Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Select Meeting: Wednesday 10 May 2023

TB2023.50

Title:	**Quality Improvement Programme Update May 2023**

Status:	**For Discussion & Decision**
History:	

Board Lead:	**Chief Operating Officer**
Author:	**Hesham Abdalla, Head of Integrated Quality Improvement & Lisa Glynn, Director of Clinical Services**
Confidential:	**Yes**
Key Purpose:	Strategy & Performance.

Executive Summary

This paper presents the approved OUH Quality Improvement (QI) Programme for 2023/24.This has been designed to focus on five core programmes **– Quality Improvement Education & Community Building, Urgent and Emergency Care, Cancer Care and Harm Reduction**. Four programmes from 2022/23 - Recruitment, Outpatients, Theatres and GIRFT will be passed over into business as usual workings.

The next year will bring challenges to our health and care system. OUH will meet these with a methodical and sustained approach to change that is embedded in evidence-based Quality Improvement methodology. This is in step with the recent the NHS England Delivery and Continuous Improvement Review which recommended focusing on outcomes that matter to patients, involving patients and staff in the improvement process, using data to drive improvement, working collaboratively with other organisations, and continuously learning and adapting.

What can you expect over the coming year?

The focus on the OUH Improvement programme will be on reducing waits, particularly in urgent and emergency care and for patients suspected to have cancer. This will be achieved through collaboration with our system partners across the ICS as we look at improving clinical pathways from the outset. To ensure changes are sustainable, we will also be applying rigorous QI methodology to reducing avoidable harm due to in-hospital falls, pressure ulcers or medication errors. We will also be building capability, competence and confidence of OUH staff to improve their own services as the QI Education programme matures. Learning from and with one another will be core to the QI Community that we will be cultivating in the organisation whilst we encourage participation in strategically important improvement programmes.

Equality, Diversity, and Inclusion

Aligned to organisational strategy, we will be deliberately viewing improvement through an equity lens as we look to ensure equitable access to services and reduce unwarranted variation in outcomes. We believe that segmenting population groups and identifying outliers is both an effective way to have a disproportionate impact on health outcomes, and will have resonance with patients and staff.

Developing the QI Infrastructure

We will be integrating QI into the organisation through development of resources and processes that catalyse change. These include communications such as the QI Zone on SharePoint. We will be improving improvement in trust assurance systems such as the Oxford Scheme for Clinical Accreditation (OxSCA) accreditation as well as linking with divisional teams and The Hill to serve as a conduit for needs-led innovation. We will also be hosting a new QI Fellowship which gives clinical staff time and training to run QI projects and we will be supporting the trust leadership development programme, so that future leaders concurrently develop their improvement skills, shifting the culture of the organisation to one in which all staff feel empowered to improve quality.

Our Approach

NHS England also highlights the importance of using a consistent organisational approach; the accompanying slide deck describes the 5-step Improvement Framework we will be using, which is congruent with the improvement methodology taught across the organisation. Up to 6 Plan-Do-Study-Act (PDSA) cycles will be instituted in each of the following programmes. More details about each step are included in the Appendix 1.

Recommendations

The Trust Board is asked to review and note the update. Updates will be 12 monthly henceforth.

Escalations:

None

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2023-24

Sara Randall

Chief Operating Officer

Oxford University Hospitals
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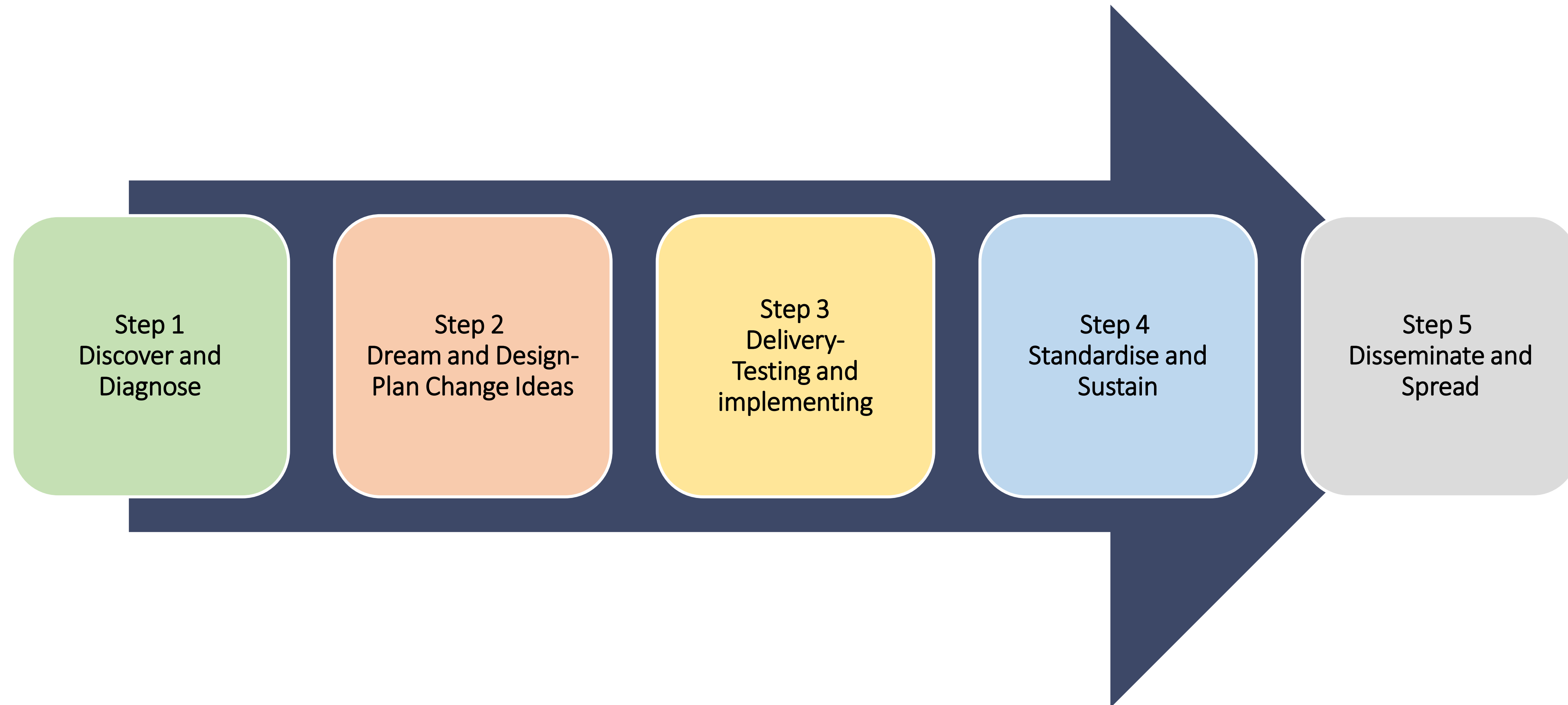
OUH Improvement Framework – 5 Steps for Sustainable Improvement



QI Education and Community Building Programme 2023/24

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Three Programme priorities for Improvement in 2023/24 - with agreed leads

1. **Continue to Deliver QI Education Plan**, underpinned by focus on strengthening key enablers for sustainable success including:
   - Growth of a core QI faculty to enable sustainable delivery of QI training
   - Ensuring inclusive access to QI development opportunities
2. **Establish a Community of *Improvers@OUHQIHub* to**:
   - Support wider collaboration and shared learning including with patients and carers
   - Establish a pipeline for QI education faculty development
   - Further embed a culture of continuous improvement at OUH
3. **Support Key Improvement Workstreams to maximise QI impact, scale and spread**
   - Train and support the teams and leaders delivering other 3 IQI programmes (Cancer, Harm Reduction and Urgent Care)
   - Embed QI into learning from incidents within the new Patient Safety Incident Response Framework (PSIRF)
   - Build wider connections with improvement partners across BOB ICB to better share learning, solutions and resources

Key Productivity Metrics for 2023/24

Final metrics in development, the following represent some current metrics under consideration:

- *Education delivery metrics*: no. trained overall and at each level; diversity and inclusivity of staff completing training; self reported confidence in applying concepts after training.
- *OUH staff survey* Q3 responses: “I am able to make improvements happen in my area of work” (Annual and Pulse surveys)
- % of registered project aligning with organisational strategic objectives
- % of Ulysses-registered QI projects with a completed IHI project progress score at project closure
- % of Ulysses-registered QI projects, and T those supported through Level 3+ training, that achieve 3 – 5 on the IHI project progress score at project closure
- To review and identify appropriate metrics to support measuring impact of QI (explore opportunities to learn from other Shelford partners)
- Number of staff who are active QI community and QI Faculty numbers
- Number of experts by experience and patient safety partners trained in QI

Key Programme Stakeholders

- **Executive Sponsor:** Interim Chief Medical Officer
- **Accountable Officer:** Deputy Chief Medical Officer and Director of Clinical Improvement

Key Aims and Desired Outcomes

- Deliver next phase of QI Education Framework, ensuring wide access QI training
- Establish a diverse and inclusive network of Improvers, including staff and wider partners in improvement including patients, carers and our wider communities
- Embed culture and systems to facilitate Scale and Spread of improvements at OUH

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Summary of QI Education Framework Delivery Schedule 22 - 25

NB. Updated from QI Education strategy 2022 – 25

	Courses	Year 1 (22/23)				Year 2 (23/24)				Year 3 (24/25)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Level 1 Introduction	E-Learning			**Development & PDSA cylces**		**My Learning Hub Launch**	**Open access via MLH**						
Level 2 Essentials	Bitesize Workshop			**Development & PDSA cylces** (Testing planned with Shared Governance Councils & OxSCA teams)		**Implementation and Prioritise Faculty Growth -** (Focused delivery to align with IQI Team Programmes, Shared Goverance Groups and open access sessions on MLH)			**BAU delivery**				
Level 3 Foundation	QSIR F	**2 Monthly**				**1 Monthly**				**1 Monthly**			
	QI Hub Programme	**2 cohorts annually**				**Review & Redesign Phase**		**1 Cohort Annually** (With more focued support over 9 month duration)				**1 Cohort Annually**	
	Modular Programme						**Review & development**	**PDSA Cycles**		**Refinement**	**Transition to open access**		
	Emerging Leaders	**2 cohorts annually**					**2 Cohorts running concurrently** (May / June Start)			**Inclusion in programme dependent on going funding for external delivery**			
Level 4 QI Champion	QSIR P (BOB ICS)	**3 cohorts annually**				**3 cohorts annually**				**3 cohorts annually**			
	QI Champions			**Redesign and test phase**				**Cohort 11**		**3 cohorts annually**			
Level 5 Sponsor & Manager	QI for Managers and Sponsors			**Development & Testing phase** (Snr Leaders Programme)		**6 - 8 sessions annually to focused prioritised staff groups** (working with culture and leadership team to align with wider leadership/managers development programmes)				Conitnued on going delivery informed by learning from 23/24			
Level 6 QI Coach & QSIR Associate	QSIR Associate		**5 Trained 22/23**			**Up to 5 annually***				**Up to 5 annually***			
	QI Coach						**Development, Design**		**Testing - PDSA - Cohort 1**		**Wider roll out 24/25**		
Level 7 Expert								**To be Confirmed** (dependant on funding and resource options, mapping of future options planned for 24/25)					

* Dependent on Act Academy QISR Associate Accreditation capacity

<table>
<tr><th></th><th colspan="2">Quarter 1</th><th colspan="3">Quarter 2</th><th colspan="3">Quarter 3</th><th colspan="3">Quarter 4</th></tr>
<tr><th></th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>March</th></tr>
<tr><td rowspan="4">2: Improvers @OUHQI Hub community</td><td colspan="3" rowspan="2">2. Dream and Design: Community
• Develop a framework for sustainable engagement of the community
• Explore opportunities external funding
• Explore digital enablers</td><td colspan="4" rowspan="2">3. Testing and Delivery
• Test (PDSA) and implement identified digital platforms
• Develop and expand digital content
• Strengthen divisional representation in QI Forum
• Build opportunities for connections across community</td><td colspan="4">4. Standardise and Sustain
• Sustainable model ideally supported by external funding
• Strengthen community links with QI Forum</td></tr>
<tr><td colspan="4">5. Disseminate and Spread
• Share model & learning with local & system partners</td></tr>
<tr><td colspan="2">2. Dream and Design: Faculty
Establish a pipeline for QI education faculty development</td><td colspan="5">3. Testing and Delivery
• Test (PDSA) faculty onboarding, education and support
• Co-deliver QI training with developing faculty</td><td colspan="4">4. Standardise and Sustain
• Standardise faculty development; ongoing faculty growth</td></tr>
<tr><td colspan="3">2. Dream and Design: Patient Involvement
• Work with Head of Patient Experience to link QI and patient partnerships (Quality Priority 8. Empowering patients – building partnerships and inclusion)
• Include QI in welcome event</td><td colspan="8">3. Testing and Delivery (In line with Quality Priority 8. Empowering patients – building partnerships and inclusion)
• Pilot new Ulysses Improvement module with inclusion of patient, carer and family involvement question included
• Train 10 Experts by Experience in Quality, Service Improvement and Redesign (QSIR) fundamentals
• Pilot (PDSA) Patient, Carer and Family involvement in QI Forum
• Pilot (PDSA) interface between Trust Patient Partnership Groups and core trust Improvement Programmes
• Pilot (PDSA) Friends and Family Test Dashboards</td></tr>
<tr><td rowspan="5">3: Support Key Improvement Workstreams to maximise QI impact, scale and spread</td><td colspan="6">3. Testing and Delivery:
• Train and support the teams and leaders delivering other 3 IQI programmes</td><td colspan="5">4. Standardise and Sustain
• Design and prepare QIQ training for 24/25 IQI Programme Teams</td></tr>
<tr><td colspan="4">2. Dream and Design : QI Fellows
• Agree priority projects for QI Fellows
• Design QI Fellows education
• Plan QI contribution to faculty</td><td colspan="7">3. Testing and Delivery
• 2 QI Fellows start August 2023 (1 year posts, 50% QI / 50% Clinical)
• Establish joint working and supervision arrangements
• IQI Team support for QI Fellow projects</td></tr>
<tr><td colspan="6" rowspan="2">3. Testing and Delivery: OxSCA
• Strengthening the OxSCA quality improvement projects
• Embedding indicators of improvement culture, including % of staff trained
• Applying QI methodology to development of OxSCA Framework</td><td colspan="5">4. Standardise and Sustain
• Embed high quality QI in OxSCA process</td></tr>
<tr><td colspan="5">5. Disseminate and Spread
• Share OxSCA projects at QI stand ups and OxSCA Forum</td></tr>
<tr><td colspan="4">2. Dream and Design: PSIRF
• Codesign with PSIRF Team QI approach for embedding learning from incidents within Patient Safety Incident Response Framework</td><td colspan="7">3. Testing and Delivery
• Pilot (PDSA) agreed QI approach for embedding learning
• Review / refine QI education alignment with PSIRF
• QI Education for PSIRF team including patient safety partners</td></tr>
</table>

Urgent and Emergency Care Programme 2023/24

Three Programme priorities for Improvement in 2023/24

1. **Clinically Ready to Proceed (CRTP)**
- Non-admitted / admitted patients within 60 minutes. *(CSU Clinical Leads)*

2. **Review of Internal Clinical Pathways**
- Focusing on patients with a particular condition. To include the review of the Professional Standards and linked to workforce. (*CPG Leads in collaboration with CCIO*)

3. **Criteria to Reside for all patients**
- Linked to Board Rounds and all patients having an estimated date of discharge.
- Includes internal focus within the Transfer of Care Hub (ToC) to expedite the patient discharge process and addressing health inequalities at an early stage. (*Deputy Director of Urgent Care, Cross-Division DD's*)

Key Productivity Metrics for 2023/24

1. Reduction in bed occupancy through reduction in length of stay for non-elective patients
2. Lean approach to diagnostic investigations
3. Reduction in the time of the patient mean length of stay within ED
4. Reduction in overall patient pathway time
5. Reduction in the readmission rate within 14 days following the increase in use of Criteria to Reside

Key Programme Stakeholders for delivery

- **Executive Sponsor:** Chief Operating Officer and Interim Chief Nursing Officer
- **Accountable Officer:** Director of Clinical Services

Key aims and Desired Outcomes

- Improvement in 4 hour performance for all types and type 1
- Reduction in 12 hour length of stay in ED
- Reduction in the number of patients who do not meet the criteria to reside
- Increase in the number of patients with an Estimated Date of Discharge set within 24hrs of admission to improve family and MDT alignment for patient discharge arrangements

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Urgent and Emergency Programme 2023/24 – Delivery Timescales

<table>
<tr><th></th><th colspan="2">Quarter 1</th><th colspan="3">Quarter 2</th><th colspan="3">Quarter 3</th><th colspan="3">Quarter 4</th></tr>
<tr><th></th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>1. Clinically Ready to Proceed</td><td colspan="2">1. Discover and Diagnose
• Stakeholder engagement with ED staff to prioritise non-admitted pathway
• Wider System learning – linking with Kings
• Understanding staff experience
• Identification of constraints – drafting driver diagrams / process maps</td><td>2. Dream and Design
• Identification of improvement workstreams
• Generation of change ideas – using 4N's / engagement event
• Refined data dashboard in Orbit+
• Introduction sustainability model – creation tool</td><td colspan="2">3. Testing and Delivery
• Identified PDSAs commenced through sprints /ramps
• Testing of the PDSAs supporting incremental learning
• Updates and escalations to Division / TWUCG through testing period
• Service redesign through issues / information gained from PDSAs</td><td colspan="4">4. Standardise and Sustain
• Timeline identified for 30, 60 and 90 day review with key stakeholders
• Excellence reporting / presentations – information shared in key forums
• Feedback and stories from participants
• Revised sustainability tool
• Review documents and logs for handover to BAU
• Review opportunity to share learning to commence admitted CRTP aligned to 5 step improvement framework</td><td colspan="2">5. Disseminate and Spread
• Presentation by ED service for non-admitted CRTP at QI Stand Ups
• Celebration and sharing – final project at TWUCG
• Supporting teams to adapt / adopt outputs
• System wide sharing</td></tr>
<tr><td>2. Review of Clinical Pathways</td><td colspan="2">Data Mining Exercise
• Presentations / Visit to Royal Free to take place
• Initial engagement meeting with TWUCG and key clinical members to take place to inform stage 1
• Digital requirements and enablers to be defined</td><td colspan="2">1. Discover and Diagnose
• Stakeholder identification and engagement with group / Accountable Officer
• Explore list of internal pathways
• Baseline data to be collected
• Undertake research and wider system learning
• Identification of constraints – drafting driver diagrams and process maps</td><td>2. Dream and Design
• Explore list of internal pathways to select 'top 3'
• Identify improvement workstreams
• Generation of change ideas
• Introduction of sustainability</td><td colspan="2">3. Testing and Delivery
• Identified PDSAs commenced through sprints / ramps
• Testing of the PDSAs supporting incremental learning
• Updates and escalations to Division / TWUCG through testing period
• Service redesign through issues / information gained from PDSAs</td><td colspan="4">4. Standardise and Sustain
• Timeline identified for 30, 60 and 90 day review with key stakeholders
• Excellence reporting / presentations – information shared in key forums
• Feedback and stories from participants
• Revised sustainability tool
• Review documents and logs for handover to BAU
• Opportunity to link to CRTP admitted priority (see priority 1) following pathway identification in step 2</td></tr>
</table>

Urgent and Emergency Programme 2023/24 – Delivery Timescales (Continued)

	Quarter 1		Quarter 2			Quarter 3			Quarter 4		
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3. Criteria to Reside for all Patients	***Data Mining Exercise*** • *Delay to start aligned to availability of QI resources* • *Discussion at TWUCG for Divisions to nominate wards to be prioritised for Board Round roll out* • *Identification of patient group link to health inequalities*			**1. Discover and Diagnose** • Stakeholder engagement with identified wards for roll out • Benchmarking and data review of key wards and patient group • Attendance at identified board rounds • Creation of driver diagram and review current processes		**2. Dream and Design** • Identification of improvement workstreams • Generation of change ideas – using 4N's / engagement events • Review against data dashboards • QI coaching / training if required • Introduction of the sustainability model – creation of tool • Discussions with ToC looking at identified patient group	**3. Testing and Delivery** • Identified PDSAs commenced through sprints / ramps • Testing of the PDSAs supporting incremental learning • Updates / escalations to Division / TWUCG through testing period • Service redesign through issues / information gained through PDSAs		**4. Standardise and Sustain** • Timeline identified for 30, 60 and 90 day review with key stakeholders • Excellence reporting / presentations – information shared in key forums • Role designs if required • Feedback and stories from participants – both staff and patients • Update of risk / issues and lessons logs for handover as BAU • Update of Board Round policy if required following completion of PDSA tests of change		

Cancer 2023/24

Three Programme priorities for Improvement in 2023/24

Access to Cancer services – Health Inequalities*

- Cancer Diagnosis via ED attendances – review of the data understanding the time of presentation, demographics and any health inequalities
- DNA Rates
- 2WW Referrals
- Appropriateness of Referrals
- Faster Diagnosis

Cancer Screening and Health Education*

- Breast
- Bowel / Cervical
- Targeted Lung Health Checks

(*Leads: Clinical Director for Radiology / OSM for Diagnostics/ICB and GP Cancer Lead/Divisional Directors*)

Treating our 'Long Waiters' sooner*

- Sustainable recovery of **over 62 day and 104 day** waiting list backlog by understanding and tackling root causes such as late Inter-Provider *Transfers* (*Lead: Clinical Lead UGI/Divisional Director for SUWON*)
- Opportunities within Pathology to improve overall cancer times (*Lead: Head of Pathology*)

**Digital, Administration, Lean Processes, review of MDTs and Health Inequalities included throughout all priorities*

Key Productivity Metrics for 2023/24

1. Increase in early Cancer diagnosis with more Patients being diagnosed at stages 1 / 2
2. Reduction in the number of DNAs/Cancellations (2WW)
3. Reduction in Cancer Health Inequalities
4. Increase in the number of complete referrals from GPs / other providers
5. Reduction in delayed Inter-Provider Transfers
6. 28 FDS Best Practice Timed Pathway compliance

Key Programme Stakeholders for delivery

- **Executive Sponsor:** Chief Operating Officer and Interim Chief Medical Officer
- **Accountable Officer:** Deputy Director for Elective Care and Clinical Director for Cancer

Key aims and Desired Outcomes

- Patients being diagnosed at stages 1 / 2 and reduction in stages 3 / 4
- Patients transferred by day 38 from other providers to improve patient experience and outcomes
- Optimal utilisation of facilities such as CDC and Digital solutions to improve productivity
- Appropriateness of referrals to ensure justified increase in demand for diagnostic services

Cancer Programme 2023/24 – Delivery Timescales

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<tr><td>1. Access to Cancer Services – Health Inequalities</td><td colspan="5"><u>3. Testing and Delivery (already at this stage for majority of work)</u>
• Current PDSAs (e.g. 6 in Gynae) to continue
• New PDSAs following data mining to be initiated on prioritised tumour sites (expected some to be from 22/23 tumour sites)
• Service redesign through issues / information
• Identification of new activities which will be aligned to the 5 step improvement framework
• Handover of activities not aligned to revised priorities</td><td colspan="4"><u>4. Standardise and Sustain</u>
• Timeline identified for 30, 60 and 90 day review with key stakeholders
• Excellence reporting / Presentations – information shared in key forums
• Feedback and stories from participants
• Review of local guidelines and protocols for BAU
• Revised sustainability tool
• Risk and Lessons Logs finalised and handover to BAU</td><td colspan="2"><u>5. Disseminate and Spread</u>
• Identified tumour sites presenting at QI Stand Ups
• Celebration and sharing through presentations and write ups
• Supporting teams to adapt or adopt outputs</td></tr>
<tr><td rowspan="2">2. Cancer Screening and Health Education*</td><td colspan="2" rowspan="3"><u>Data Mining Exercise</u>

Following re-prioritisation within the Programme, a data mining exercise will be undertaken in this period to align current work to new priorities.

All tumour sites will be reviewed to provide a prioritised list aligned to the key headings in the three QI priorities. Resources will then be deployed to the prioritised list.

Identification of one key health inequality within Cancer for focus work.</td><td colspan="2"><u>1. Discover and Diagnose</u></td><td><u>2. Dream and Design</u></td><td colspan="2"><u>3. Testing and Delivery</u></td><td colspan="4"><u>4. Standardise and Sustain</u></td></tr>
<tr><td colspan="9">*Should commence in July – following data mining exercise and align to QI resource availability – timeline will be confirmed post review</td></tr>
<tr><td>3. Treating our ‘Long Waiters’ sooner</td><td colspan="2"><u>1. Discover and Diagnose</u>
• Aim Statements
• Stakeholder engagement with key tumour sites
• Benchmarking and data review – create baselines
• Identify constraints against current pathways explore – using Driver Diagram and Process Mapping
• Exploration of sustainability tool</td><td><u>2. Dream and Design</u>
• Detailed improvement workstreams and QI support prioritised
• Refinement of data in Cancer dashboard
• Project groups commence
• PDSAs identified</td><td colspan="2"><u>3. Testing and Delivery</u>
• Identified PDSAs commenced through sprints / ramps
• Testing of the PDSAs supporting incremental learning
• Service redesign through issues / information gained through PDSAs</td><td colspan="4"><u>4. Standardise and Sustain</u>
• Timeline identified for 30, 60 and 90 day review with key stakeholders
• Excellence reporting / Presentations – information shared in key forums
• Feedback and stories from participants
• Revised sustainability tool – providing updated sustainability score
• Review of local guidelines and protocols for BAU - SOPs
• Handover to key services as BAU
• Risk/Issues log and lessons learnt log to be finalised</td></tr>
</table>

Harm Reduction Programme 2023/24

Three Programme priorities for Improvement in 2023/24 - with agreed leads

1. **Falls Programme** - **Reduction in the number of avoidable unwitnessed falls** (Quality Priority 3) *(Falls Prevention Practitioner and Deputy to Associate Chief Nurse)*
   - Focus on support core actions with QP including;
     - **Action 2:** Increasing Multifactorial Falls Risks Assessment (MFRA) compliance,
     - **Action 4:** Improve Falls Benchmarking and Performance – accurate representation of falls through effective data
     - Exploring innovation and digital opportunities to reduce falls – proposals include testing Rambleguard electronic falls detection system / Paroseal in identified ward following data deep dive and clarification of aims and measures
2. **Reducing Medication Errors** *(Medicines Safety Consultant Pharmacist; Chair of Medicines Safety Group, Deputy CMO)*
   - ***Improving safety of diabetes perioperative management*** – offer QI input and support into defined project with identified leadership by Diabetes Specialist Nurse. Need for improvement was identified from diabetes GIRFT review recommendations (2019) when OUH was outlier for diabetes inpatient increased LoS post operatively
   - ***Focus on safer injectable opioids*** – opportunity to support improvements through increasing the use of safer and ready-to-use opioid injectables in the inpatient setting
   - ***Review infrastructure for identifying medicines risk and safety*** – explore data and methods of triangulation to support wider understanding of medicines risk, safety and impact of interventions in the long term
3. **Increasing Dementia and Delirium Assessments**, (*Confirming appropriate leads with support from Deputy CMO*)
   - Review QP and work with key stakeholders to agree key areas QI can add value

To support wider programme and culture of learning around patient safety and harm reduction; a community of practice to be established to support sharing of practice and learning across teams, services and divisions.

The following slide with proposed timelines is initial overview and will be reviewed and updated to align with learning from the initial discover and diagnose step and will be shared following this process of refining and defining.

Key Productivity Metrics for 2023/24

1. **Proposed Falls Measures**
   - Reduction in no. falls per 1000 occupied bed days
   - No. falls per 1000 occupied bed days resulting in moderate to severe harm
   - Increased MFRA compliance on monthly audits - target 90% (Process Measures)
   - Nursing and AHP staff to have completed e-Learning training by March 2024 (Process Measures)

Metrics to be confirmed for Programme 2 and 3 *following agreement of QI focus suitable metrics to capture benefits and impact will be identified*

Key Programme Stakeholders

- **Executive Sponsor:** Interim Chief Medical Officer / Interim Chief Nursing Officer
- **Accountable Officer:** Director of Nursing/Deputy Chief Nursing Office

Key Aims and Desired Outcomes

- Programme to support application of QI approach to reducing avoidable incidences of harm on focused trust priorities, supporting ongoing development of culture of patient safety

Harm Reduction Programme 2023/24 – Delivery Timescales

	Quarter 1		Quarter 2			Quarter 3			Quarter 4		
	May	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
QI Priority 1: Reduction in the number of avoidable unwitnessed falls	**1. Discover and Diagnose** • Review QP to align QI support to appropriate elements. Initial focus proposed on unwitnessed Falls • Falls Summit – stakeholder engagement and inform future Designs / PDSAs • Deep data diver, to Identify appropriate wards to engage in testing phase • This phase will include		**2. Dream and Design** • Focused improvement workstream groups with identified wards. • Supporting exploring local change ideas with identified wards / setting.	**3. Testing and Delivery** • Testing of Electronic monitoring impact on unwitnessed falls ward to be identified through deep dive		**4. Standardise and Sustain** • Timeline identified for 30, 60 and 90 day review with key stakeholders • Excellence reporting / Presentations – information shared in key forums • Feedback and stories from participants • Review of local guidelines and protocols for BAU • Revised sustainability tool • Risk and Lessons Logs finalised and handover to BAU				**5. Disseminate and Spread** • Presenting at QI Stand Up • Celebration and sharing through presentations and write ups • Supporting teams to adapt or adopt outputs • Share improvement and learning through agreed reporting routes	
QI Priority 2: Medication Safety		**1. Discover and Diagnose** Initial areas of focus of data deep dive, mapping and wider stakeholder engagement agreed as: • Improving perioperative management of diabetes • Opioid management from inpatient perspective • Infrastructure for identifying and understanding medicines safety		**2. Dream and Design** • Refinement of data triangulation • Project groups commence • PDSAs identified	**3. Testing and Delivery** • Agree PDSAs following discover and diagnose to agree on prioritised areas • Identification of new activities which will be aligned to the 5-step improvement framework			4. **Standardise and Sustain** Timeline identified for 30, 60 and 90 day review with key stakeholders and ongoing assurance of sustainability Excellence reporting / Presentations – information shared in key forums Feedback and stories from participants Review of local guidelines and protocols for BAU Revised sustainability tool Risk and Lessons Logs finalised and handover to BAU			
QI Priority 3: Delirium and Dementia Assessments			***Should commence in late June / July – following refining opportunity with key stakeholders with support from Deputy CMO – building to starting step 1 of OUH QI Framework by data mining exercise to align to QI resource with best opportunity – timeline will be confirmed post review and agreement**								

NB –Proposed stages outline are tentative and will be directly influenced through the priorities and outcomes of phase 1 discover and diagnose

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Activities and Outputs- 5 Steps to Quality Improvement

Step 1: Discover and diagnose

Understanding the issues

- **Core activities:** Stakeholder engagement;
- Benchmarking;
- Research and wider system learning ;
- Data review;
- Walking patient pathway;
- Staff and Patient experience;
- Mapping interdependencies;
- patient stories
- Understanding 'burning platform'

- **Outputs:**
- Baseline data
- Stakeholder map
- Cause and Effect Analysis
- Driver Diagram (draft)
- Literature review/ identification of exemplars
- Process Map (understating bright sparks/ constraints)
- and subject matter experts at start of project

Step 2: Dream and Design

Establishing the vision
Defining aim and project workstreams

- **Core Activities:**
  Codesign programme workstreams with stakeholders and patients; Demand and capacity modelling; explore all opportunities for improvement, thinking within current system and "thinking differently"

- **Outputs**:
- Stakeholder Event – defining your core "guiding council" (clinical, administration, patient, business change manager)
- Defined Improvement Workstreams, and identified groups
- Improvement programme Dashboard (time series data; outcome / process / balancing measures)
- Integrated QI Training and Coaching in preparation for stakeholders and project groups
- Planned PDSA cycles

Step 3: Delivery

Iiterative testing of change ideas and building confidence managing risk

- **Core Activities**:
  Establish "improvement big room"; Generate change ideas and new theories of change; Design test of change cycles (PDSA) to support incremental learning and testing of theory of change; include simulation and real tests of change

- **Outputs**:
- Completed PDSA Cycles
- Emerging improvement, with increased confidence in route and options to address complex system challenges
- Updated Dashboard (inclusive of local measures for tests of change)
- Graded approach to improvement support, reviewing application of priority matrix for support initiatives and ideas out of big room

Step 4: Implement and Sustain

Establishing the Changes as Business as Usual

- Implementation phase – becoming BAU
- Less focus on learning more predictable data
- Greater people impacted
- Celebration and sharing (local)
- Reporting Excellence
- Onboarding others – how do you locally spread tests of change
- Engaging wider parties who will support spread

- **Outputs:**
- Updated Sustainability Score
- Standardised Operating Processes
- Role designs
- Feedback and stories from participants
- Risk and issues log
- Lessons learnt log
- Excellence reports
- "Play book" for other teams
- Report on project progress
  - To help dissemination
  - To improve project template design

Step 5: Disseminate and Spread

Influencing the system and growing the community

- ***Core activities***
- Celebration and sharing
- Presentation at QI Stand up and other trust fora
- Publication in journals/ posters/ conferences
- Support other teams to adapt or adopt outputs from step 4

- **Outputs**
- Presentations and write ups
- Growing membership of the trust improvement
- System wide impact