



Quality Strategy

2017 - 2020

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*Our vision **to be the best** - delivering and leading outstanding heart and chest care and research.*

Context of the Strategy

This Quality Governance Strategy is a refreshed version of the Quality and Safety Strategy 2014. This combined overarching Strategy outlines the plans for our continued development of Quality and Governance at Liverpool Heart and Chest Hospital (LHCH) Foundation Trust.

Our approach to ensuring a quality improvement model, built around patient and family centred care, means we are clear on the measurable outcomes we expect, in ensuring we continue to improve our current rating of Outstanding by the CQC (2016).

The delivery of our quality objectives is through our leadership structures; strengthening accountability through Triumvirate working. Our mission is to deliver excellent compassionate and safe care, for every patient, every day.

We have made significant improvements to quality since our first Strategy was published in 2014, with engagement from staff to make changes in organisational culture. Our front line staff have been involved in Listening into action groups focusing on quality improvements that have been generated by them. Alongside this we have focused on developing a culture of being open, honest and transparent with our patients and their families. Quality of care is at the heart of everything we do. This is supported by a welcoming, honest and compassionate approach to our delivery of health care. We will continue to engage with our patients and families in order to improve our services whilst learning from incidents and errors. We will strive to deliver excellent healthcare, whilst supporting our staff to speak out safely, to reduce avoidable harm.

The core elements to this Strategy are:

- Patient safety
- Patient and family experience
- Clinical Outcomes and effectiveness
- Regulation compliance and assurance

This document is closely aligned to our Trust Quality accounts, quality priorities and the Care Quality Commission domains - safe, effective, caring, responsive, and well led.

Our approach to quality supports our overall vision 'To be the Best' with patient outcomes reflective of the best care. This Quality Strategy brings the core elements together in one refreshed comprehensive document.



Jane Tomkinson
Chief Executive



Defining Quality and Governance

Liverpool Heart and Chest Hospital (LHCH) NHS Foundation Trust strives to deliver a model of care that is underpinned by safety, quality and value for money, with the patient and their family truly at the heart of everything we do.

Our approach to care recognises patients deserve their individual care needs assessed and met by a highly skilled workforce. This approach encourages families and carers to be part of care giving, thus also working jointly with healthcare teams to deliver a truly excellent hospital experience that they would wish for others.

Our model of Patient and Family Centred Care
- ensuring quality and safety

Liverpool Heart and Chest Hospital **NHS**
NHS Foundation Trust

Reputation

"I would recommend this hospital to family and friends."



Arrival

"My family and I were expected at the hospital and felt welcomed by all."



Contract of Care

"My family and I were involved in planning my care."



Stay

"Compassionate, safe and personalised care was delivered with dignity and respect."



Treatment

"I felt safe because all staff communicated well and displayed the skills to deliver excellent care."



After Stay

"My family and I felt supported on discharge and received ongoing support."



Excellent, Compassionate and Safe care for **every patient**, every day

www.lhch.nhs.uk

What we are trying to achieve?

Our ambition is to create a culture of continuous improvement and empowerment that is both patient centred and safety focused. We will continue to:

- **Listen** to patients, their families and staff
- **Work** with our stakeholders, listening to their views
- **Develop** our values and behavior by involvement of all staff
- **Focus** on human factors – how we deliver care within our teams

Quality Governance is defined as encompassing three equally important elements:

Care that is safe



*...by reducing
mortality and
harm*

Care that is clinically effective



*...by providing
reliable care and
reducing variation*

Care that provides a positive experience for patients, families and care providers

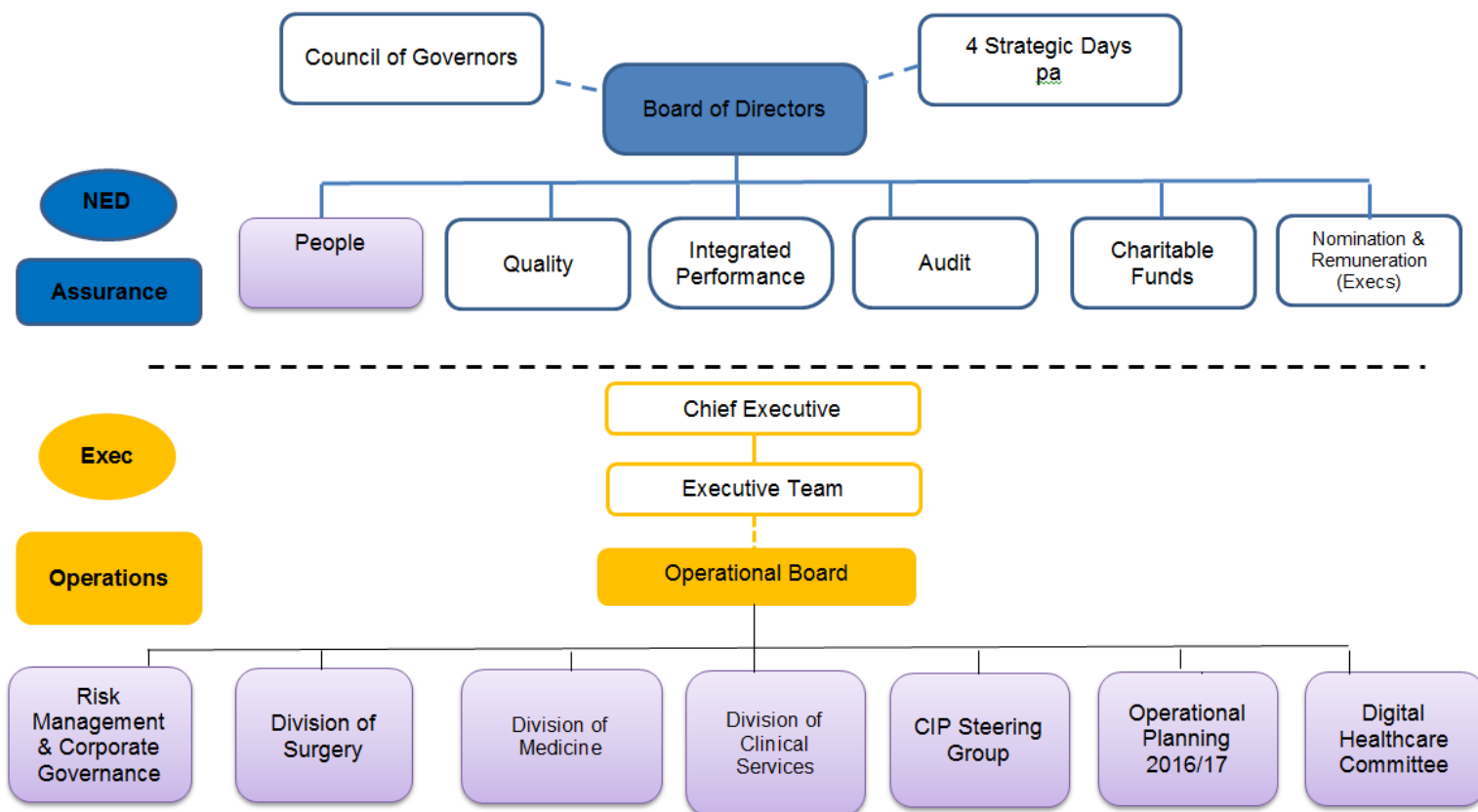


*...by improving
patient and staff
experience*

Quality Governance Committee Structure

Quality Governance is the combination of structures and processes at and below Trust Board level.

At LHCH these include:



Our Safety Strategy

The foundation of our Quality Governance Strategy is based on continuous improvement actions, which are intrinsically linked to our longer term corporate vision ***to be the best - delivering and leading outstanding heart and chest care and research.***

Our principles for safety

- Promotion of our hospital values and behaviors
- Triumvirate quality streams within and across the divisions
- Triumvirate accountability for quality and continuous improvement
- Divisional responsibility for clinical effective care
- The use of analysis and quality data to drive improvements and divisional performance

What we want to achieve

- Continue to promote a culture of safe care with reduction of clinical errors and adverse events
- Improvements of the patient and family experience with excellent outcomes with a focus on reduction of variation with measurable improvements in quality of care
- Have an open and honest hospital where safety is at the centre of care and where HALT becomes the vehicle for staff to prevent harm occurring for patients and/or staff
- Safe evidenced and effective care that adheres to best practice
- Listen to patient and family feedback, put in place measurable quality actions for improvements required
- Triumvirate leadership within the divisions with focus on development of clinical and non-clinical teams. Having the right skill and staff in the right place and at the right time for patients
- Adapt to the changes in healthcare needs – encompassing seven day working



Our PACT

- We will constantly provide the best possible standards of compassionate care.
- We will develop a behavioral standard framework created by our staff that gives a clear picture of expectations aligned to our performance process within My PACT.

A Trust's culture is driven by the values and behaviours of its people. Staff at LHCH have identified the values and behaviours that are essential to delivering our vision and these are summarised in our PACT .



Human Factors

During 2014/15 we began to explore the role of human factors in safety. Using human factors to understand and improve how we behave and interact with others in the environment we work. Leading by example will help us to continually improve for the benefit of our patients, their families and our staff, making our Trust as safe as can be.

The Trust is committed to:

- developing awareness
- developing knowledge
- developing expertise.

We have agreed the training for six human factor apprentices. This group will support the development of Trust expectations for all staff to take responsibility for their own personal behaviour, to work effectively with others, and to challenge and speak up, where they feel things are not right which could lead to a patient or staff safety incident occurring. The apprentice roles will support root cause analysis for serious incidents and support the development of Schwartz rounds (identification of team decision making issues, feelings and targeted support to make improvements).

Other areas where human factors have been adopted are the Trust-wide safety huddle: from November 2014 we implemented a daily safety huddle across the Trust, led by the Chief Executive. All clinical areas and support teams are encouraged to attend to discuss any potential safety incidents that may occur or incidents that have occurred, thus sharing opportunity for learning and improvement.



Safety Seven

Safe care for our patients and staff is driven by proactive staff engagement in preventing possible harm through many mechanisms of communication and action.

This safety seven wheel describes the initiatives our staff use to communicate within their teams or through the many safety forums to inform and share learning in regard to patient and staff safety.



Achievements 2015/16

Our inpatient survey results confirmed LHCH as top in the country for the eighth time out of the previous ten years with outstanding results for:

- waiting to get a bed on a ward
- the hospital and ward
- doctors
- nurses
- care and treatment
- overall experience.

We will continue to improve our services based on what our patients are saying about the care they have received. LHCH is committed to ensuring safe, compassionate, quality driven care for every patient every day.

- **Improvements of electronic patient records** following a successful bid to the Nurse Technology Fund. This provided frontline staff with the ability to have patients' clinical observations recorded and placed directly into their record. Benefits to further improve the system will continue in to 2016-2018, with electronic MEWS alerting to medical and outreach staff from the electronic patient record, thus providing a seamless emergency response when MEWS has been triggered.
- **Implementation of Datix** – the Trust moved to a bespoke incident reporting system developed with all professional groups.
- **Care Partner inclusion** in all planned care for our patients - families and carers given the opportunity, and encouraged to work alongside healthcare professionals in the delivery of patient care.
- **Patient flow** – investment in creating a discharge lounge where patients could wait in a comfortable environment, whilst waiting for all their discharge information to be completed.
- Second phase of our **Excellent Compassionate Safe reviews** on all ward areas resulted in all ward/department areas achieving a green status – certificate notices of their achievements displayed outside each ward/department area for patients and families to see.

Training for Quality Improvement at LHCH 2017-20

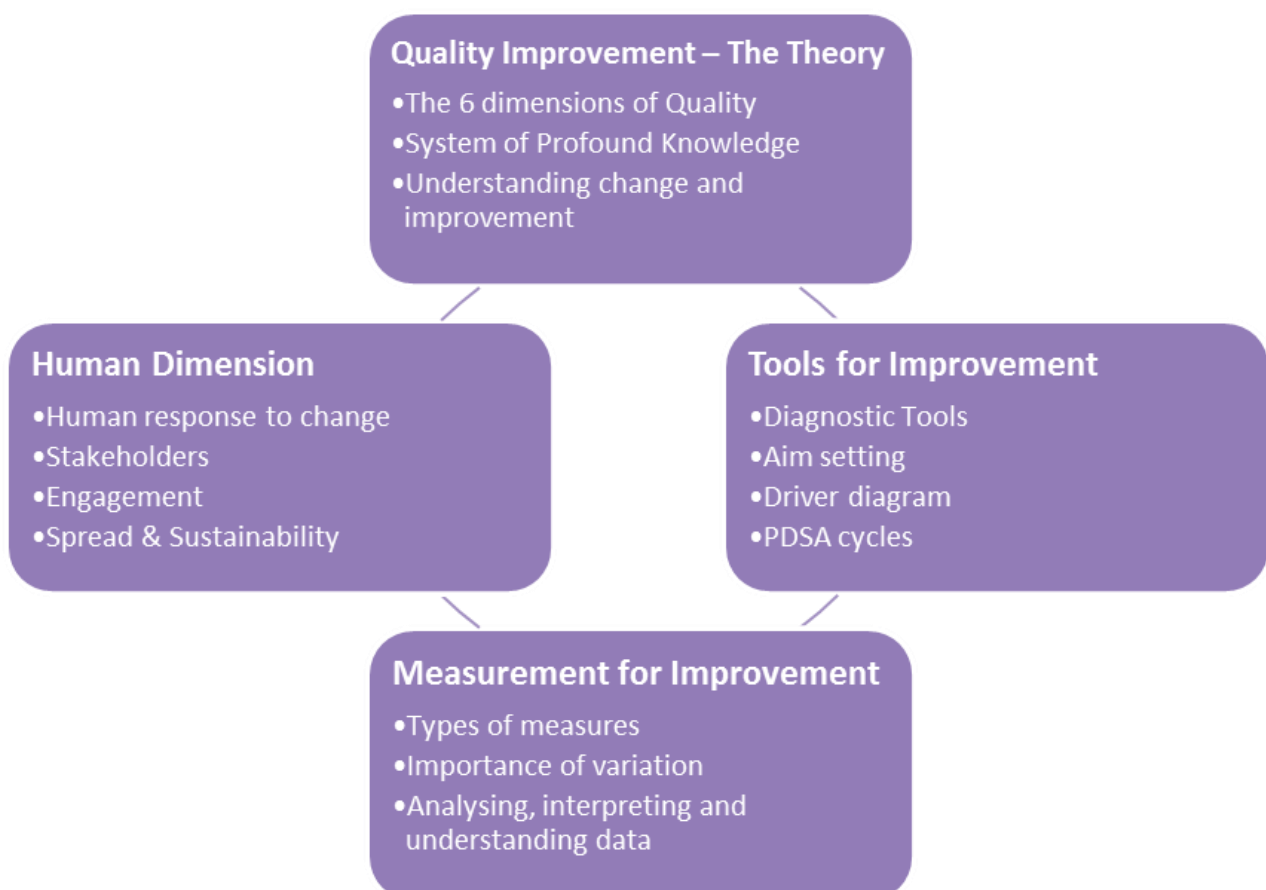
Through our collaboration with AQuA we are developing a programme of Quality Improvement training to help us embed a culture of quality and service improvement.

We are aiming at skilling our workforce to lead on quality projects to further enhance the excellent care we provide for our patients and their families at LHCH.

We will be providing different levels of training:

1. Quality Improvement (QI) Basics Programme

A teaching and facilitation resource designed to provide individuals with a single day introduction and exploration of Quality Improvements key themes and terminology, to enable to gain a conceptual understanding of QI basics and how they can develop and implement this in practice.



Target: all staff.

2. Introduction to Improvement

An LHCH hosted three-day Introduction to Improvement programme which will provide delegates with an entry point into quality improvement – introducing the core concepts and supporting delegates to apply these to an actual improvement project.

The programme will give attendees a greater understanding of how to:

- lead and implement improvement initiatives
- engage and motivate teams
- keep pace and momentum
- measure for improvement
- share results and learning
- spread and sustain results.



Target: geared at front line staff / operational leaders wanting to gain an introduction to the fundamentals and concepts of quality improvement methodologies.

3. Improvement Practitioner

Intermediate QI skills development course aimed at individuals wishing to develop from existing basic QI knowledge and skills. Standalone day sessions which can be linked to achieve an Improvement Practitioner Certificate (3 core + 1 optional module):

- Measurement (core)
- Culture for improvement (core)
- Spread and sustainability (core)
- Coaching for leaders (optional)
- Managing change and QI (optional)
- Resilience (optional)
- Human factors (optional)
- All share, all learn event (optional)

Target: we have 5 places for off-site training sessions. To be identified by Head of Nursing HoN / Divisional Head of Operation DHoO.

4. Advanced Improvement Practitioner

Advanced QI skills development course. 12 days spread over 8 months. This multi-day development programme aims to develop a deep understanding of improvement to lead change at an organisation and system level.

Target: 2 places. There is a competitive application process requiring completion of organisational sponsor and utilisation of gained skills.

Quality Teams

There have been a number of improvements made to strengthen Divisional leadership to provide support and challenge to the operational management teams.

Clear roles of responsibility and accountability are reflected in the triumvirate teams leading clinical teams. Through the review of governance structures, there has also been a reduction in the number of committees and attendance required.

Each division will identify 5 key individuals within their respective areas to lead the division as quality improvement champions and ensure that they receive the education and training required during 2017 to support them in this role. The divisions have reviewed their quality priorities for the forthcoming year and many of these are reflected in the Trust objectives. In addition, there are other key quality improvements that the divisions have set as priorities for 2017/2020 that are pertinent to their own division (see appendices).

Corporate departments will also identify a quality improvement lead who will work together to lead departmental quality priorities and contribute to the development and achievement of Trust-wide quality improvements. Each division is required to have a divisional governance structure and have regular meetings to discuss and oversee all governance issues within their division. The divisions are required to submit an annual report to Operational Board as assurance of progress made to the delivery of their quality governance priorities, as detailed on page 15-16.

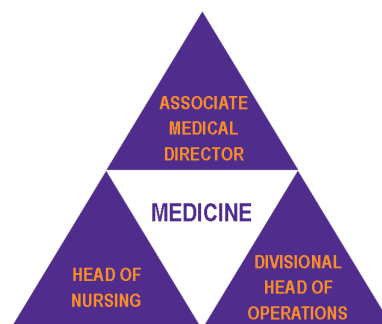
This will support the Trust's objective of integrated governance from ward to Board.



Dr Raphael Perry
Medical Director



Sue Pemberton
Director of Nursing
& Quality



Appendix 1

Quality Targets 2017-20

SAFE

Continuously seek out and reduce patient harm

- Increasing incident reporting by 20% by 2020
- Reduce the incidence of falls by 20% across our three surgical wards
- Continue to maintain our low incidence of infections - C.Diff and MRSA bacteraemia
- Communicate our systems for staff to report any concerns relating to patient or staff safety, such as Speak Out Safely, daily safety huddles, Freedom to Speak Up Guardian roles, using our HALT process.
- Achieve 80% compliance with mortality reviews being carried out within 30 days of a patient death
- Implement the Trust's Human Factors strategy
- End of life care - to implement the actions identified in our CQC improvements action plan

EFFECTIVE

Deliver the highest rate of reliable care

- Achieve 90% compliance with the sepsis bundle within one hour - by systematic screening for sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review
- Antimicrobial resistance - aim to reduce antibiotic consumption by encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours
- Continue to maintain our low incidence of pressure ulcers by implementing the pressure ulcer prevention bundle
- Acute Kidney Injury - scope the improvements required during 2017 and set targets for improvement
- Ensure safe staffing levels by reviewing all of our nurse staffing establishments utilising the methodology for care hours per patient day and the care team approach to delivery to ensure safe staffing
- Structured medical ward rounds with transparency on times for patients and families providing opportunities for families to be present
- National clinical audits - participate in all audits applicable to the Trust

CARING

Ensure that all care delivered is patient and family centred

- Achieve 95% or above in our friends and family recommending the Trust
- Ensure all our patients are offered the opportunity to have a care partner
- Bedside handovers across all wards
- Ensure all families are aware of times of medical ward rounds in order that they have an opportunity to attend and feel involved
- 80% of all appropriate inpatients will be assessed for frailty
- Reduce clinical care complaints by 20% by 2020
- All staff members to carry out one shadow each year and feedback the learning to be built into personal development plans

Appendix 1

Quality Targets 2017-20

RESPONSIVE

To ensure that patients are discharged as planned and improve patient satisfaction with the discharge experience

- To ensure that patients have a planned date of discharge on admission to hospital - achieve 80% compliance
- Increase the use of the discharge lounge
- Meet the four priority standards for seven day services

WELL-LED

To provide demonstrable changes in practice or care from the learnings shared from complaints / incidents / claims / serious incidents and progress towards implementation of our organisational learning policy

- Quarterly learning and sharing forum
- Key actions and learning to be shared Trust-wide via organisation learning bulletin
- 6-monthly presentation of learnings from Team Brief
- Demonstrable changes in practice as a result of the learnings

How will we Measure Progress?

Progress against the quality improvement targets will be measured through the Trust's governance systems. The Clinical Quality and Patient and Family Experience Committee will be responsible for monitoring progress against the set quality improvements and will provide assurance to the Quality Assurance Committee and the Board of Directors on progress.

Progress against the improvements will also be presented to the Council of Governors.

The Trust's Operational Board will monitor exceptions to achievement of the quality improvements and the divisional teams will manage these exceptions and address them to ensure that the quality, safety and experience of patients is not compromised.

The delivery of high quality, safe care along with an exceptional patient and family experience lies at the heart of Liverpool Heart and Chest Hospital.

This quality improvement strategy confirms our commitment to ensure this is achieved.



Appendix 2

Key Quality Improvements **Surgery** 2017

Safe	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Reduce the incidence of falls by 20%	Focus for reduction Oak ward Cedar Ward Elm Ward	Matron for Surgery HoN	December 2017		
Increase incident reporting by 20%	Focus of improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	Matron for Surgery Matron for Theatres AMD	December 2017		
100% compliance with WHO Checklist	Focus of improvements Theatre	Matron for Theatre	December 2017		
Development of SOPs for Loccsips	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	Matron for Surgery Matron for Theatres AMD	September 2017		
80% compliance with MRG reviews medical and nursing to be completed within 30 days of allocation	Focus for improvements Medical staff Nursing staff	AMD for Surgery HoN for Surgery	December 2017		
Decrease missed medication errors by 20%	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery Matron for Theatres AMD	December 2017		

Appendix 2

Key Quality Improvements **Surgery** 2017

Effective	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 80% compliance with sepsis bundle – 1 st antibiotic given within 1hr to appropriate identified patient	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	Matron for Surgery Matron for Theatres AMD	December 2017		
72 hour antibiotic review to reduce antibiotic consumption	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	AMD Surgery	December 2017		
Safe Nurse staffing – utilising care hours per patient per day	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery Matron for Theatres	September 2017		
Structured medical ward rounds giving families the opportunity to be present	Focus for improvements Oak Ward Elm Ward Cedar Ward Mulberry Ward	AMD	December 2017		

Appendix 2

Key Quality Improvements **Surgery** 2017

Caring	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 90% in our friends and family recommending the Trust	Focus for improvements Oak Ward Elm Ward Cedar Ward Mulberry Ward	HoN Surgery Matron for Surgery	December 2017		
90% of all cares and families have the opportunity to be a care partner	Focus for improvements Oak Ward Elm Ward Cedar Ward Mulberry Ward	HoN Surgery Matron for Surgery	December 2017		
All inpatients to receive a nursing bedside handover of their care needs	Focus for improvements Oak Ward Elm Ward Cedar Ward Mulberry Ward	HoN Surgery Matron for Surgery	December 2017		
80% of all those inpatients needing a frailty assessment will receive an assessment of their care needs	Focus for improvements Oak Ward Elm Ward Cedar Ward Mulberry Ward	HoN Surgery Matron for Surgery	December 2017		
Reduction of clinical care complaints by 5% in 2017	Focus for improvements Oak Ward Elm Ward Cedar Ward	HoN Surgery Matron for Surgery AMD Surgery	December 2017		
80% of all staff to have undertaken a patient shadow	Focus for improvements Theatre Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery AMD Surgery	December 2017		

Appendix 2

Key Quality Improvements **Surgery** 2017

Responsive	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
80% of all inpatients have recorded a planned date of discharge	Focus for improvements Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery AMD Surgery	December 2017		
Development of systems required to ensure patients are discharged by 12 midday on the day of discharge	Focus for improvements Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery AMD Surgery	December 2017		
Increase utilisation of the discharge lounge to 20%	Focus for improvements Oak Ward Cedar Ward Elm Ward Mulberry Ward	HoN Surgery Matron for Surgery AMD Surgery	December 2017		
Develop systems to meet the four priority standards for seven day services	Focus for improvements Surgery Division	DHoO Surgery AMD Surgery HoN Surgery	December 2017		

Appendix 2

Key Quality Improvements **Surgery** 2017

Well Led	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Development of learning and sharing structures within Surgery Division	Focus for improvements – Surgery Division	DHoO Surgery AMD Surgery HoN Surgery	June 2017		
Once a year presentation of learning examples at team brief	Focus for improvements – Surgery Division	DHoO Surgery AMD Surgery HoN Surgery Matron Surgery	To be scheduled		

Appendix 3

Key Quality Improvements **Medicine** 2017

Safe	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Reduce the incidence of falls by 20%	Focus for reduction Birch Ward	Matron for Medicine HoN	December 2017		
Increase incident reporting by 20%	Focus of improvements Cath Lab Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	Matron for Medicine Matron for Cath Labs AMD	December 2017		
100% compliance with WHO Checklist	Focus of improvements Cath Labs	Matron for Cath Labs	December 2017		
Development of SOPs for Loccsips	Focus of improvements Cath Lab Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	HoN Medicine Matron for Medicine Matron for Cath Labs AMD Medicine	September 2017		
80% compliance with MRG reviews medical and nursing to be completed within 30 days of allocation	Focus for improvements Medical staff Nursing staff	AMD for Medicine HoN for Medicine	December 2017		
Decrease missed medication errors by 20%	Focus of improvements Cath Lab Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	HoN Medicine Matron for Medicine Matron for Cath Labs AMD Medicine	December 2017		

Appendix 3

Key Quality Improvements **Medicine** 2017

Effective	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 80% compliance with sepsis bundle – 1 st antibiotic given within 1hr to appropriate identified patient	Focus of improvements Cath Lab Birch Ward Maple Suite Cherry Ward Coronary Care Unit	Matron for Medicine Matron for Cath Labs AMD	December 2017		
72 hour antibiotic review to reduce antibiotic consumption	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	AMD Medicine	December 2017		
Safe Nurse staffing – utilising care hours per patient per day	Focus of improvements Cath Lab Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	HoN Medicine Matron for Medicine Matron for Cath Labs	September 2017		
Structured medical ward rounds giving families the opportunity to be present	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	AMD	December 2017		

Appendix 3

Key Quality Improvements **Medicine** 2017

Caring	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 90% in our friends and family recommending the Trust	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	HoN Medicine Matron for Medicine	December 2017		
90% of all cares and families have the opportunity to be a care partner	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite	HoN Medicine Matron for Medicine	December 2017		
All inpatients to receive a nursing bedside handover of their care needs	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	HoN Medicine Matron for Medicine	December 2017		
80% of all those inpatients needing a frailty assessment will receive an assessment of their care needs	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	HoN Medicine Matron for Medicine	December 2017		
Reduction of clinical care complaints by 5% in 2017	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	HoN Medicine Matron for Medicine AMD Medicine	December 2017		
Development of systems so that all patient's next of kin receive a telephone call within 2 weeks of an inpatient bereavement	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite Cath Labs	HoN Medicine Matron for Medicine Matron for Cath Labs AMD Medicine	December 2017		
80% of all staff to have undertaken a patient shadow	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit Holly Suite Cath Labs	HoN Medicine Matron for Medicine Matron for Cath Labs AMD Medicine	December 2017		

Appendix 3

Key Quality Improvements **Medicine** 2017

Responsive	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
80% of all inpatients have a planned date of discharge recorded	Focus for improvements Birch Ward Maple Suite Cherry Ward Coronary Care Unit	HoN Medicine Matron for Medicine AMD Medicine	December 2017		
Development of systems required to ensure patients are discharged by 12midday on the day of discharge	Focus for improvements Birch Ward Maple Suite Cherry Ward	HoN Medicine Matron for Medicine AMD Medicine	December 2017		
Increase utilisation of the discharge lounge to 20%	Focus for improvements Birch Ward Maple Suite Cherry Ward Holly Suite	HoN Surgery Matron for Surgery AMD Surgery	December 2017		
Develop systems to meet the four priority standards for seven day services	Focus for improvements – Medicine Division	DHoO Medicine AMD Medicine HoN Medicine	December 2017		

Appendix 3

Key Quality Improvements **Medicine** 2017

Responsive	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Development of learning and sharing structures within Medicine Division	Focus for improvements – Medicine Division	DHoO Medicine AMD Medicine HoN Medicine	June 2017		
Once a year presentation of learning examples at team brief	Focus for improvements – Medicine Division	DHoO Medicine AMD Medicine HoN Medicine Matron Medicine	To be scheduled		

Appendix 4

Key Quality Improvements **Clinical Services** 2017

Safe	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Safe staffing across service lines	Focus areas: Critical Care Intensivist cover - Critical Care OPD CNP service Radiology Co-Ordinators Therapies	DHoO AMD HoN Head of Therapies	December 2017		
Increase Incident reporting by 20%	Focus of improvements Critical Care OPD CNP service Radiology Co-Ordinators Therapies	Matron for Clinical Services AMD HoN Head of Therapies	December 2017		
100% compliance with WHO Checklist	Focus of improvements Radiology	Matron for Clinical Services HoN	December 2017		
Development of SOPs for Locssips	Focus for improvements Critical Care OPD Radiology Co-Ordinators Therapies	Matron for Clinical Services Matron for Critical Care AMD HoN Head of Therapies	September 2017		
80% compliance with MRG reviews medical and nursing to be completed within 30 days of allocation	Focus for improvements Medical staff Nursing staff	Matron Clinical Services HoN	December 2017		

Appendix 4

Key Quality Improvements Clinical Services 2017

Effective	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 80% compliance with sepsis bundle – 1 st antibiotic given within 1hr to appropriate identified patient	Focus for improvements Critical Care Unit	Matron Critical Care HoN AMD	December 2017		
72 hour antibiotic review to reduce antibiotic consumption	Focus for improvements Critical Care	AMD Clinical Services	December 2017		
Structured medical ward rounds giving families the opportunity to be present	Focus for improvements Critical Care	Matron Critical Care HoN Clinical Services	September 2017		

Appendix 4

Key Quality Improvements Clinical Services 2017

Caring	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 90% in our friends and family recommending the Trust	Focus for improvements OPD	HoN Clinical Services	December 2017		
Reduction of clinical care complaints by 5% in 2017	Focus for improvements OPD Critical Care	HoN Clinical Services Matron Critical Care	December 2017		
80% of all staff to have undertaken a patient shadow	Focus for improvements Critical Care Intensivist cover Critical Care OPD CNP service Radiology Co-Ordinators Therapies	Matron for Clinical Services Matron for Critical Care AMD HoN Head of Therapies	December 2017		

Appendix 4

Key Quality Improvements **Clinical Services** 2017

Responsive	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Develop systems to meet the four priority standards for seven day services	Focus for improvements – Clinical Services	Matron for Clinical Services Matron for Critical Care AMD HoN Head of Therapies	December 2017		

Appendix 4

Key Quality Improvements Clinical Services 2017

Well Led	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Development of learning and sharing structures within Surgery Division	Focus for improvements – Clinical Services Division	Matron for Clinical Services Matron for Critical Care AMD HoN Head of Therapies	June 2017		
Once a year presentation of learning examples at team brief	Focus for improvements – Clinical Services Division	Matron for Clinical Services Matron for Critical Care AMD HoN Head of Therapies	December 2017		
4hr delayed discharges from critical care	No more than 30% total of admissions	Matron for Critical Care AMD HoN	Jan 2018		
Mixed sex breaches	No more than 15 per year of mixed sex breaches	Matron for Critical Care AMD HoN	Jan 2018		

Appendix 5

Key Quality Improvements Community - CVD & KCRS Services 2017

Safe	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Implementation of EMIs in community	Implementing a community electronic patient's record in EMIS will ensure safe effective prescribing, communication and quality of care provided	HoN Medicine Matron for CVD Matron for KCRS Lead Nurse Community	December 2017		
Increase incident reporting across all elements of the community service by 20%	Feedback in all team meetings Ensure staff are trained and monitor reporting trends	HoN Medicine Matron for CVD Matron for KCRS Lead Nurse Community	December 2017		
Development of SOPs and ratification of existing for all community areas	Presented at Team meetings and in Governance	HoN Medicine Matron for CVD Matron for KCRS Lead Nurse Community	September 2017		
Undertake Community Mortality Reviews where appropriate	Community Leads to identify appropriate reviews and share findings at Governance	HoN Medicine Matron for CVD Matron for KCRS Lead Nurse Community	December 2017		
Decrease inpatient medication errors by 20%	PGDs – 100% clinical staff in KCRS compliant with training NMP – all staff to undertake peer review annually. Annual audits	HoN Medicine Matron for CVD Matron for KCRS Lead Nurse Community	December 2017		

Appendix 5

Key Quality Improvements Community - CVD & KCRS Services 2017

Effective	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Compliance with NICE guidance to evidence good practice	Regular attendance at CAEG Sharing Audits at Team meetings and contract reports Ensure identified actions are adhered to.	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
Antibiotic review to reduce antibiotic consumption	Audit of PGDS in KCRS Safe Effective Prescribing	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
Results reported in a timely manner	Set up systems in EMIS to ensure alerts and tracking are in place	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	September 2017		

Appendix 5

Key Quality Improvements Community - CVD & KCRS Services 2017

Caring	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Achieve 95% in our friends and family recommending the Community Services	Ensure all patients are given questionnaire at every contact. Introduce text message feedback Ensure staff follow the Trust Vision and Values	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
70% of all service users and carers and families feel supported by the service	Ensure all patients are given questionnaire at every contact	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
Evidence support for services users with special requirements across all elements of the service.	Capture patient stories where special requirements where considered	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
Reduction of clinical care complaints by 5% in 2017	Monitoring all complaints, completing RCAs and action plans to be shared at team meetings	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		

Appendix 5

Key Quality Improvements Community - CVD & KCRS Services 2017

Responsive	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Provide 6 monthly report on agreed Equality Objective plan outlined in service specification	Ensure that report is written and shared in E&D Group, clarifying with the commissioner the information to be collected	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		
Share learning from introduction of the seven day community services	Focus for improvements – Medicine Division	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	December 2017		

Appendix 5

Key Quality Improvements Community - CVD & KCRS Services 2017

Well Led	Action	Person Responsible	Date for Completion	Progress and Date	RAG Rating
Once a year presentation of learning examples at Team Brief	Ensure that this is timetabled for both services to present.	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	To be scheduled		
Development of Community Governance Committee	Set up group, agree dates, TOR, invite members, agree reporting structure and action	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	April 2017		
Development of Community Strategy	In line with Nursing Strategy and AHP strategy	HoN Medicine Matron for CVD Matron for KCRS Community Consultants Lead Nurse Community	April 2017		