Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Quality and Safety Strategy 2019 – 2024

January 2020

Contents

Outstanding care every time

Introduction

Quality and safety is a key part of the **Trust Strategy for 2019 – 2024**, *delivering outstanding care, every time*.

Delivering outstanding care, every time

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.
We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estate
- We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients' homes
- We will work with neighbouring hospitals to make sure patients get the care they need
- We will work with others to meet the changing needs of our ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

This quality and safety strategy recognises the challenges we face now and sets out the ambitions for the future.

It harnesses the opportunities to maximise what we do well, learn from patient safety incidents and to embed a culture of quality, safety and learning culture

It identifies areas where we will prioritise our efforts to ensure we can address our challenges and maximise the opportunities.

What do we mean by quality?

A single definition of quality for the NHS was first set out in ***High Quality Care for All in 2008*** and has since been embraced by staff throughout the NHS and enshrined in legislation through the ***Health and Social Care Act 2012.***

This definition sets out ***three dimensions of quality***: ***clinical effectiveness, patient experience*** and ***patient safety*** which has been expanded by the ***World Health Organisation*** to cover six dimensions of healthcare quality and states that healthcare must be:

1. Safe: Avoiding harm to patients from care that is intended to help them

2. Timely: Reducing waits and sometimes harmful delays

3. Effective: Providing services based on evidence and which produce a clear benefit

4. Efficient: Avoiding waste

5. Person-centred: Establishing a partnership between practitioners and patients to ensure care respects patients' needs and preferences

6. Equitable: Providing care that does not vary in quality because of a person's characteristics.

Sources:
High Quality Care for All: NHS Next Stage review Final Report, Department of Health, June 2008. Available at: http://www.dh.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_0858255
Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
World Health Organisation, quality definition: accessed via: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/

Engaging with our staff and patients

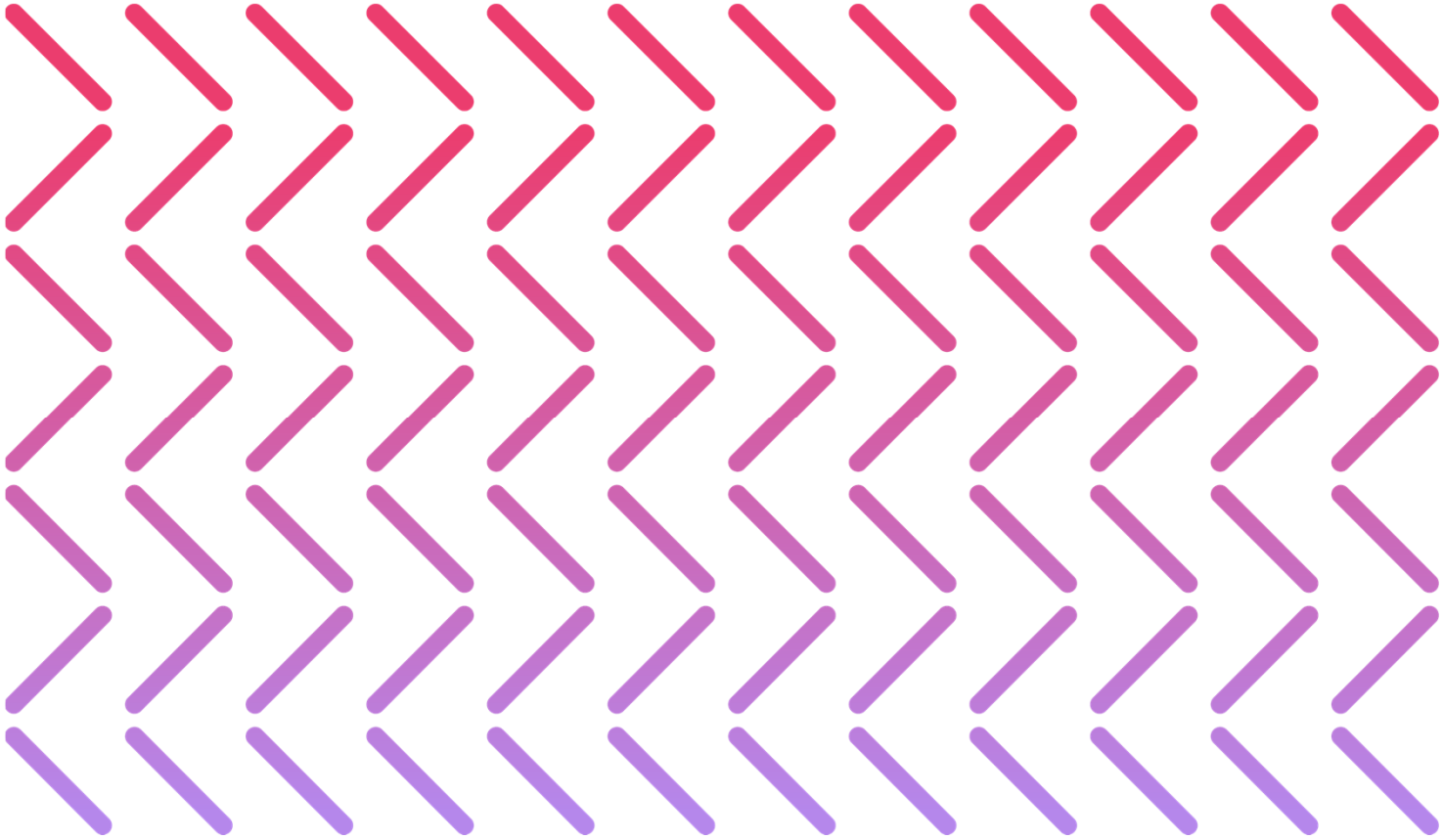
In developing this strategy we held a number of engagement events with a range of staff, patients and the public. We also conducted a Trust wide electronic staff survey.

In addition we reviewed the following:

- NHS Staff Survey results for 2017/18 and preliminary results for 2019
- Findings of inpatient patient survey July 2018
- Findings of ward and departmental accreditations 2019
- Care Quality Commission inspection report 2019
- Trust's Quality Improvement Programme 2018-19 and aligned Quality Account priorities for 2019-20
- Medical Engagement Scale (MES) Survey November 2019

The feedback we received and the review of key reports helped shape our plans for the future.

Where we have come from, and where we are now



Our quality and safety journey so far:

Treat the patient, treat the person is a key organisational objective within the Trust's strategic priority **Strong Foundations**.

To fulfil our ambition to deliver outstanding care every time for 2019-20 we identified three clinical priorities and one non-clinical priority:

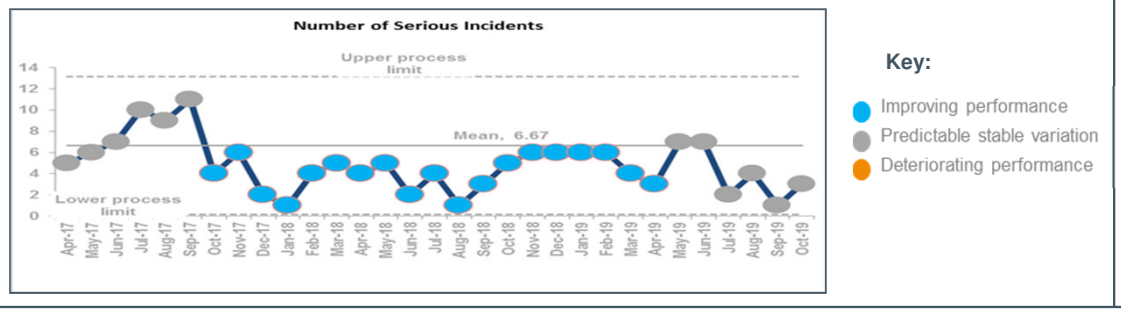
- all non elective adults to have a ***treatment escalation plan*** within 24 hours of admission
- Appropriate response and treatment for the ***deteriorating patient***
- Proper protection and care for patients who lack ***mental capacity***

- Standardise ***quality governance***, safety and learning

We also have a Quality Improvement programme to drive improvements in a further eight areas: team working; fundamentals of care; complaints; mental health; dementia; acute pain; staffing; and reducing variations in care.

Our focus on improving quality and safety has seen our Care Quality Commission inspection rating improve from ***Inadequate in 2016 (placed in quality special measures)*** to ***Requires Improvement in 2019 (with a recommendation to be removed from quality special measures)***

Progress against our quality and safety priorities 2019-20

Priorities 2019-20	Key progress to date	Remaining areas to address
Our clinical priorities		
Emergency patients will have treatment escalation plans (TEP) within 24 hours of admission	• Treatment Escalation Plan developed (paper format) and implementation commenced • Electronic Treatment Escalation Plan built in test domain of iClip (electronic patient records)	• Trust wide roll out of iClip TEP at pace supported by education and training of staff
Patients who lack mental capacity will have proper protection and care	• Developed staff reference cards – information and guidance at a glance to support staff making evidence based treatment decisions on a range of key topics e.g. Mental Capacity Assessment and Depravation of Liberty assessment, safeguarding children and adults • Achieved compliance with level 1 training and saw improvement in level 2 • Developed South West London audit/ staff knowledge survey to understand the baseline knowledge in our staff groups, benchmark our position with other trusts and assess the impact of our level 1 and 2 training programmes	• Improve and sustain compliance in level 1 and level 2 training • Implement South West London audit/ staff knowledge survey to inform targeted training and support
Inpatients who deteriorate will be recognised and treated promptly	• The updated national early warning score assessment process (NEWS2) implemented in iClip • Critical Care Outreach team launched December 2019 to improve quality of care provision and patient outcomes • Improved compliance across all staff groups for the 3 resuscitation modules. However, the Trust target of 85% compliance was not met, as of January 2020 Trust performance was 73.6%	• Completion of recruitment to critical care outreach team • Improve and sustain compliance in resuscitation training modules • Provide on-going training and education of our clinical staff • Explore further IT solutions for patient observations
Our non-clinical priority		
We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	• Completed 2 external governance reviews • Developed an action plan to capture the recommendations and commenced implementation • Investment secured for additional staff to strengthen governance processes • The number of serious incidents has reduced from in 2019/20 and the general trend over the last 2 years has been a significant reduction (see figure 1 below) Figure 1. Number of Serious Incidents 2017-2019 	• Increase pace of delivery against review recommendations e.g. recruit to the enhanced governance team structures and mortality monitoring meeting coordinators • Review and embed optimal governance reporting systems from ward/ department to board

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The local and national environment is changing bringing new opportunities:

National Patient Safety Strategy 2019

- New national standards and guidance published July 2019 to support continuous improvement in patient safety
- The strategy builds on 2 foundations: ***a patient safety culture*** and ***a patient safety system***
- ***Three strategic aims*** are detailed in the strategy:

  - **INSIGHT:** adopt and promote ***key safety measurement principles and use culture metrics*** to better understand how safe care is; and use ***new digital technologies*** to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a ***new safety learning system***; and introduce the ***Patient Safety Incident Response Framework*** to improve the response to and investigation of incidents.

  - **INVOLVEMENT**: the ***whole healthcare system*** is involved in the safety agenda; create the first ***system-wide and consistent patient safety syllabus, training and education framework*** for the NHS; establish ***patient safety specialists*** to lead safety improvement across the system; and ***equip people to learn*** from what goes well as well as to respond appropriately to when things go wrong

  - **IMPROVEMENT:** designing and supporting programmes that ***deliver effective and sustainable change*** in the most important areas. Commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population

St George's University NHS Foundation Trust

- Delivery of the Trust's Clinical Strategy 2019-2024
- Our focus on improving quality and safety has seen our Care Quality Commission inspection rating improve from ***Inadequate in 2016 (placed in quality special measures)*** to ***Requires Improvement in 2019 (with a recommendation to be removed from quality special measures)***
- Workforce and Digital strategy approved by Board in 2019, Education Strategy to be approved by Board in January 2020, all driving improved quality of care provision which is key to the delivery of outstanding care every time
- Readiness to adopt the new ***Patient Safety Incident Response Framework*** in Autumn 2020 with full implementation from summer 2021

Quality and safety matters to our staff, patients and partners

In developing this strategy we have engaged with a range of staff, patients and the public. The detail in the strategy is informed through bottom-up engagement with professional staff groups

Staff Feedback

- Want to see a **quality and safety culture** and a change towards '**Always Events**'
- **Reduce avoidable harm**
- Improve patient flow **to improve patient safety and experience**
- **Health and wellbeing initiatives** need to be **more accessible for** staff
- Enable provision of high standard **compassionate consistent care**
- Enable **consistent communication** which is clear and timely both internally and externally for patients and colleagues that we work with
- Provide **suitable environments** to care for our patients
- **Improve care through learning**
- Enable **patient centred care** and shared decision making
- Want **all staff groups** to be included
- Want to get the **basics right**
- Want **more visibility of the Quality Improvement Academy** and how it can support us to make improvements
- Want to improve care through learning and to **exploit external opportunities for system learning**
- Need the right staff at the right time with the right skills
- Want improved systems for triage **and responsiveness** to referrals

Patients and Public Feedback

- Want to see **safety first** and a clear commitment **to reduce avoidable harm**
- Want **easily available and clear information** for staff and patients on known risks and what help is available to reduce incidences
- Want to see **continual learning,** make SGUH more resilient to risks and clinical incidents
- Want to extend the reported **outcome measures, co-produced with patients**
- Want **honest and transparent interaction**/ Duty of Candor
- Want a **culture in which staff never hesitate to raise a concern** if they feel safety is compromised
- Want **compassionate care provision**
- Need to get the **workforce right**, in terms of the numbers and skills required
- Need an **estates strategy- fundamental to safety and quality ambitions**

We face a range of strengths, weaknesses, opportunities, & threats – which drive where we go next

Strengths:

- We established ***a Quality Improvement Academy***
- We have ***strong governance processes for reporting, declaring and investigating serious incidents***
- We can demonstrate good promotion of privacy and dignity
- We have improved infection control management
- We have improved the experience for our patients
- We have improved our discharge arrangements
- We have a high performing major trauma centre
- We have stroke and renal services which are the best in London
- We have improved our complaints response rate

Opportunities:

- We can deliver the recommendations from the ***Clinical governance reviews*** to improve our ***quality and safety governance***
- We can strengthen our current processes for the management of falls, pressure ulcers, Venous Thrombosis Embolism (VTE) and learning from deaths to ***reduce avoidable harm***
- We can further ***improve patient experience***
- We can develop a ***culture for learning, quality and safety***
- We can develop the ***role of our business intelligence service to inform our Quality Improvement***
- We can further develop our ***mentorship & career development programme***
- We can ***improve staff satisfaction*** and NHS Staff Survey results
- We can ***engage in innovative practices with links to research*** and develop networks/centres of excellence with clinical and academic partners to ***to improve patient outcomes***
- We can bring ***health and wellbeing initiatives for staff*** to the wards and departments
- progress with improvement plan
- We can **improve our CQC rating**
- We can improve our financial efficiency and productivity
- We can improve the condition of our estate supported by NHSI capital investment

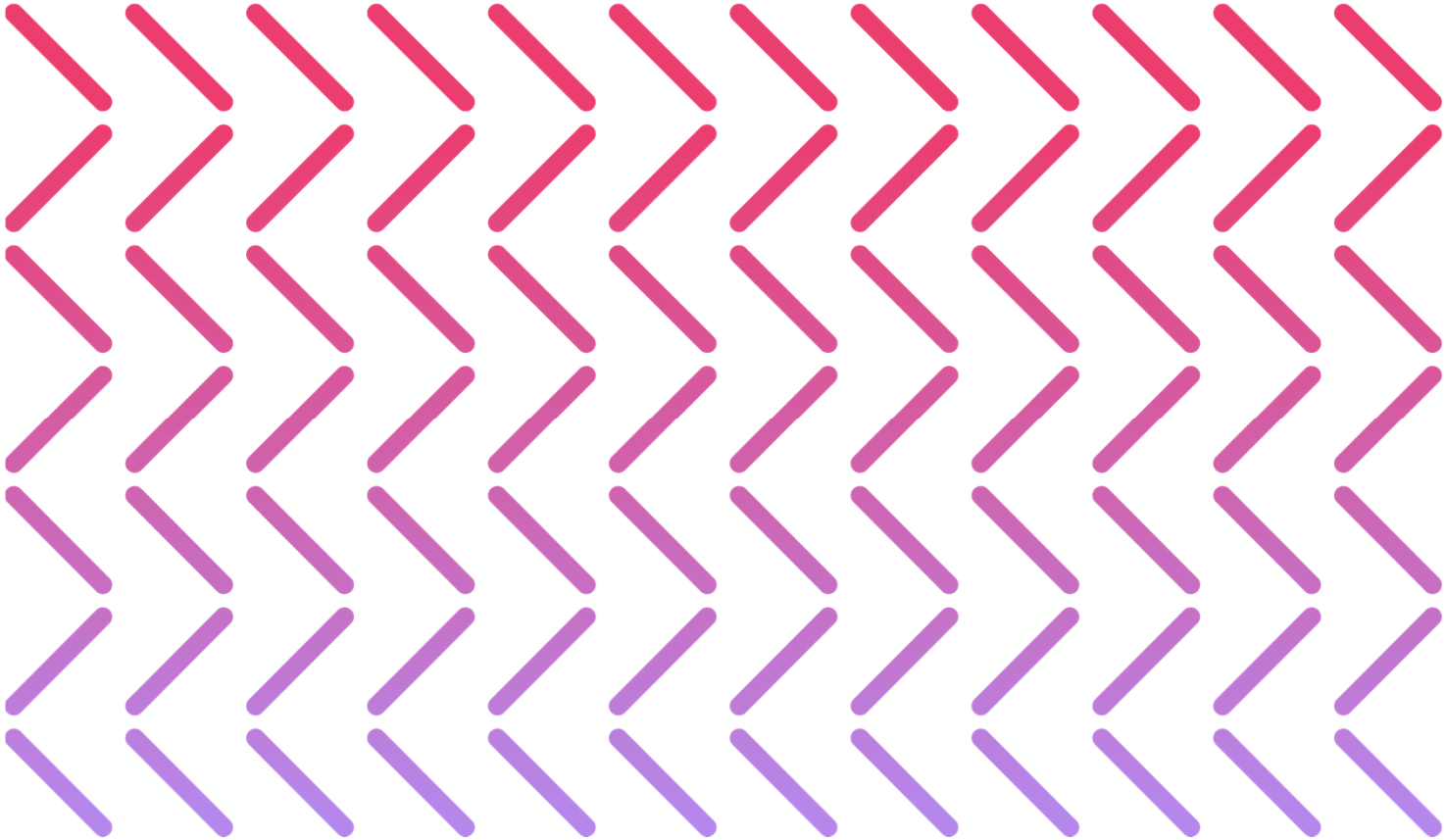
Weaknesses:

- We need a stronger ***quality and safety culture***
- We need to improve ***quality and safety governance***
- We need to **improve flow** to improve patient safety and experience
- We need to **triangulate quality and safety information** and own, understand and use data more systematically to achieve better patient outcomes and results
- We need to achieve ***parity of esteem*** and safe care of our mental health patients
- We need to improve our outpatient services
- We need to improve our NHS Staff Survey results, in particular reduce bullying and harassment, improve staff engagement and our focus on diversity and inclusion for staff
- We need to improve our capacity to implement change as part of usual business
- We need to improve the visibility of our quality improvement academy
- We need to monitor and report on the completion of actions from complaints investigations
- We need to improve our evidence of compliance with National Institute of Clinical Excellence guidance
- We need to improve the condition of our estates and health and safety

Threats:

- Our financial constraints
- Our workforce constraints
- The expected ***cultural shift*** does not happen, or does not happen quickly enough

Where we go next :quality and safety priorities 2019-24



Our vision for quality and safety at St George's 2019-2024:

Quality is at the heart of our Trust Strategy 'Delivering outstanding care every time' and by 2024 St George's will be an outstanding Trust delivering the best experience and outcomes for patients, with happy staff who are fully equipped to provide high quality and safe services , within a culture of continuous quality and safety improvement

Strategic quality and safety priorities for 2019 – 2024

1. We will **minimise avoidable harm across** our organisation, utilising the developments in technology, reducing unwarranted variation and embedding further, robust quality assurance and learning processes

2. We will **improve outcomes for patients** through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

3. We will **provide patients with an excellent experience** through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

4. We will improve **staff experience**, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

5. We will **provide patients with an equity of access and quality** by proactively improving access and care for vulnerable groups

6. We will **embed a culture** in which **quality, safety and learning** is embraced across the organisation, and is supported by robust systems of safety governance

7. We will be at the forefront of **providing and developing pioneering and leading edge treatments** for today and for the future

Strategic priority 1: We will minimise avoidable harm across our organisation

Why are we focussing on this?
Patients are safer when there is a safety culture that is fully embedded in our everyday business. All staff have a responsibility to identify and intervene to prevent an event or chain of events that may cause patient harm.

Proposal: Everyone will have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation.

- We will focus on the ***key priorities*** of ***falls, pressure ulcers, infection control, Venous Thromboembolism (VTE), learning from deaths, patient flow and consent***
- We will drive improved performance through ***existing processes*** e.g. safety thermometer, ward and departmental accreditation scheme, quality observatory and through the introduction of the ***new patient safety incident response framework*** and ***new medical examiner system***
- We will ***review each year*** as we make progress to ensure we are sighted on emerging risks of avoidable harm
- We will also monitor the impact of ***clinical systems*** and our ***estate*** on our ability to deliver safe care

What will success look like?
We will see a **year on year improvement** against our agreed Key Performance Indicators.

Strategic priority 2: We will improve outcomes for patients through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

Why are we focussing on this?
We want to be an organisation that supports continuous learning and drives through healthcare innovations and improvement.

Proposal: We want to make it easier to do the right thing, to demonstrate measurable improvement in patient outcomes, to reduce unwarranted variation and to participate in research.

- We will use **our data** to focus on improving access and quality of care where evidence shows patients are disadvantaged e.g. Black and Minority Ethnic patients, homeless patients, vulnerable older people and those living with mental health issues, dementia or a learning disability

- We will engage with the **national patient safety improvement programme**, building on the existing focus of preventing avoidable deterioration and adopting and spreading safety innovations

- We will drive improved performance through ***existing processes*** e.g. safety thermometer, ward and departmental accreditation scheme, quality observatory, through the introduction of the ***new patient safety incident response framework*** and through the learning derived from collaboration with other healthcare providers in the local system

- We will implement a strengthened **corporate quality and safety governance structure**

What will success look like?
Our **clinical audit programme** and the **external quality surveillance programme** will demonstrate a year on year improvement in patient outcomes and unwarranted variation. We will sustain our improved recruitment of patients to clinical research trials.

Strategic priority 3: We will offer patients an excellent experience through their journey with us by monitoring and acting on feedback to ensure continual improvements in the areas that matter most to our patients

Why are we focussing on this?
We want to provide the fundamentals of care that matter to our patients meeting both their emotional and physical needs - communication, privacy, dignity, safety, nutrition and hydration, comfort and warmth.

Proposal: We will use patient feedback for continuous improvement.

- We will focus on tracking the delivery of actions in response to complaints investigations and on improving the dissemination of learning from complaints and feedback from the Friends and Family Test
- We will build on our existing patient partnerships to ensure that patients are involved in improvement projects from the earliest stage
- We will focus on improving the experiences of care to our most vulnerable patients and their carers, including children, our homeless patients and those living with dementia, a learning disability, mental health issues
- We will focus on improving shared decision making and consent
- We will focus on engaging all staff in the Trust on improving patient flow
- We will drive improved performance through ***existing processes*** and through the introduction of the ***new patient safety incident response framework***

What will success look like?
We will see year on year improvement in Friends and Family Test, inpatient survey results and a reduction in formal complaints.

Strategic priority 4: We will develop further our approach to improving staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

Why are we focussing on this?
We want our staff to feel valued, supported and safe and equipped to deliver high quality safe care.

Proposal: We will ensure all staff have the training, development and resources needed to deliver outstanding care every time, and we will take positive action to encourage and celebrate the diversity of our workforce.

- We will drive this through the **deliver of the Trust's workforce, education and the diversity and inclusion strategy**
- We will support our staff through the delivery of the key objectives of the **health and well being strategy 2018**
- We will continue **to embrace the diversity of our workforce and embed staff networks**

What does success look like?
We will see improved scores in the NHS Staff Survey, improved feedback from Friend and Family Test, improved engagement with staff networks and increased uptake of training.

* *Workforce Strategy launched November 2019, Education Strategy to be launched February 2020,* Diversity and Inclusion Strategy launched January 2019

Strategic priority 5:We will provide patients with equitable access and quality by proactively improving access and care for vulnerable groups

Why are we focussing on this?
We serve a diverse population and we want our patients and communities to have equal access to our services which we are currently not achieving.

Proposal: We will improve our use of data to understand where issues with patient access exist and utilise this to optimise equitable provision.

- We will **increase patient participation**, including dedicated initiatives to engage with our seldom heard patient groups
- We will focus on **improving the experiences of care to our most vulnerable patients and their carers**, including children, our homeless patients and those living with dementia, a learning disability and mental health issues

What will success look like?
We will reduce incidents relating to patient access to care and reduce avoidable incidents in vulnerable patient groups.

Strategic priority 6: We will work to embed a culture where governance of quality, safety and learning is embraced across the organisation

Why are we focussing on this?
We want our patients and staff to recognise that quality and safety comes first and is at the heart of everything we do. Patients are safer when there is a safety culture that is fully embedded in our everyday business. All staff have a responsibility to identify and intervene to prevent an event or chain of events that may cause patient harm.

Proposal: We will respond to the findings of our external reviews and maximise new investment by developing and embedding a culture of quality and safety to enable our staff to deliver outstanding care every time, and we will take positive action to encourage our staff to report and learn from patient safety incidents.

- We will **raise the level awareness of psychological safety** and encourage staff to speak about their concerns, and we will improve in our responsiveness to their concerns
- We will continue our bespoke human factors training and support increasing numbers of staff to train and **coach our staff in quality improvement**
- We will **recruit culture champions** and work differently to develop new initiatives
- We will **equip our staff with skills in critical thinking to drive improvement**, support them to get the time and space to create the conditions for change, encouraging our staff to develop quality and safety improvement projects and to access our quality improvement academy for support
- We will drive this by ensuring 'quality and safety first' is seen as everyone's responsibility, through **increasing the visibility of our Freedom to Speak up Guardian** and staff champions, surrounding our patients and staff with quality and safety messages Trust wide, implementing the patient safety incident response framework and developing quality improvement plans at care group level aligned to the clinical outcomes in our quality and safety strategy
- We will **upgrade our current ward and departmental accreditation scheme** to include a platinum rating in addition to our current ratings of bronze, silver and gold and we will extend the programme to include finance and performance

What does success look like?
We will see increased incident reporting, with a decrease in the proportion of incidents causing harm, increased use of the Freedom To Speak Up Guardian and Champions, and year on year improvement in our agreed metrics. We will see a high level of visibility and transparency of quality and safety issues at Board level.

How we will develop a culture where governance of quality, safety and learning is embedded across the organisation

Our approach to Quality Improvement is to help teams solve problems at their own level:

To embed a culture where governance of quality, safety and learning **we will create the conditions for change**. Our staff will continue to develop a **culture of continuous improvement** where staff are empowered to identify issues in their own area of work and are skilled to make improvements that enable them to provide better and safer care for patients. Our experience, supported by our colleagues in the Institute of Health Innovation, is that we will best achieve this by continuing to use a simple yet effective improvement model to bring about changes.

Our **method for improvement** is simple – plan, do, study, act (**PDSA**):

Staff undertaking improvement initiatives will be able to draw on support from our **Quality Improvement Academy** with particular emphasis on the leadership support, accountability and culture and reliability and sustainability

Strategic priority 7: We will be at the forefront of providing and developing pioneering and leading edge treatments for today and in the future

Why are we focussing on this?
We want to extend our national and international reputation as a leading edge Trust and provide the most up to date care and treatment to maximise outcomes for patients.

Proposal: We will be at the forefront of providing and developing pioneering and leading edge treatments for today and in the future.

- We will pursue and encourage **new and novel procedures** e.g. more day case surgery, provision of virtual clinics, use of virtual reality in clinical settings
- We will **integrate our medical devices with the hospital electronic systems** e.g. monitoring vital signs to be sent directly to the electronic patient record
- We will be a **research active organisation** encouraging our patients to participate in research trials and develop our staff to embrace research and evidence based practice
- We will extend our successful **surgical school** 'Get set for Surgery' for our cancer patients to other surgical specialities
- We will communicate our success and share learning locally, nationally and internationally

What does success look like?
We will be able to demonstrate pioneering and leading edge treatments across a wide range of services and our patients will report positive experience and outcomes.

Summary: Our vision for Quality and Safety at St George's 2019-2024

Quality is at the heart of our the Trust Strategy '*Delivering outstanding care every time'* and by 2024 St George's will be an outstanding Trust delivering the best experience and outcomes for patients, with happy staff who are fully equipped to provide high quality and safe services within a culture of continuous quality and safety improvement

By 2024 we will know we have met our ambition because our:

- Patients will receive outstanding care every time
- Staff will have the training, development and resources needed to deliver outstanding care every time
- Trust will have an outstanding record of patient safety
- Trust will be soundly governed and compliant with the requirements of our regulators
- Trust will be rated Outstanding by the Care Quality Commission

Above all:
Our communities will have equal access to the best care and treatment when they need it and St George's will be among the best and safest places in the country to receive care.

Next step:
Implementation plans will be produced for each of the seven priority areas, setting out in detail the actions needed, clear targets, Key Performance Indicators and an accountable owner. The governance of the plans will rest with the Patient Safety Quality Group, the Trust Executive Committee, and the Quality and Safety Committee reporting up to Trust Board.