Buckinghamshire Healthcare
NHS Trust

Quality Improvement Strategy 2013 - 2015

Safe & compassionate care,

every time

1.0 Introduction

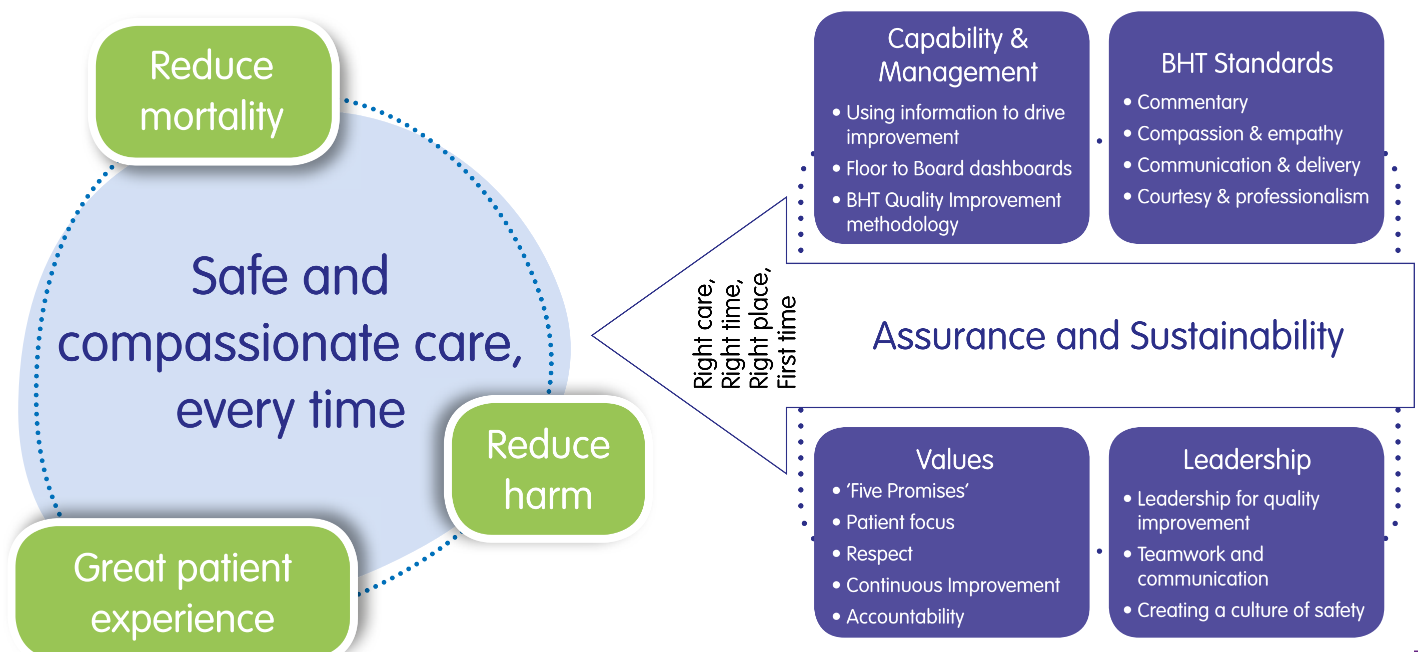
The mission statement of Buckinghamshire Healthcare NHS Trust (BHT) is to provide safe and compassionate care, every time. The Trust will focus on right care, right place, right time, first time and this will enable improvements across all services and patient groups.

In order to achieve this we will focus on three strategic quality goals:

1. **Reduce mortality**
2. **Reduce harm**
3. **Great patient experience**

All projects undertaken within the Trust will focus on one of those three areas. We will ensure that they not only achieve the key performance indicators, but that they will also improve the safety culture of the organisation and report openly and transparently with specific monitoring processes. In this way, the Trust will develop a continuous improvement methodology which will help us to ensure that safe and compassionate care is really delivered every time.

The diagram below illustrates what we intend to accomplish through implementing this quality improvement strategy.

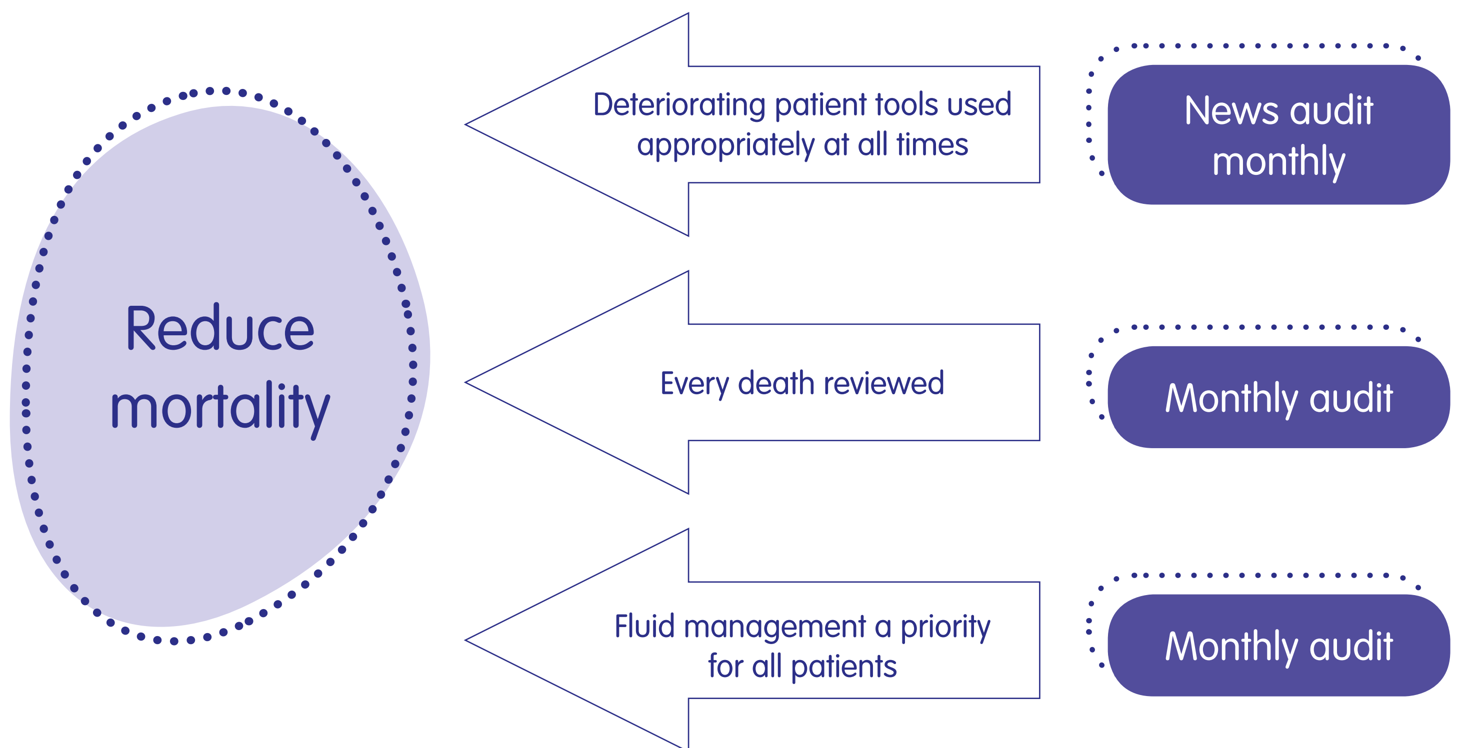


2.0 Mortality

Goal: Reduce mortality as reported by HSMR by 5 each year, for the next 2 years, from 2012/13 baseline of 109.26

Hospital mortality refers to the number of patients who die whilst in hospital. The Hospital Standardised Mortality Ratio (HSMR) standardises the measurement of this by comparing the actual mortality rate to the one that would have been expected given the characteristics of the patients who were treated. This gives the risk-adjusted expected mortality ratio.

This measure takes into account many factors including age and sex of patients, their diagnosis, and any other illnesses they may have had. An example of this is that a hospital may have a risk-adjusted mortality rate of 100 and, if the number of patients who died was above that number, then more people would have died than had been expected. Similarly, if the number was below 100, then fewer people would have died than had been expected.



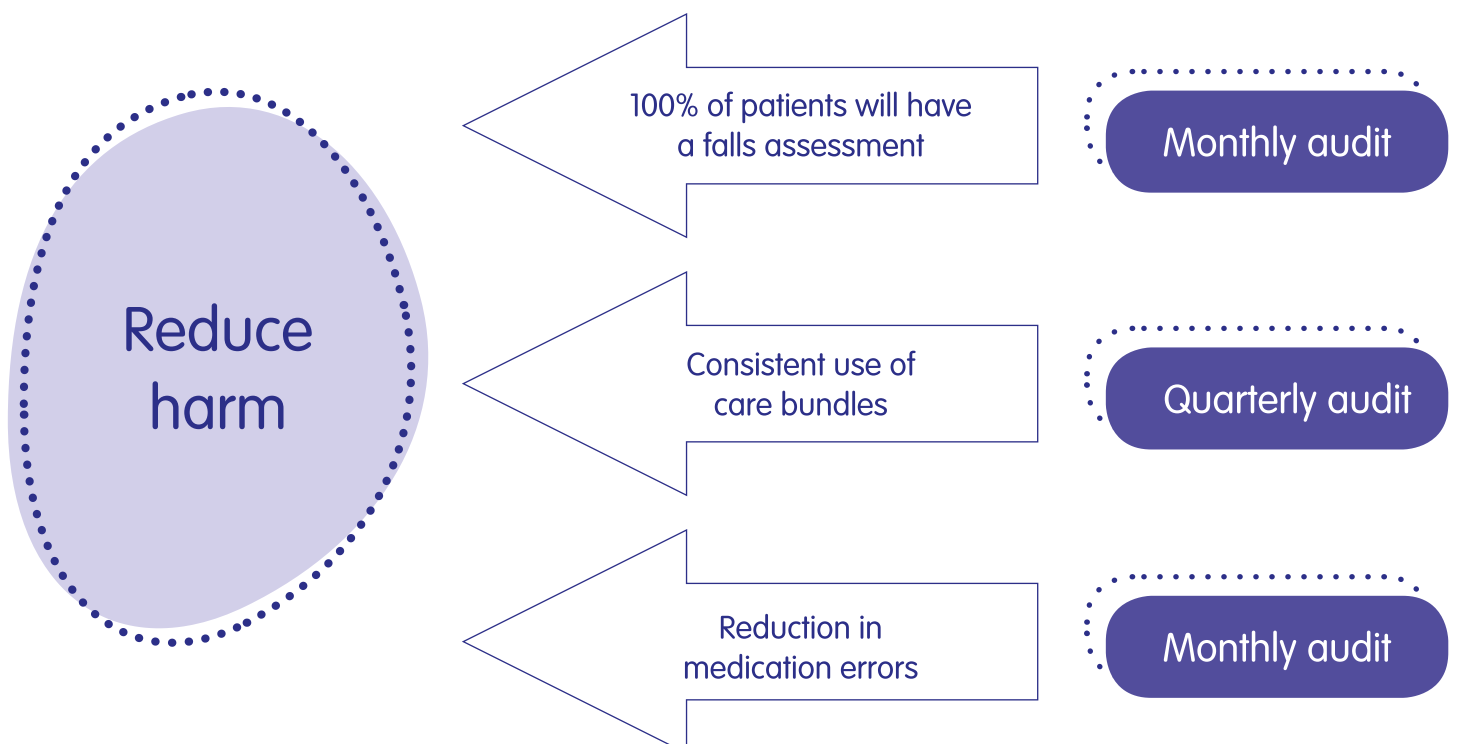
3.0 Harm

Goal: Reduce harm by ensuring that at least 98% of all patients cared for by the Trust receive harm free care, as measured by the four harms of the NHS Safety Thermometer from April 2013 baseline of 91.11%

These four harms are as follows:

1. **Pressure ulcers**
2. **Catheter associated urinary tract infections (CAUTI)**
3. **Venous thromboembolism (VTE)**
4. **Harm from falls**

All of the above, together with medication errors and healthcare associated infections, are examples of harm that are commonplace in healthcare organisations. Despite the care taken and the safety processes put into place they do occur, and this is a measure of sub-optimal care of our patients that occurred because of something we did, when we shouldn't, or didn't do when we should.



4.0 Experience

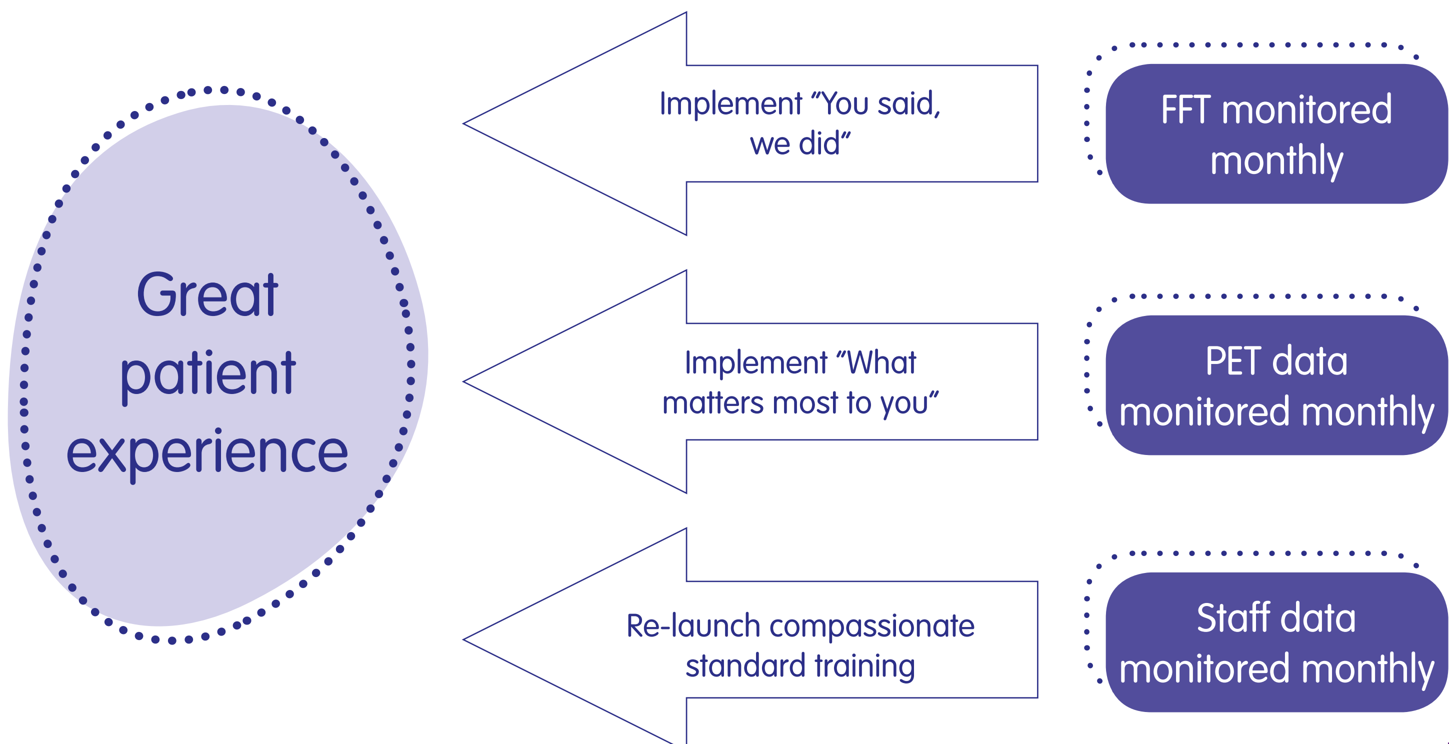
Goal: Great patient experience measured by improvement in National Inpatient Survey from 2012 baseline and Friends and Family Test (FFT) net promoter score of 95 from current baseline of 76

The experience of our patients is of significant importance to the Trust. We have in place our five promises that relate to this. These are outlined below:

Our promises to you:

- clean and safe practice, clinics and hospitals
- a caring, helpful and respectful attitude
- respect for your time
- easy access to comfortable and modern facilities
- the best clinical care.

In addition, real-time patient experience data will be collected in every area and this will be published on the Trust website and displayed on each ward.



5.0 Organisational safety culture

The safety culture of any healthcare organisation can be difficult to determine but is vitally important. This can be defined as the understanding between the staff of an organisation in relation to the way they should work together, be treated and treat their patients.

During 2013 the Trust has undertaken an initial self-assessment of its safety culture using the Manchester Patient Safety Framework (MaPSaF) tool. The self-assessment was undertaken at various levels of the Trust, from the Board down through Divisions, Service Delivery Units and individual teams. The results indicated that the predominant style was 'Bureaucratic' with some 'Proactive' areas.

Level	Type	Description
A	Pathological	Why do we need to waste our time on patient safety issues
B	Reactive	We take patient safety seriously and do something when we have an incident
C	Bureaucratic	We have steps in place to manage patient safety
D	Proactive	We are always on the alert / thinking about patient safety issues that might emerge
E	Generative	Managing patient safety is an integral part of everything we do

The Trust has an ambition to improve its culture to Generative and this will be crucial if we are to reach our mission of providing "safe and compassionate care, every time".

The framework uses ten dimensions of patient safety, as described below, to describe what level of safety culture is present in the organisation:

	Dimension	Description
1	**Commitment to overall continuous improvement**	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2	**Priority given to safety**	How seriously is the issue of patient safety taken within the organisation?
3	**System errors and individual responsibility**	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed – as an opportunity to blame or improve?
4	**Recording incidents and best practice**	Who investigates incidents and how are they investigated? What is the aim of recording the incident?
5	**Evaluating incidents and best practice**	How are incidents evaluated? What recognition is there of safe practice? How is the resultant data used?
6	**Learning and effecting change**	What happens after an event? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
7	**Communication about safety issues**	What communications systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
8	**Personnel management and safety issues**	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures?
9	**Staff education and training**	How, why and when are education and training programmes about patient safety developed? What do staff think of them?
10	**Team working**	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

The self-assessment will be undertaken at planned intervals to measure changes. These will be published on the Trust's website.

6.0 Improvement methodology

The Trust has previously used the Intermountain Advanced Training Programme (ATP) and has had over 100 members of staff undertake projects using this methodology.

A thorough review of this and other methodologies, including Institute for Healthcare Improvement (IHI), was carried out and the Trust has determined to use a revised version of the Intermountain ATP methodology in the future. The principles of Lean are embedded within the programme and it is multi-disciplinary and multi-agency in its use.

Training and support will be provided to ensure that all staff are enabled to learn and use the methodology in practice through learning collaboratives. Each topic of the learning collaborative will relate directly to reducing mortality, reducing harm or improving patient experience. A significant benefit of the training will be the inter-disciplinary nature of the teams and the opportunity to use reliable and recognisable measurement processes, which will provide open and transparent feedback across the organisation.

All improvement projects will be developed using this methodology and will focus on the three strategic quality goals of the Trust to achieve safe and compassionate care, every time.

7.0 The quality improvement plan

The Trust has determined that there will be a Quality Improvement Plan (QIP), which will be a rolling three month plan detailing the specific projects in place to impact on the agreed quality improvement goals: reduce mortality, reduce harm, great patient experience.

The QIP will be monitored by the Quality Committee, although individual projects will have detailed monitoring processes. The QIP will be updated by the Chief Nurse and Medical Director and presented to the Board at least bi-annually to assure them of improvement and to inform them as quality projects become business as usual.