The Royal Wolverhampton
NHS Trust

How do we become even better?
3 December 2018

Agenda Item No: 7.6

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	3rd December 2018
Title:	How do we become even better?
Executive Summary:	This paper sets out the case for developing a Trust wide Continuous Quality Improvement Programme and the development of a team dedicated to supporting this programme. It also proposes changes to the way in which the Trust manages its CIP programme.
Action Requested:	The Trust Board are asked to receive and note the report
For the attention of the Board	
Assure	That the Trust is developing a systematic approach to quality improvement and strengthening our internal capability to deliver CIP
Advise	
Alert	
Author + Contact Details:	Mike Sharon, Director of Planning and Performance Tel 01902 695944 Email mikesharon@nhs.net
Links to Trust Strategic Objectives	Supports Trust Vision and all strategic objectives
Resource Implications:	Creates a cost pressure against budget but reduces current expenditure
CQC Domains	**Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	None
Risks: BAF/ TRR	Addresses SR8 SR9 SR12 and SR1
Risk: Appetite	
Public or Private:	Public
Other formal bodies involved:	None
References	None
NHS Constitution:	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details

DIRECTORATE CEO	PROJECT LEAD (ACCOUNTABLE OFFICER) Mike Sharon

BACKGROUND INFORMATION *(where are we now including drivers for change) - Information to help the reader unfamiliar with the service to understand the service and impact of the improvement)*

RWT has recently achieved a "Good" CQC rating. We have also delivered significant service improvement projects such as the Physician A model.

Many successful Trusts have embarked on quality improvement programmes. These programmes all rely on some level of a centralised approach both in terms of the methodology to be used, training and education of leaders and of programme management. In some cases Trusts have invested significant sums both in providing a central resource and in engaging external support.

This case argues that RWT should invest some more additional internal resource but does not argue for external support nor does it advocate a highly centralised model.

1 CASE FOR IMPROVEMENT *(where do we want to get to) - include quantitative data showing the performance gap and how the proposal fits with Trust Strategy)*

While we have recently achieved a "Good" CQC rating, the Executive team believe that we are unlikely to achieve consistently outstanding services without a more systematic approach, methodology and support for service improvement in all areas.

We have delivered significant service redesign and improvement and innovation but we believe we could go further faster if we better joined up and coordinated our efforts to support improvement using tried and tested methodologies.

The support of corporate departments to front line services is not always aligned to provide a comprehensive range of support to front line services. For example the service redesign team, governance, and education departments are not routinely asked to share knowledge of the organisation, approaches they are taking or ideas about how to solve problems.

Our financial position is more challenging in 18/19 than it was in previous years. We are unlikely to deliver the CIP target, nor a 2% recurrent CIP. Therefore it is assumed that CIP delivery also needs strengthening.

There is a service redesign team of six people whose focus is primarily on CIP and the Clinical Excellence programme. We have been unable to recruit a leader for this department and rely on external support, which is not sustainable.

Therefore there is a case to improve the way in which we meet our quality and CIP challenges. This change is set out below.

We will take a strategic approach to Continuous Quality Improvement based on the following elements

1. Our approach will be driven by the IHI Triple Aim http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx or something similar. Therefore we will always aim to deliver:

- Better care
- Improved health
- Greater efficiency

We will ensure that this approach to improving performance is linked to our values, to recruitment, appraisal and job planning

2. We will adopt a standardised approach to improvement, and train and educate our staff in its use. We will tailor the approach so that it is appropriate for the scale of projects

3. We recognise that improvement is everybody's business so we will better co-ordinate corporate functions and resources to support front line staff.

4. No one gets out of bed for a spreadsheet. We will minimise paperwork as much as possible

Proposals

To achieve our aims, a number of specific changes are proposed:

To set up a RWT CQI programme with the objective of supporting our staff to deliver consistently outstanding services.

Appoint a relatively small steering group at deputy director or just below level to steer the CQI programme. The purpose of this group is to provide a test bed for ideas and to ensure that key departments/services are fully engaged in the activities of CQI. As a first task the group will agree the service improvement methodologies to be adopted by the Trust.

This group should, as a minimum, include representatives of

- Medicine
- Nursing
- Operational teams
- Education
- HR
- Finance
- Information
- Governance

This group will also be key in aligning existing activities and resources across the Trust to support the programme. A mix of current and additional resources is likely to be required. Current resources should include:

- Some of the existing Service Redesign Team (see below)
- Education and training spend
- Governance spend on improvement projects such as Team Optimisation
- Support from finance, information and communication departments

The activities of the CQI programme will be reported via the Executive Director to TMC on a regular basis.

The Quality Improvement Team
The Service Redesign Team will be re-orientated to focus primarily on supporting the CQI programme. To allow this re-focus, a separate CIP team will be created. It is expected that existing team members will be a member of either team but not both.

The team will be the “improvement experts” for the organisation, trained to a high level with analytical and project management support. This team would directly run some large scale projects and would also provide training and advice to staff across the organisation who are running their own projects.

The team would continue to support the Clinical Excellence programme and could potentially also support other key programmes such as mortality improvement.

Efficiency gains can be expected as a result of quality improvement so the CQI team will work with finance colleagues to identify financial savings as a result of quality improvement projects.

The team will also support large scale service change eg West Park project, where the scale and/or complexity means it cannot be supported by Divisions.

The team is likely to remain with the Director of Strategic Planning and Performance

The CIP Team
This team will support the Trust’s CIP programme providing project management analytical support and reporting capability. It will initially be externally supported but a key objective will be to recruit to a lead for the team, which should be easier if the role is separated from quality improvement, and to resource it entirely from employed staff.

The Financial recovery Board will continue to steer the work of the CIP team but it is proposed to alter the way in which FRB operates to reduce the number of meetings for attendees other than Executive Directors. More detail is shown at Appendix 1.

It is suggested that this team is manged by the COO as the Director with most influence over organisation spend.

The Wider Organisation
Staff have provided feedback to say that they do not always know where to find help to translate improvement ideas into action. Support does currently exist from various sources but many staff are not aware of what is available.

The proposed approach, with effective communication and resources will provide a broader offer. A key task for the CQI programme will be to ensure the following:

- Leaders at all levels know that their job is to improve services
- Leaders believe they have permission to make improvements
- Leaders know where and how to look for help to make improvements

In addition, it is proposed that we train and educate a wider cohort of staff, including medical staff at ST and above levels, in the chosen improvement methodologies. Eventually our education and training approach should create:

- A core central team of up to 10 people trained to a senior level in improvement methodology
- Up to 30 improvement champions trained to an intermediate level
- All leaders above Band 6 having basic improvement methodology training

2 OPTIONS *(Brief description of alternative ways to achieve the improvement)*

Do nothing – means we are unlikely to be able to recruit to Deputy Director role and does not address how we create capacity for systematic improvement

Maintain a single CIP/CQI team – means we are unlikely to be able to recruit to Deputy Director role, CIP and CQI require slightly different approaches and it will remain difficult for a single team to provide sufficient focus and expertise in each area. A benefit of splitting the team is to locate CIP in operations while allowing a different director to support CQI. If both CIP and CQI is located under one director it is likely that less support can be given to each area.

Separate CIP and CQI teams - to support a greater clarity of focus for each team and to improve the ability to recruit leaders of those teams. This is the preferred option.

BENEFITS OF PREFERRED OPTION *(What will this do for Performance (targets, payment, costs), Commissioners (GP, PCTs), Patients (quality, time, perception, environment – including impact on space utilisation), Process (productivity, legal, innovation) and Staff (release potential, involvement, learning & development, environment) i.e. quantifiable measures so that we will know when the benefits have been delivered)*

Benefit	*Measure and approach*	*Date benefit will be realised*
Ability to appoint to leadership roles for both CQI and CIP	*Appointments made*	*April 2019*
Increased delivery of CIP	*Improvement over 2018/19 delivery*	*From April 2019*
Effective implementation of GIRFT recommendations	*Reporting system to be developed*	*From April 2019*
An agreed approach and support package that leaders can use to deliver the improvements that are important to them	*Approach agreed and support package in place*	*September 2019*
Improved staff morale	*Relevant staff survey questions*	*2020 staff survey*
Improved SHMI/HSMR indicators	*Published SHMI/HSMR*	*From mid 2019*
Reduced number of Serious incidents and never events	*Number of NEs and SIs*	*Late 2019*
Ability to reduce and then eliminate external support expenditure	*Spend on external support*	*Fully achieved by September 2019*

RESOURCE IMPACT *(Staffing, time, costs -capital and revenue, source of funding)*
Financial proforma

The following tables set out a starting point for discussion about the **minimum staffing** resources needed to commence function of the two teams. It does not address the issue of which team existing staff may prefer to work in and it is likely that, as both programmes gain further momentum additional resources will be required.

CIP Team

Role title	Hours	Role description	Probable Banding
Head of Service Efficiency and Delivery	Full time	Lead team, provide expertise, manage priorities and relationships across all departments	8d
Programme partner x3	Full time	One programme manager per division plus support for corporate teams to manage programmes, identify ideas, support front line managers to implement change	8a
Programme partner development role/Programme support manager	Full time	Set up and maintain reporting processes, directly support corporate programmes and provide administrative support	6/7
Information support	N/A	Assume no specific role within the team but clear expectation of what support information dept will provide	N/A
Financial support	N/A	Assume no specific role within the team but clear expectation of what support finance dept will provide	N/A
TOTAL WTE	5		

CQI Team

Role title	Hours	Role description	Probable Banding
Managerial lead (already funded)	Part time	Lead team, provide expertise, manage priorities and relationships across all departments	8D or above
Clinical Lead/Associate Medical Director	Part time (assume 0.5 WTE)	Provide clinical and redesign expertise and leadership for the team and the wider organisation	TBC
Programme partner x3	Full time	Programme partners leading on a Division each plus support for corporate functions, clinical excellence programme and mortality programme.	8a
Senior Programme partner	Full time	Undertake major service planning projects such as West Park, Cancer Centre	8c
Programme administrator	Full time	Set up and maintain reporting processes, provide programme support	5/6
Information support x 1.9	Full time Plus part time	Provide analysis to support problem solving, Support the identification and mapping of pathways and analysis of clinical variation. Posts may be located within Information department.	8a and 6

Financial support		Assume no specific role within the team but clear expectation of what support finance dept will provide	N/A
TOTAL WTE	7.5 (assuming managerial and clinical leads are half time)		

In addition to these posts it is expected that existing roles in other departments will be aligned to support the CQI programme. For example:

- The Team Optimisation approach run within Governance should be guided by CQI programme priorities
- The current Chief Registrar postholder has been training junior doctors in improvement methodology. The future role of the Chief Registrar should be formalised to include an element of supporting the CQI programme

The service redesign budget currently supports:

- Band 8D
- Band 8C
- Band 8A x4 (one of which is devoted to pathology which will continue for 18 months)
- Band 6

Excluding the managerial and clinical leads for CQI the minimum requirement is to fund an additional 4.5 posts. It is assumed that the current analytical support for mortality would be incorporated into the team
Significant changes to non-pay expenditure, such as for training staff in improvement methodology has not yet been costed because the extent to which current spend can be utilised has not yet been examined.

The financial proforma shows that an increase in investment is required. However, this does not take into account the fact that the Trust has spent significantly more than the additional expenditure in each of the last two years on external support. If this case is approved, that external spend will cease.

RISKS AND DEPENDENCIES *(Partners, other projects in progress, availability of resource/people, Service Improvement capability within team, contingency plans & mechanism to stop the improvement if benefits cannot be delivered i.e. exit strategy, Risk Register implications)*

Risk	***Grade (R,A,G)***
Inability to recruit to teams	*A*
Central teams do not engage effectively with front line staff	*A*

PUBLIC CONSULTATION – *(determine which level of consultation, if any, is appropriate)*

None required

EQUALITY IMPACT ASSESSMENT

No differential impact identified on any protected characteristics groups

HIGH LEVEL IMPLEMENTATION PLAN

Key Actions	Person responsible	Timescale
Recruit to team	Mike Sharon	November 2018
Agree steering group membership	Mike Sharon	December 2018
Appoint leads	Mike Sharon	December 2018

SUBMITTED BY:

Clinical Director .....Mike Sharon..... *(Name)* ..... *(Sign)* 9/11/18 *(Date)*

Matron ..... *(Name)* ..... *(Sign)* .....
(Date)

Dir. Mgr ..... *(Name)* ..... *(Sign)* .....
(Date)

APPROVED BY:

Divisional Director ..... *(Name)* ..... *(Sign)* .....
(Date)

Divisional Manager ..... *(Name)* ..... *(Sign)* .....
(Date)

Divisional Accountant CHRISTIAN JONES *(Name)* ..... *(Sign)* 20/11/18 *(Date)*

Head of Nursing ..... *(Name)* ..... *(Sign)* ..... *(Date)*

FOR CAPITAL INVESTMENT ONLY

Head of Estates Development (On behalf of Capital Review Group)

..... *(Name)* ..... *(Sign)* ..... *(Date)*

Appendix 1

Financial Recovery Board – revisions to meetings schedule

Financial Recovery Board to meet twice per month

- The first meeting of each month will:
  - focus on delivering the 2018/19 CIP plan
  - receive the financial outturns from the previous month in the form of a CIP Performance Report
  - identify and appoint Executive Leads for any recovery areas
  - review and challenge progress made to deliver all recovery areas
  - Continue to be Chaired by the Chief Executive and attended by all Trust Executives (but not their Deputies)
  - Take place for one hour prior to Weekly Executive Directors on the second or third Wednesday of each month (depending on the date of financial outturns)
  - Produce a formal report for Finance and Performance Committee, Trust Management Committee, Trust Board, and NHSI

- The second meeting of each month will:
  - focus on developing the 2019/20 CIP plan
  - receive the progress reports from the outputs of the Service Redesign Engagement Events, as follows
    - § Division 1 and Theatres – Deputy Chief Operating Officer (Division 1)
    - § Division 2 and Outpatients – Deputy Chief Operating Officer (Division 2)
    - § Division 3 and Patient Flow – Deputy Chief Operating Officer (Division 3)
    - § Workforce – Medical Director, Chief Nurse, and HR Director
    - § Estates and Facilities – Head of Estates and Facilities
    - § Corporate Functions – Director of Finance
  - review and challenge progress made to develop credible CIP plans for 2019/20 in each the areas listed
  - Continue to be Chaired by the Chief Executive and attended by all Trust Executives and their Deputies (Division 1, 2, 3, and Estates)
  - Take place for one hour prior to Weekly Executive Directors on the final Wednesday of each month
  - Produce a consolidated progress report for all Executives at the end of each month

Business Case: How Do we Become even better

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Version: 1 Ref: 02057

CAPITAL COST:-	Capital £ Year 1	Life Years	Capital £ Year 2	Life Years	Capital £ Total
TOTAL CAPITAL	*0*		*0*		*0*

ACTIVITY & OTHER INCOME:-	Activity Year 1	Activity Year 2 FYE	Tariff Year 1	Tariff Year 2 FYE	Income Year 1 Assume April 2019	Income Year 2 Recurring
Description			£	£	£	£
					0	0
TOTAL INCOME					0	0

REVENUE COST:-

Note: All entered as minus values (-£)

Pay Costs Description	Department	Date wef	Pay Band	PAs/ Other	Cost per WTE £	WTE	Spend Year 1 2019/20 £	Spend Year 2 Recurring £
Pay - Direct Clinical								0
						0.00	0	0
Pay - Clinical Support								
CIP Team								
Head Of CIP		01/04/2019	8D		(88,828)	1.00	(88,828)	(88,828)
Programme Partner		01/04/2019	8A		(53,204)	3.00	(159,612)	(159,612)
Programme Partner Development Rol		01/04/2019	7		(41,421)	1.00	(41,421)	(41,421)
CQI Team								
Managerial Lead		01/04/2019	8D		(88,828)	0.50	(44,414)	(44,414)
Clinical Lead		01/04/2019	Consultant		(98,706)	0.60	(59,224)	(59,224)
Programme Partner		01/04/2019	8A		(53,204)	3.00	(159,612)	(159,612)
Senior Programme Partner		01/04/2019	8C		(74,579)	1.00	(74,579)	(74,579)
Programme Administrator		01/04/2019	6		(28,349)	1.00	(28,349)	(28,349)
Information Support		01/04/2019	6		(34,792)	1.00	(34,792)	(34,792)
Information Support		01/04/2019	8A		(60,105)	0.91	(54,696)	(54,696)
Current Budget						(8.41)	536,727	510,125
						4.60	(208,800)	(235,402)
Total Pay Costs						4.60	(208,800)	(235,402)
Non Pay Costs								
Non Pay - Direct Clinical								
						0	0	0
Non Pay - Clinical Support								
CIP Team								
Training							(5,000)	(5,000)
Printing & Stationary							(184)	(184)
Computer Hware/Sware							0	0
							(2,500)	0
CQI Team								
Training							0	0
Printing & Stationary							(184)	(184)
Computer Hware/Sware							(2,500)	0
Current Budget							184	184
						0	(10,184)	(5,184)
Total Non Pay Costs						0	(10,184)	(5,184)
TOTAL CLINICAL AND CLINICAL SUPPORT COSTS						5	(218,984)	(240,586)

TOTAL CONTRIBUTION TO TRUST OVERHEADS	(218,984)	(240,586)
AS PERCENTAGE (Should be 20% or above)	N/A	N/A

OVERHEAD COSTS:-		
TOTAL OVERHEAD COSTS	0	0
TOTAL EBITDA	(218,984)	(240,586)
MARGIN AS PERCENTAGE (Should be 10% or above)	N/A	N/A
CAPITAL CHARGES:-		
Note: All entered as minus values (-£)		
Depreciation	0	0
Rate of Return	0	0
TOTAL COST OF CAPITAL	0	0
NET SURPLUS	(218,984)	(240,586)
MARGIN AS PERCENTAGE (Should be 3% or above)	N/A	N/A

Divisional Accountant

Name:

Date: 13/11/18

Divisional Manager / Director

Name:

Date: 13/11/18