professional to gain quality improvement experience in the Directorate, a capability building role at the Trust. **Research Associate:** responsible for providing analytical research on QI Directorate projects to guide the Trust's Quality Improvement Plan; upon conclusion of projects, will provide Trust with a final report and suggestions for future projects. **PA/Directorate Assistant:** responsible for the day-to-day management of the Associate Director's diary and while ensuring requirements and deliverables are met; will help QI Directorate staff schedule programmes/meetings and provide professional onsite support. **Clinical Secondment:** a rolling six month position to gain hands on quality improvement experience in the Directorate with a strategic plan to return to their clinical post with new expertise; a capability building role at the Trust. **4th year Business Student:** provides general support to the Directorate while gaining experience.


QUALITY
MATTERS

Salford Royal NHS
NHS Foundation Trust

University Teaching Hospital

safe • clean • personal

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You can visit our Trust website www.srft.nhs.uk if you need any further information about the hospital.