Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
1st April 2021

AGENDA ITEM NUMBER		15.1.1
TITLE OF PAPER		Draft Quality Account Improvement Priorities for the year ending March 2022.
Confidential		**NO**
Suitable for public access		**YES**
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
Quality of Care Committee		
STRATEGIC OBJECTIVES		
Quality Of Care	✓	This paper supports the Trust's Quality of Care Strategic Objective
People	✓	
Modern Healthcare	✓	
Digital	✓	
Collaborate	✓	

EXECUTIVE SUMMARY

Quality Account Priorities for the year ending March 2022.

In line with the Trust's 'Together We Care' Strategy 2018-2023, the Quality of Care Strategic Objective remains unchanged which is to *'Create a learning organisation and culture of continuous improvement in order to reduce repeated harms and improve patient experience'.*

Trust wide Quality Improvement Priorities 2021/2022: The Trust wide Quality Improvement Priorities continue to align to our Business Plan, the 'Quality of Care' Strategic Objective, as well as the New Operating Model and Infection Prevention and Control Strategy following the Covid-19 pandemic. The Quality Improvement Priorities on the whole remain unchanged from 2020/2021, albeit the target metrics have changed on some of the priorities, as it is recognised the Trust is on a journey with this work. Schedule 1 outlines the Quality Improvement Priorities with the proposed objectives and measures to meet them.

Statutory Quality Account Improvement Priority KPIs 2021/2022: As per the Quality Account Regulations the Trust is required to set 3 improvement objectives (KPIs) for each of the categories of Patient Safety, Clinical Effectiveness and Patient Experience and to report against these in the Annual Quality Account. The priority KPIs are outlined in Schedule 2 and are a subset of the measures outlined in Schedule 1. These priorities have been consulted on with staff internally and externally which includes Healthwatch, North West Surrey Integrated Care Partnership and Surrey County Council.

The Committee is asked to approve the 2021/2022 Quality Account Priorities in Schedule 2.	
AUTHOR	Jacqui Rees, Associate Director of Quality
PRESENTED BY	Andrea Lewis, Chief Nurse
DATE	1st April 2021
BOARD ACTION	The Board to **Approve** the paper.

Trust wide Quality Improvement Priorities

Schedule 1 shows the Trust's quality improvement priorities for 2021/22.
Our overall priority is to 'Create a learning organisation and culture of continuous improvement in order to reduce repeated harms and improve patient experience'.

Our core quality priority areas will be:

Improving medication safety by reducing harm to patients resulting from medication errors and serious incidents.

Improving infection prevention and control by reducing the incidence of avoidable harm from infections and ensuring best practice use of antimicrobials.

The objectives and measures that will be used to evidence achievement of the Trust wide priorities are shown in Schedule 1 on page 3.

Statutory Quality Account Priorities
The Quality Account Regulations require the Trust to set 3 improvement objectives (KPIs) for each of the core quality categories of patient safety, clinical effectiveness and patient experience and to report against these in the Annual Quality Account.

The Trusts proposed 12 Quality Account Priorities for 2021/22 outlined in Schedule 2 on page 4 align with the Trust strategy. The Quality Account priorities are a subset of the Trust wide priorities in Schedule 1.

These priorities have been consulted on with staff and external stakeholders including Healthwatch, North West Surrey Integrated Care Partnership and Surrey County Council.

SCHEDULE 1 – TRUSTWIDE QUALITY IMPROVEMENT PRIORITIES

STRATEGIC QUALITY OF CARE OBJECTIVE: Create a learning organisation and culture of continuous improvement in order to reduce repeated harms and improve patient experience

Aim: To embed learning throughout the organisation in order to eliminate avoidable harm to our patients

KEY QUALITY PRIORITIES

Improving Medication Safety

Reduce harm to patients resulting from medication errors and serious incidents

Patient Safety:
Learning from medication errors to reduce avoidable harm

Clinical Effectiveness:
Learning from deaths and addressing episodes of poor care

Measures

The number of medication errors resulting in harm, of any severity, will be on average < 7 per month (<84 per year).

To achieve a target of 50% reduction in medication errors from the baseline with a continuity in the aim to meet the WHO 'medication without harm' patient safety challenge.

Actively support, the development of the new Electronic Patient Record, Cerner Millennium (EPR), to deliver enhanced medicines safety via sophisticated electronic prescribing and ensure intelligence from our medication safety programme is captured within.

To enhance the learning of the 10 key medication safety priorities.

Reduce avoidable harm through the reduction of the number of clinical systems used across the Trust through implementation of EPR ensuring the majority of the patient's clinical journey is stored in one location and accessible from all Trust locations simultaneously.

Measures

Establish a Patient Safety Learning and Investigation Team to implement the NHS Patient Safety Strategy, Patient Safety Incident Response Framework and lead on patient safety improvement across the system

Enhance the learning through the use of SIs and learning from death sessions whilst linking in with the Trusts Education Strategy and Quality Improvement Work plans.

That 100% of applicable deaths receive a structured judgement review and are shared with the National Learning Disabilities Mortality Review (LeDeR) Programme where appropriate.

Within 2 years to achieve 95% target for in hospital deaths having an initial review within 2 days with a 60% improvement in year 1 and a 40% improvement in year 2.

That 100% eligible Medical Certificate of Cause of Death (MCCD) issued to families within 72 hrs.

Realise overall reduction in avoidable harm through implementation of EPR Surrey Safe Care Project

Through our Harms Free Care Team and Strategy reduce avoidable harms of Cat 2 Pressure Ulcers by 10% and Cat 3 by 75%, reduce Falls with moderate or severe harm by 10% and reduce repeat Falls by 10%. Introduce a consistent practice standard and baseline audit for Catheter Care. Preventable Hospital Associated Thrombosis (HAT) to be less than 7.5% of all cases of HAT and that 95% of Malnutrition Universal Screening Tools (MUST) are correctly completed within 48 hours of admission. Improve by 25% correct completion of Fluid Balance Charts.

Improving Infection prevention and Control

Reduce the incidence of avoidable harm from infections and ensure the best practice use of antimicrobials

Patient Safety:
Reduce in-hospital infection to prevent avoidable harm

Patient Experience:
To embed the learning culture to reduce harm and improve patient experience

Measures

To reduce Surgical Site Infection (SSI) rates by 5%

To reduce definitive Hospital Acquired COVID-19 to zero by the end of 2021/2022.

To reduce avoidable cases of E.Coli (community and hospital onset) bacteraemia by 25% by the end of 2021/2022. To reduce avoidable Klebsiella and Pseudomonas bacteraemia's by 3% and to reduce avoidable cases of MRSA and MSSA bacteraemia to zero by the end of 2021/2022.

A new sepsis QI programme will commence to improve the adult ED and inpatient Sepsis6 care bundle performance by 25% from baseline by the end of Q4 2021/22.

To promote Antibiotic Guardianship in order to reduce resistance.

Measures

As per the National Patient Experience improvement Framework, expand the use of evidence based co-design workshops with patient safety partners, patients and families.

Exploit and enhance the collection and quality of patient feedback via the new Viewpoint patient feedback platform. This will enable us to measure the baseline achievement and report against the following strategic patient experience objectives bi monthly. Our patients would say 1.They were treated with compassion during their treatment/stay, 2. They were involved as much as they wanted to be in decisions about their care, 3.They were treated with respect and dignity whilst they were in hospital. By the end of Q4 2021/22 an improvement goal will be set and a QI improvement programme commenced where achievement is less than 95%.

Triangulate the learning from complaints, concerns and PALS, with incidents and claims and for such learning to be captured effectively within the Trusts Education Strategy and Quality Improvement work plans.

Progress the Healing Arts program across the Trust in collaboration with our community partners.

SCHEDULE 2 – (DRAFT) 2021/22 STATUTORY QUALITY ACCOUNT IMPROVEMENT PRIORITIES

Patient Safety – learning from errors and reducing avoidable harm and in-patient infection

- The number of medication errors resulting in harm, of any severity, will be on average < 7 per month (< 84 per year).

- To reduce Surgical Site Infection (SSI) rates by 5%.

- To reduce definitive Hospital Acquired COVID-19 to zero by the end of 2021/2022.

- To reduce avoidable cases of E.Coli (community and hospital onset) bacteraemia by 25% by the end of 2021/2022. To reduce avoidable Klebsiella and Pseudomonas bacteraemia's by 3% and to reduce avoidable cases of MRSA and MSSA bacteraemia to zero by the end of 2021/2022.

- A new sepsis QI programme will commence to improve the adult ED and inpatient Sepsis6 care bundle performance by 25% from baseline by the end of Q4 2021/22.

Clinical Effectiveness – learning from deaths and addressing episodes of poor care

- That 100% of applicable deaths receive a structured judgement review and shared with the National Learning Disabilities Mortality Review (LeDeR) Programme where appropriate.

- Within 2 years to achieve 95% target for in hospital deaths having an initial review within 2 days with a 60% improvement in 2021/22 and a 40% improvement in 2022/23.

- That 100% Medical Certificate of Cause of Death (MCCD) are issued to families within 72 hrs.

- Through our Harms Free Care Team and Strategy reduce avoidable harms of Cat 2 Pressure Ulcers by 10% and Cat 3 by 75%, reduce Falls with moderate or severe harm by 10% and reduce repeat Falls by 10%. Introduce a consistent practice standard and baseline audit for Catheter Care. Preventable Hospital Associated Thrombosis (HAT) to be less than 5% of all cases of HAT and that 95% of Malnutrition Universal Screening Tools (MUST) are correctly completed within 48 hours of admission. Improve by 25% correct completion of Fluid Balance Charts.

Patient Experience – To embed the learning culture to reduce harm and improve patient experience

- As per the National Patient Experience Improvement Framework, expand the use of evidence based co-design workshops with patient safety partners, patients and families.

- The total response rate to Friends and Family Test survey questions will increase to 20% of all eligible patients.

- To measure the baseline achievement and report against our strategic patient experience objectives bi monthly where our patients would say;

    - They were treated with compassion during their treatment/stay
    - They were involved as much as they wanted to be in decisions about their care
    - They were treated with respect and dignity whilst they were in hospital

  By the end of Q4 2021/22 an improvement goal will be set and a QI improvement programme commenced where achievement is less than 95%.