The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	Trust Board
Paper Title	Report from the Director for Clinical Effectiveness
Date of meeting	28th November 2019
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Responsible Director	Edwin Borman
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Executive Summary

The Directorate for Clinical Effectiveness was created in order to allow the Trust to identify, at an earlier stage, areas requiring improvement, and to provide greater capacity within the Trust to deal with the broad range of challenges that we are addressing.

The Directorate began functioning in June of this year, bringing together Clinical Audit, Clinical Informatics, Complaints and PALS, Patient Safety (including Learning from Mortality), and Research and Innovation. More recently, the Chaplaincy service has been included. This is the first report to the Board from the Directorate, and provides an overview of progress.

The post of Director for Clinical Effectiveness will continue to evolve, with a continuing focus on areas requiring improvement. This already has included support for the development of improved clinical pathways.

Previously considered by	

The Board (Committee) is asked to:			
☐ Approve	☑ Receive	☐ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*N/A*

Report from the Director for Clinical Effectiveness

Introduction

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The Directorate began functioning in June of this year, bringing together Clinical Audit, Clinical Informatics, Complaints and PALS, Patient Safety (including Learning from Mortality), and Research and Innovation. More recently, the Chaplaincy service has been included. This is the first report to the Board from the Directorate, and provides an overview of progress. Some of the work described in this report began before the directorate was formally established, as part of cover arrangements for the Director of Finance and the Director of Nursing.

Developing the team(s)

Monthly meetings have been held, attended by the heads of each department and using the methodology supported by the Transforming Care Institute. The agenda follows a "standard work" agenda format, with a short update from each area, a focus on areas of shared importance, and confirmation of actions completed and those to be performed.

This approach has supported colleagues from previously unconnected departments to start to work together in more innovative ways, such as exploring the potential for research related to the implementation of improvements in patient safety, and linking the approach to complaints and to patient safety incidents.

The heads of department are:

- Clinical Audit Sally Allen
- Clinical Informatics Julie Waters
- Complaints and PALS Julia Palmer
- Patient Safety Pete Jeffries
- Research and Innovation Kelly Hard, Helen Moore
- Chaplaincy Petro Hryziuk (joined as of 1st November)
- Director Edwin Borman

The shared agenda

Prior to the commencement of the new directorate, each head of department was invited to review their area of responsibility with the incoming director, with the aim of developing objectives for this NHS year and beyond. These have been agreed, and were included in a presentation to the Trust's monthly meeting with regulators (NHSI, NHSE, CQC, GMC, NMC), representative organisations and commissioners: the System Oversight and Assurance Group (SOAG). The relevant parts of that presentation are included as appendix 1.

In addition to this process of identifying agreed developmental outcomes, specific areas of concern have been identified in some departments, each requiring more focused intervention. The combination of the two approaches has provided an agenda for intervention and for development. Progress on this is set out below.

Clinical Audit

Introduction

The Clinical Audit Department consists of a small team of 15 members of staff (11.43 wte) based on both hospital sites. The teams are responsible for developing and implementing the clinical audit forward plan, working to support staff in the Care Groups to carry out relevant audits and implement changes to practice where necessary. The teams also publish and update Clinical Guidelines and Policies on the Intranet, manage the dissemination and monitoring of NICE guidance, collect and submit Friends and Family Test data and carry out local surveys.

The work programme of the Clinical Audit department is based on four main areas of responsibility:

1. confirming the implementation of new national guidance – such as from NICE and the Royal Colleges – ensuring that these are reviewed, agreed for implementation and published on the Trust's Intranet

2. National audits, based on national guidance from HQIP (Healthcare Quality Improvement Partnership) list and the NCAPOP (National Clinical Audit and Patient Outcomes) list. These include the Friends and Family Test and National Patients' Survey.

3. Audits related to commissioner or national priorities – including CQuINs, and specific clinical audits, such as Trust-wide infection control audit programme.

4. locally determined audits, usually audits of clinical practice according to standards provided in Royal College guidelines, but also including surveys of patient experience within the Trust.

As an indication of the workload involved, for the year April 2018 to March 2019, the team conducted 237 audits in total**:** local 173, national 34**,** mandatory 30

Progress on areas identified for improvement in this year has included:

Out-sourcing of national surveys

- SaTH was one a small number of Trusts that has conducted these "in house". However, following a review, these now are being conducted by external companies, with a net saving in cost and the added benefit of freeing staff for other priorities.

Strengthening the system for ensuring that local policies and guidelines are updated with relevant NICE guidance

- while the team already has a robust system for tracking all NICE guidance – developed with support from the regional NICE representatives and monitored by the Trust's Clinical Governance Executive committee –the challenge has been to ensure that the clinical leads review these and keep them updated
- after identifying in May 2019 that, of the 1469 clinical policies or guidelines on the Intranet, 503 were out of date, the team has worked with the clinical leads to bring this number down to 56

Conducting priority audits

- in addition to their already very busy work programme, the team readily adds priority audits as such as the ongoing audit of the Trust's fulfilment of the duty of candour and clinical audits in specialities under enhanced monitoring, the results of which are helping us to improve care and performance in these areas.

Clinical Informatics / Information

Introduction

The Clinical Informatics / Information is based on three sites, and is comprised of a team of 25 members of staff (23.08 wte). Their responsibilities can be summarised as covering three main areas:

- information management, including data management (department and Trust databases) and content management (storage, retrieval and display of this information)
- information governance: including the safe and appropriate management of documents and records
- training for staff: on use of the Trust's digital and information systems

Transfer of Executive Director responsibility,for Clinical Informatics / Information initially began in February.

Progress on areas identified for improvement in this year, of necessity, has been considerable:

Given concerns about the fragility of SaTH's digital systems, the first priority was a review of the approach to the informatics and information technology (IT) systems in the Trust. This identified significant problems, in particular the need for increased staffing resources and improved infrastructure, and the financial challenge of addressing these.

In order to prioritise the large agenda of "business as usual" and urgent improvements, a weekly "digital huddle" meeting was convened. This has had the added benefit of strengthening co-operation between colleagues working in informatics and those in IT. This meeting follows TCI methodology and takes no longer than 45 minutes.

In order to address the problems with the Trust's informatics functions, investment in a new Data Warehouse was prioritised, with support from a successful application for regional funding for the first year of this project and, on the understanding that further applications would be made for years two and three, Board level approval for underwriting these development. Progress with implementation of year one of this development is well under way and an application has been submitted for funding of year two.

In June, the Trust engaged with the regional team from NHS England (Digital) for support and an invited review. This provided an external expert assessment of the Trust's informatics and IT systems, with recommendations for prioritised interventions and expert support for the teams from NHS England (Digital) and the TSSM, including involvement in the "digital huddle" meetings.

Actions on the key priorities agreed with TSSM have included:
The implementation of a robust Governance pathway for Digital systems and developments. The structure of this is as set out in Appendix 2. A key initial step was the Trust-wide introduction of a "digital pause", allowing a review of all digital systems, and the agreement of the means of prioritizing further developments. This has allowed the Trust to document fully the more than 440 systems that are linked to the Intranet and associated digital infrastructure backbone. Further developments have included ITIL mapping of the full digital infrastructure inventory, with service lifecycle to support a renewal and replacement programme.
The Trust has extended its focus beyond the immediate digital agenda to prepare for the redevelopment of SaTH's two hospital sites and to engage more fully with system partners and to prepare for greater connectivity of SaTH's digital systems with those of our system partners.

A further significant step, combining the efforts of the IT and Informatics teams and respective directors, has been the decision by the Board to support the introduction of a new IT system for the Emergency Departments. This will be introduced by the end of March 2020.

During October, responsibility for this department has transferred to the Director of Finance, facilitated by the appointment of a new Director of Digital Transformation

Complaints and PALS (Patient Advice and Liaison Service)

Introduction

The combined Complaints, PALS and Bereavement Team currently comprises 14 staff (12.83 TWE) based on both sites.

The Complaints service manages all formal complaints received in the Trust, approximately 680 per year. The team will receive all new complaints, acknowledge them, coordinate an investigation and then draft a response on behalf of the Chief Executive. They also will facilitate meetings between complainants and senior managers, and will liaise with the Parliamentary and Health Services Ombudsman in relation to any complaints referred for independent review.

The PALS service responds to around 1500 contacts with patients and families per year. The team offers support to resolve any immediate problems that may arise related to care or services in the Trust. In addition the team provides the Trust's Bereavement Service, issuing Medical Certificates of Cause of Death to relatives of patients who die in the hospital and facilitating bereavement meetings where these are needed. Since April 2019, the team also has supported the Medical Examiner service at RSH.

Progress on areas identified for improvement in this year has included:

Complaints

- use of high quality questions (using ThinkOn methodology) and improved action plans on complaints statement forms to make learning more robust
- an updated escalation process for overdue responses from Care Groups to ensure that complainants receive a response in a timely manner
- the development of a complaints responses convention to standardise the style of responses
- further use of lean methodology to map and improve the Complaints processes
- the development of plans to progress to paper-light system with a view to going paper-free

PALS and Bereavement

- implementation of the Medical Examiner service across RSH. This ensures robust, transparent and independent scrutiny of the death certification process and offers even greater support to families, allowing a discussion about likely cause of death, and the opportunity for family members to raise any concerns or ask any questions
- appointment of Medical Examiner Officers to support the Medical Examiners
- updating the Trust's bereavement booklets
- identifying and providing a waiting area for bereaved families moved off main corridor at RSH
- preparing for the introduction of clothes cupboard for patients who don't have suitable clothing when discharged from ED (e.g. homeless patients)

Further work planned includes:

- the continuation of complaints process mapping to identify areas where improvements can be made
- introduction of the Medical Examiner Service at PRH, for which interviews are underway and initial appointments have been made.

Patient Safety (including Learning from Mortality)

Introduction

SaTH has a small Patient Safety team, of 8 members of staff (7.03 wte) who work closely with the governance leads in the Care Groups. Based on both hospital sites, the team's work involves all aspects of clinical care throughout the Trust.

This includes providing:

- support for the detection, identification of and management of clinical incidents
- support for the identification of learning and actions to reduce risk for patients
- support for the identification of key areas of risk to patient safety
- specialist advice to staff and management on individual patient safety issues
- the delivery and evaluation of the provision of educational activities to support patient safety.

The work of the team involves directly dealing with 40 to 50 Serious Incident investigations per year, supporting colleagues in the Care Groups with 70 to 80 High risk Case Reviews per year, and overseeing and monitoring the Trust-wide Datix incident reporting system, with approximately 14.000 incident reports per year.

Progress on areas identified for improvement in this year

A key priority for the team has been to improve how the Trust responds to incident reports involving moderate or serious harm, with emphasis on deriving learning points to support improvements in care. Working with a wide range of colleagues, we have redesigned the Trust's incident handling and monitoring pathway with particular emphasis on these more serious incidents. (See Appendix 3) The changes highlighted have strengthened oversight and assurance.

The process has been redesigned to improve decision-making regarding the route an incident will follow (whether declared as a formal Serious Incident raised on the national reporting system, StEIS, or internally as a High Risk Case Review). This has focused around strengthening the existing weekly Corporate Rapid Review meeting, introducing the Executive Serious Incident Review Group (ESIRG) and enhancing the governance and reporting systems around these. The remit of ESIRG include oversight of the Patient Safety system, with emphasis on ensuring that areas for improvement are identified and actions are completed appropriately.

The Patient Safety team has worked closely with investigating officers to ensure that Serious Incident (SI) reports are of high quality. The team has further developed a 'check and challenge' for SI reports to ensure they have focused on key lines of enquiry to identify causal factors. Feedback following review from ESIRG has been positive and this feedback is used to inform further improvements.

The Patient Safety team identified issues relating to a build-up of Datix reports that had not been reviewed in a timely fashion. The team has ensured that any potential moderate or higher risk case have been reviewed fully, and has been working with Care Groups to focus on ensuring the backlog is removed.

'Doing Datix differently': A consultation has been undertaken with staff and the Care Group relating to improving both processes around Datix reporting and improving feedback and sharing learning from incidents. This has supported the identification of a set of themes and suggested actions which has been supported by the Clinical Governance Executive. A full action plan will be developed to improve the use of Datix incident reporting and how this links to safety learning and feedback.

Improved use of data within key governance reports: data relating to key harms such falls and hospital acquired infections now are being presented in SPC format in quality governance report. This is aligned with the 'Making Data Count' development session received by the Trust Board.

Research and Innovation

Introduction

The Research and Innovation team is active on both sites, with 27 members of staff (21.2 wte) supporting and managing clinical and other trials.

The team has been very effective in attracting trials, but recent challenges involving access to aseptic chemotherapeutic agents has affected the Trust's ability to provide and support these important developments. Efforts are being made by the team to ensure that the budgetary challenges that result from this reduced activity are mitigated.

Progress on areas identified for improvement in this year

SaTH's Research and Innovation team has continued to perform in the top 100 recruiting Trusts in the country and has a good reputation for enrolment and completion of trials accepted. This is reflected in the regional key performance indicators, with SaTH continuing to meet 80% of the target for recruitment to time and target, as well as performance in initiating and delivery compliance reporting.

A strategic review has been undertaken and a number of recommendations have been put forward to address efficiency, with a 5 year plan incorporating a responsible approach to investment and development.

And some further good news!...

- SaTH's Oncology team was awarded the NIHR WMCRN Team of the year 2019 award. SATH submitted its first grant application for £2m with a SATH employee as Chief Investigator; this is pending a decision with the national HTA board

Further developments for the Directorate

Following discussion with the Chief Executive and the Chairman – this post was developed through similar discussions – the post of Director for Clinical Effectiveness will continue to evolve, with a continuing focus on areas requiring improvement.

This already has included support for the development of improved clinical pathways.

The first of these is the pathway for patients presenting with Acute Chest Pain to the Emergency Departments and/or the Acute Medical Units. A new clinical pathway that incorporates the use of more sensitive testing for Troponin to support more speedy and clinically-stratified decision-making. National funding has been sought to support a new model of care, that would support out-patient monitoring for some of these patients.

Further pathways being explored include those for patients with:

- long-term respiratory conditions (COPD; Bronchiectasis);
- potential pulmonary embolism, and;
- frailty and complex conditions.

These pathways will be based on joint working with colleagues in primary and community care.

Edwin Borman
Director for Clinical Effectiveness

Appendix 1

The Shrewsbury and Telford Hospital NHS
NHS Trust

Director of Clinical Effectiveness

"Putting safety at the heart of care"

Edwin Borman
Medical Director

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Current Situation

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Together We Achieve

New Reporting Structure

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Make It Happen
We Value Respect
Together We Achieve

High-level outcomes

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

How best to achieve this

- Reducing silo working
- Shifting from reactive to creative
- Synergies from connected departments
- Improved analysis of clinician and speciality performance: Datix, complaints, legal cases, outcomes
- Clinician engagement
- Safety I and Safety II
- Learning from, evidencing & celebrating success

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Patient Safety

Working together to develop

- Continuous improvement of the quality of serious incident investigations
  - linked to measurable actions to improve safety
- A culture of psychological safety and a 'just culture' to support this
- Improve feedback and sharing of learning at all levels of the organisation
- Develop a human factors faculty
  - apply human factors insights to support patient safety
- Develop learning and insights from what goes well
  - 'learning from excellence'

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Complaints, PALS & Bereavement

- Greater focus on learning and actions arising from complaints and PALS contacts
- Expand and link our systems for capturing positive feedback
- Full implementation of the Medical Examiner System across both sites
- Improved analysis of clinician and speciality performance

Clinical Audit

- Embed a reliable system for ensuring that local guidelines are updated with relevant NICE guidance
- Develop online tools to improve:
  - survey response rates
  - learning from patients' responses
- Further develop our engagement in national audits
  - to ensure that appropriate actions are taken

Research and Innovation

- Support all clinical specialties to become research active
- Develop the portfolio of trials at SaTH
  - focus on Biologics
  - to offer the latest cutting edge treatments to our patients
  - to strengthen the case for University Hospital Status
- Learning from Research and Innovation in order to improve the quality of clinical practise

Informatics

- A single source of data truth
  - clinical, operational, financial, performance
- A new data warehouse
- Building a new foundation of more robust reporting systems
- Intelligent analytics to support improvement and clinical engagement and improvement

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Immediate priorities

- Progressing EPR implementation
  - the foundation to
    - efficiency & quality improvements, and
    - new ways of working
- Addressing the digital workforce to underpin our digital future and programmes

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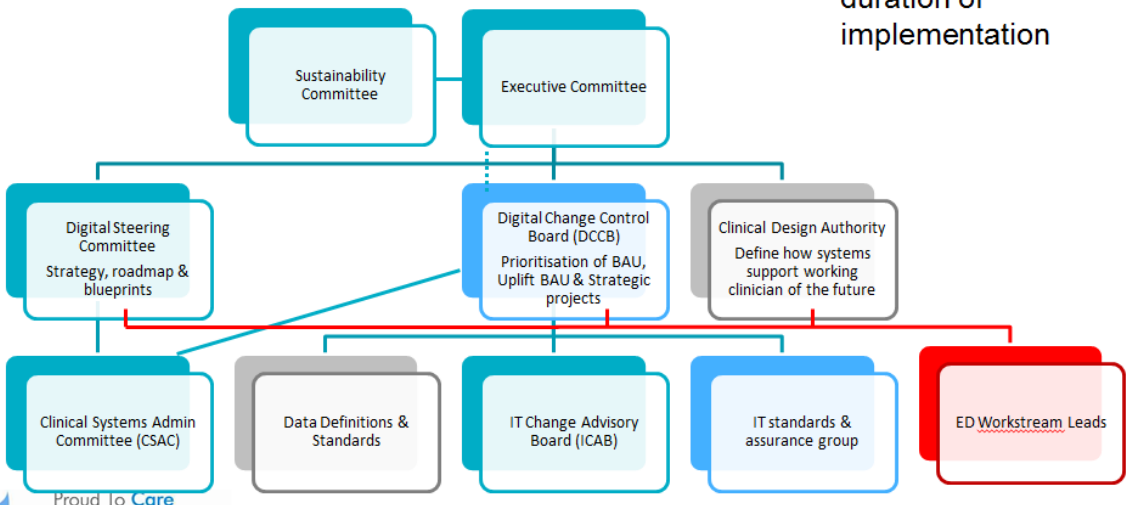
We Value Respect
Together We Achieve

Appendix 2

SaTH Digital Governance Structure

The picture represents our emerging digital governance landscape which will be retained long after EPR has been implemented. We continue to receive support from NHS Digital 'Trust System Support Model' (TSSM) team in getting this in place.

- In place currently
- Not yet in place
- Purely for the duration of implementation



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We Value Respect
Together We Achieve

What the groups do….

Group	What it does
Sustainability Committee	Tier 2 committee. Subset of board members (Exec & Non Exec) plus senior managers. Assurance on digital and SSP agendas progress. Digital section largely about improving baseline awareness in members at present due to low digital understanding across all disciplines.
Digital Steering Committee (renamed from EPR Steering Group)	Exec/SLT level. Setting strategic direction and significant decisions for digital agenda. Creating the digital roadmap and approving 'blueprints' developed which state our working environment decisions.
Clinical Systems Admin Committee (CSAC)	System administrators of the top 27 systems the Trust has. Formed 30 April 2019. Focussing on digital change control process for below initially. Then will progress to standards and consistency in Clinical Systems Administration - remember, systems administration isn't centralised.
Digital Change Control Board (DCCB)	Formed 31 July 2019: a process to get control of the prioritisation of digital projects that the Trust wants, and aligning to the Trust wider strategic agenda.
IT Change Advisory Board (ICAB)	Technically focussed group. Network and infrastructure implications of our digital projects. ICAB reviews and authorises changes prior to roll out. It identifies changes suitable for categorisation as 'standard' (pre approved) changes. The service it provides is a final check before rollout/go live based on a risk based peer review.

What the groups do….

Group	What it does
Clinical Design Authority – not in place yet but outline of duties drawn up and initial members identified	As we get control of our digital project prioritisation, it will become important that we implement standards in clinical system design to allow good interoperability, data quality, robustness in system design and configuration etc. It will create a blueprint of the digital clinician of the future. It's important that this is clinically led.
Data Definitions & Standards – not in place yet	As we progress further with our new data warehouse, and later Phase 2 Reporting overhaul, it will become important to have similar standards as above, but in relation to implementation of data consistency, how we apply national guidelines etc.
IT Standards & Assurance Group – first meeting 18 Sep 19?	Reviews requirements and makes sure they have appropriate detail and clarity. Engages with Clinical Design Authority to ensure the solution is in line with clinical requirements.

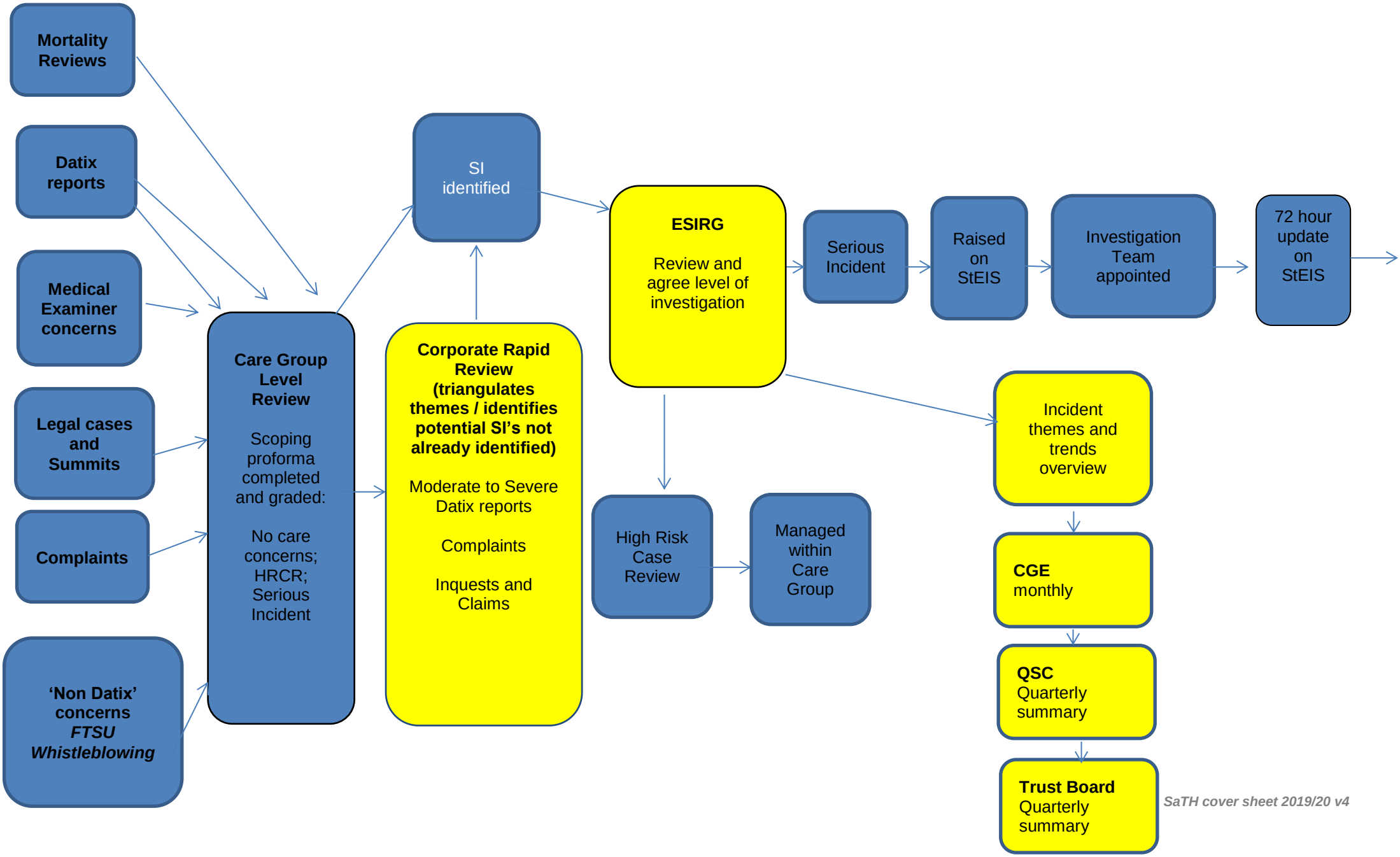
There are other groups that exist that aren't yet officially tied to the digital governance structure outlined here. They include:

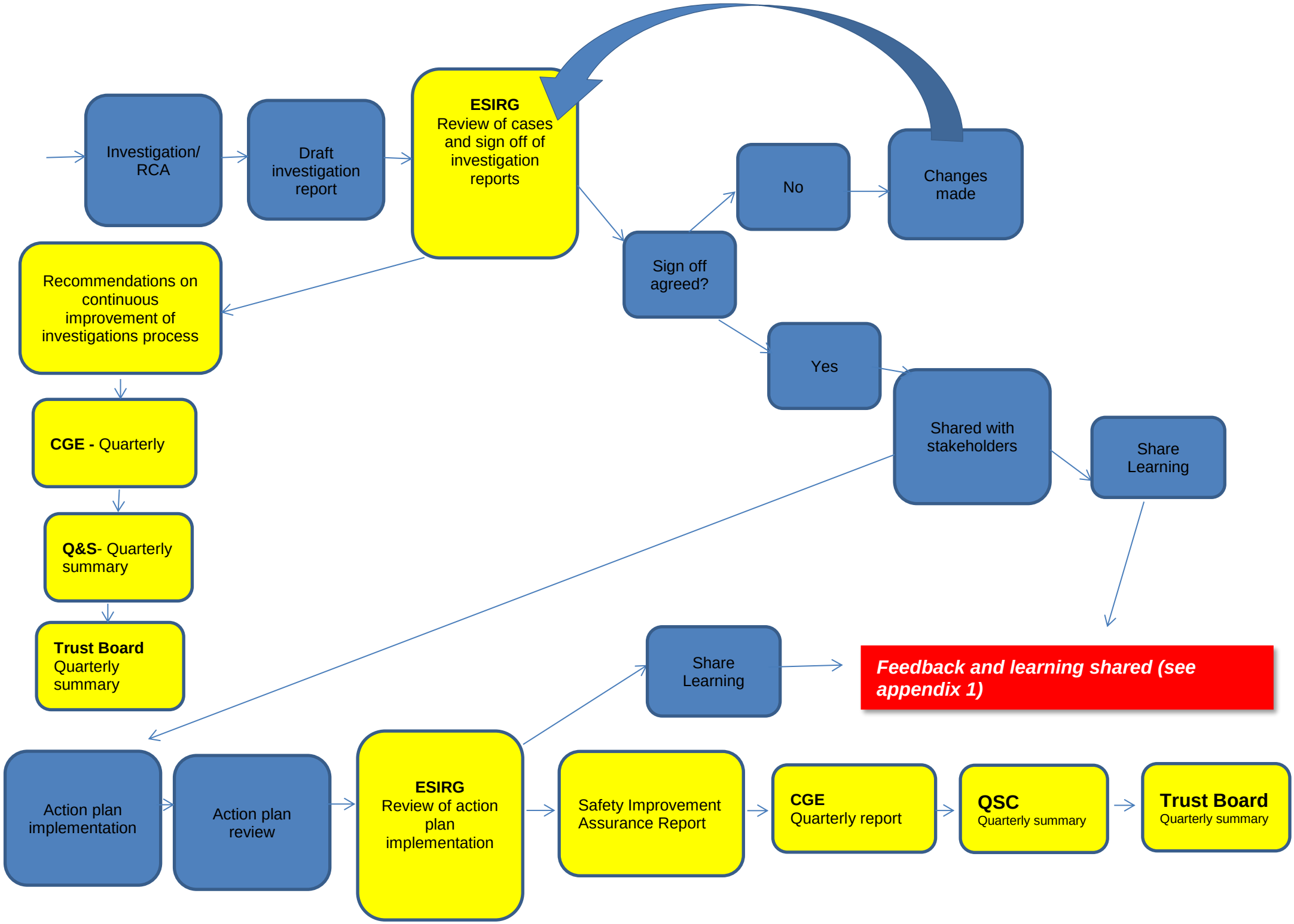
- Medical Records Committee
- Information Governance Committee
- SemaHelix User Group & Data Quality Meeting

Also IM&T have representation on the SSP Steering Group & externally at STP Digital Enabling Group (DEG). IG are also represented on the Digital Roadmap IG Group.

Appendix 3

High Level Overview Patient Safety Incident Process




Investigation/ RCA
Draft investigation report
ESIRG Review of cases and sign off of investigation reports
Sign off agreed?
No
Changes made
Yes
Shared with stakeholders
Share Learning
Recommendations on continuous improvement of investigations process
CGE - Quarterly
Q&S- Quarterly summary
Trust Board Quarterly summary
Share Learning
Feedback and learning shared (see appendix 1)
Action plan implementation
Action plan review
ESIRG Review of action plan implementation
Safety Improvement Assurance Report
CGE Quarterly report
QSC Quarterly summary
Trust Board Quarterly summary

Appendix 3: Framework for sharing feedback and learning from incidents