

Item 4.1a

# Quality and Safety Improvement Strategy 2014-2017



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# Introduction

Liverpool Heart and Chest Hospital (LHCH) 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. We provide specialised heart and chest services using the latest techniques and equipment and delivered by world class professionals; this combination achieves outstanding clinical outcomes.

Our approach to care recognises each patient as part of a wider group including families, friends and carers and we embrace this resulting in our unique patient and family centric care approach. Improving the quality, safety and experience of care for patients and families is a key strategic objective for LHCH and is aligned to the National Quality Board definition of quality. It is imperative that the Trust has well-defined quality strategies; encompassing the 'Safe from Harm' and 'Patient and Family Centred Care' visions with clearly articulated outcomes.

The Trust's Patient and Family Experience Vision outlines the six steps of our patients' journey and sets out our ambition for how patients will find their care experience at the Trust.



# Our Patient Safety Strategy

An integral part of the Patient and Family Experience vision is our Safe from Harm vision. This sets out the standards that we aspire to deliver in relation to keep patients safe from harm.



## Our patient safety strategy includes:

**Staff Education** - To deliver outstanding outcomes staff must have the skills and competencies. This is why we have invested in ensuring that our staff understand the methodology required in quality improvement. To support our Safe from Harm vision we have invested in the Patient Safety Champions Programme run by the Advancing Quality Alliance and supported 13 Patient Safety Champions who have attended the requisite training. We are also recruiting human factors champions who will play a lead role in educating and sharing examples of human factors in practice trust wide.

**Patient and families information** - We are keen to explore how families can act as safety champions and we have patient representatives on our patient safety group who are key to helping us to develop this principle. During 2014/15 we developed with our patient representatives, a "top ten tips" for safety information booklet that will be sent to our patients prior to admission and will be available on admission to the clinical areas. During 2015/16 we will implement a speak-out safely process for our patients and families. This is a key quality priority for us this year and is one of our four quality account priorities.



**Human Factors** – During 2014/15 we began to explore the role of human factors in safety. We have identified a group of human factor champions who will lead and drive the awareness of human factors. Our ambition is to build capability across the Trust during 2015/16 together with:

- Reviewing our incident form to include human factors
- Examine the training and education required to support human factors awareness – non-technical skills and building human factors into induction and preceptorship
- Standardise the safety huddles in each area to include awareness of human factors
- Implement CUS (I am concerned, I am uncomfortable, Stop) –Trust wide
- Look at how we can reduce distractions –The Trust has red tabards for use whilst carrying out medicines administration – the trust will relaunch the importance of these.

**Trust wide Safety Huddle** – In November 2014 we implemented a safety huddle across the trust led by the Chief Executive. All clinical areas and support teams are encouraged to attend to discuss any safety incidents that may have occurred and any potential safety risks/concerns. The feedback from staff is that this has been productive in addressing and sharing key safety concerns. The information discussed at the huddle is recorded and fed back to the leads and circulated for discussion and dissemination within their teams. A white board is used to collect the issues raised during each month and at the end of the month those issues are reviewed to ensure that solutions have been found and the issue is closed or to monitor the progress with the actions.

**Speak out safely** – We implemented the speak out safely campaign in 2014/15 and to date have received 22 concerns which have been investigated and feedback given to the staff who have raised the concern. We have learnt that timely feedback is important and we will be setting out a clear process that all concerns will be responded to and dealt with in 28 days. In addition, we have recently signed up to the national Listening into Action providing further opportunities for our staff to raise issues/concerns and to work together to find solutions.

**Developing a safety culture** – Encouraging and developing a safety culture Trust wide is a key priority. We carried out an extensive safety culture survey in August 2014. Following this all teams have received their results and have worked with neutral facilitators to agree the areas for improvement and the associated actions that are required. All teams are scheduled to present their actions to team brief as part of the "Your Chance to Shine" campaign to share their learning with leaders across the trust. We will carry out a repeat survey in Autumn 2016.

## **Sign up to Safety**

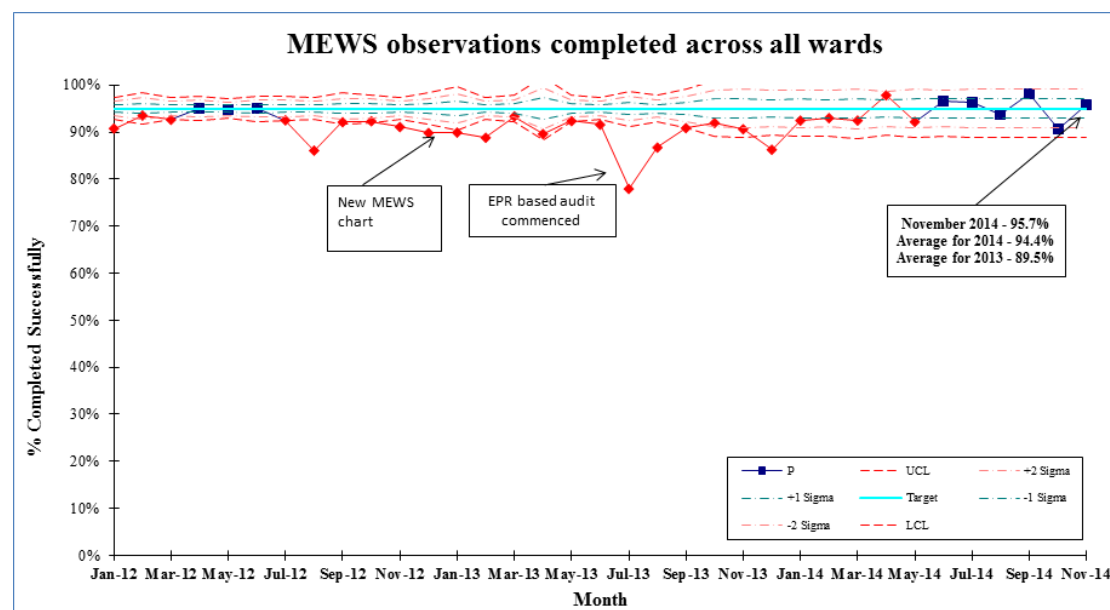
The Trust has signed up to the national Sign up to safety campaign. A review of past NHSLA claims highlights that a large proportion of our claims relate to issues with communication and documentation.

The two action areas we will focus on in our Sign up to Safety campaign will be:

### **Action Area One:**

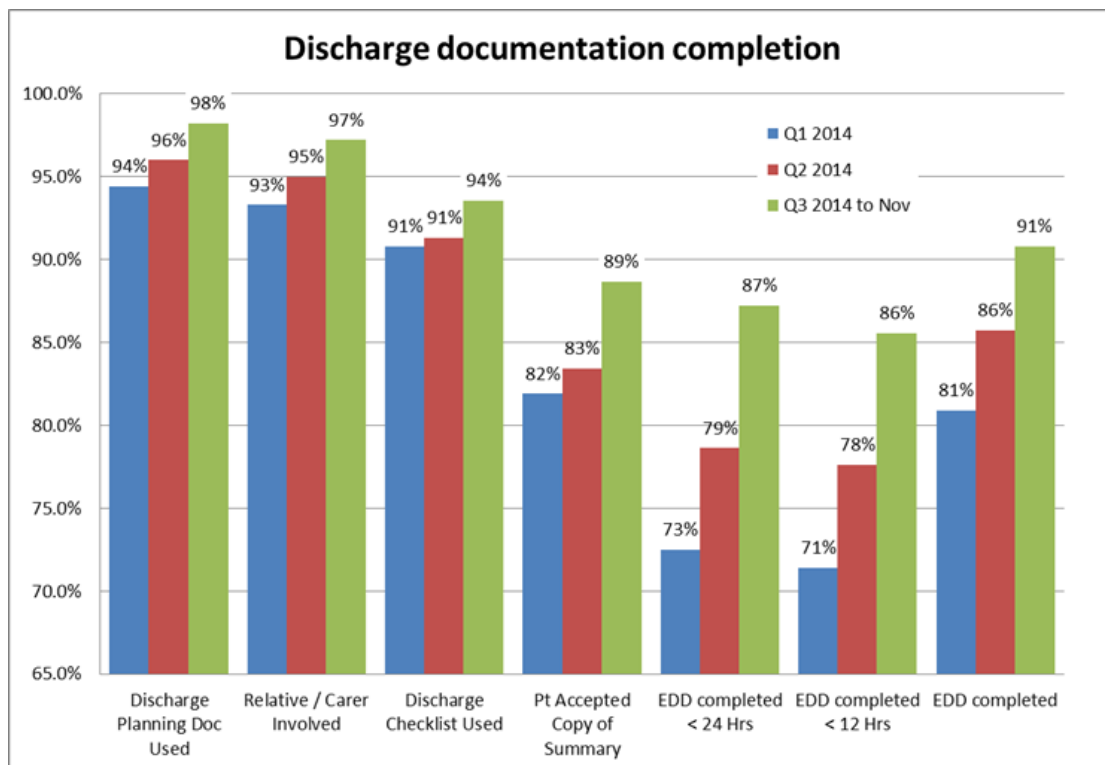
## **Develop a reliable care bundle to improve documentation of care by 50% by 2017**

- We will develop then audit the use of this bundle which will enable clinicians to identify where timely care has been given and to improve upon this. This will enable the development of improvement cycles to be embedded in practice.
- The reliable care bundle will consist of a set of 'always' events which will be:
  1. All patients will be reviewed by a Senior Clinician, Registrar or Consultant, with clear medical plans documented.
  2. The modified early warning score will be recorded when each set of observations is recorded, calculated correctly and when necessary escalated to a senior clinician to review the patient and there will be clear documentation to support that this has been done



3. There is clear documentation when a patient is transferred to another ward or home in the information shared on transfer/discharge. The

chart shows data regarding discharge documentation completion. Documentation when a patient is transferred to another ward is under development.



In addition we will implement:

- Advanced training on the electronic health record for all SpRs, Clinical Fellows, Advanced Nurse Practitioners and Consultant grades
- Development of an electronic alert which will flag to a Senior Registrar and Consultant deranged haemodynamic and MEWS scoring. This is predicated on the development of the technology
- The Trust is keen to develop the use of the electronic information available and for this to be used in real time to help identify care required for patients and improve timely delivery. Clinical leaders will be able to monitor this information on a facilities board which will be available on a computer screen in each clinical area.

## **Action Area Two:**

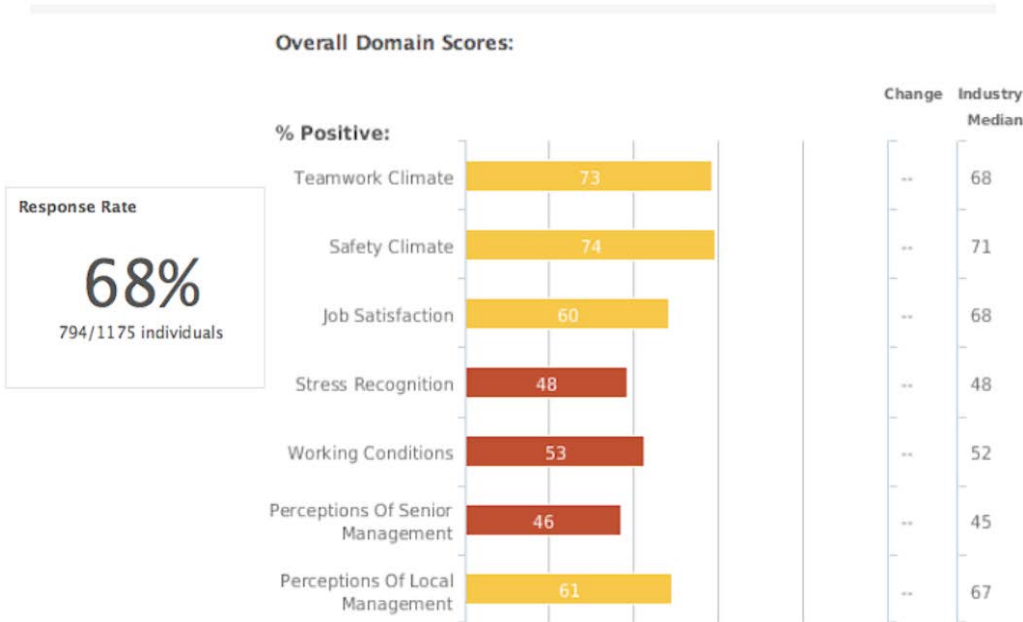
### **Improving the safety culture within the organisation**

We have conducted annual surveys since 2009 recording the safety culture within the organisation. In 2014, an external company who are experts in conducting safety culture surveys administered and supported the survey. From this information the Trust established a good baseline data from staff responses regarding the culture within their specific areas of work. We are working with the leads within the Trust to support staff in implementing the

improvement plans from their responses to the culture questions. The specific actions we will take include:

1. Monitoring the improvement plans via the Patient Safety Group, who will discuss the plans and offer direction on taking the plans forward. We will monitor the outcomes from the actions identified and carry out a further safety culture each year with the expectation of seeing an increase in those scores below that scored less than 60%

## Overall Data: Liverpool Heart & Chest Hospital

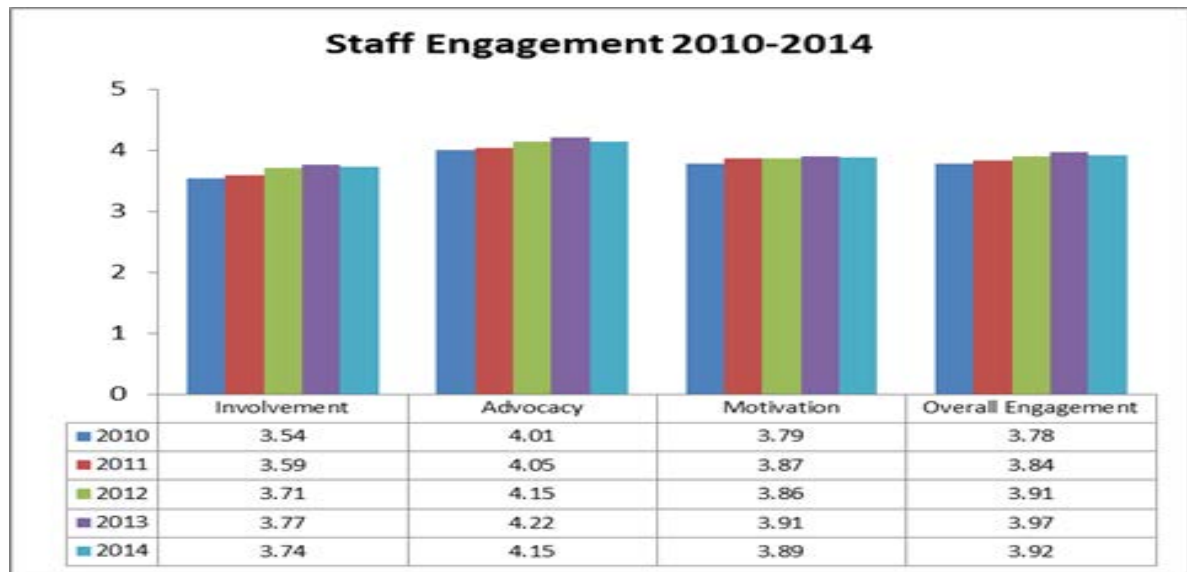


Red= <60%

The chart above demonstrates the results of the culture survey undertaken in the summer of 2014.



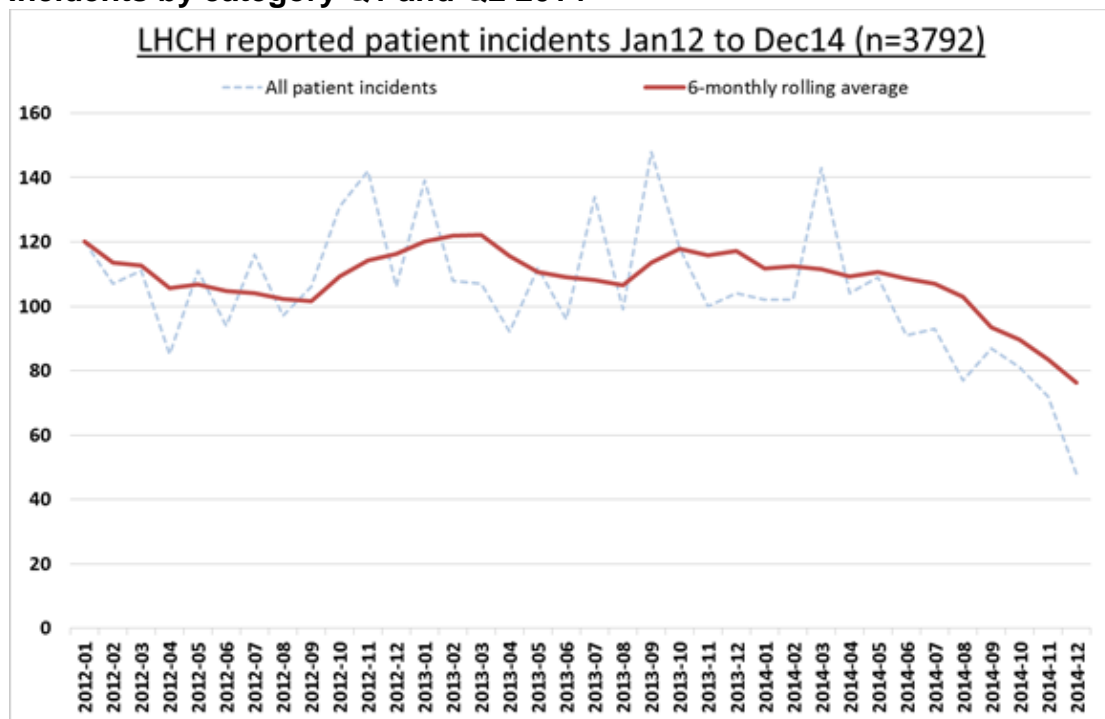
## 2. Staff survey



The chart represents an overview of the most recent (2014) staff survey results. The Friends and Family test is also undertaken and scores collated. Triangulation of the results from the surveys will be gathered and the cross over results such as job satisfaction, feedback from incidents and staff feeling happy with the standard of care being given to patients will be assessed and added to action planning to improve safety culture.

## 3. Improve incident reporting by 50% by 2017

### Incidents by category Q1 and Q2 2014



Incident reporting is one indicator of an organisation's safety culture. Feedback from staff has indicated that the methods for incident reporting in the organisation could be improved. The aim is to improve incident reporting by 50% by 2017. The specific actions we will take include:

- Review our current software system and carry out a specification procurement exercise early 2015 to replace the current system.
- Continue to promote the Speak out Safely campaign as a means of raising concerns to encourage staff to raise any patient or staff safety issues.
- Our daily safety huddle is a further way to raise concerns and/or safety issues. We will work on strengthening this process and understanding the themes that emerge from the huddles so we can build our safety culture.
- We are focussing on feedback from incident reporting and will to include this in our monthly team brief and in communications to all staff groups.

## ***Embedding the Learning from National Reviews***

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The Trust has considered the key learning from the Francis recommendations (2013), the Keogh Reviews (2013) and the Berwick report (2013) to inform its key priorities for 2014/2017. In addition, the Chief Nursing Officer launched the Compassion in Practice care strategy in December 2012 and the implementation plans were launched in April 2013. This has been embraced by the Trust with clear actions identified for how we can further improve an excellent patient and family quality experience. Our ambitions are to support people to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes. The national vision and strategy recognises the changing landscape of the health care sector and articulates the nursing and midwifery profession's role in delivering health care and improved health outcomes. Therefore it is imperative that our clinical quality strategy for 2014-2017 is underpinned by the 6Cs: care, compassion, competence, communication, courage and commitment.

The Trust has responded to the key learning from the Francis recommendations and the Berwick, Keogh, Clwyd/Hart and Cavendish reviews. The outcome of these reviews is aligned to our mission to deliver excellent compassionate and safe care to every patient every day. Key actions taken include:

- The Trust has signed up to the Nursing Times Speak Out Safely campaign and reviewed its whistleblowing policy to make it as easy as possible to raise concerns
- Safety is our priority and we have invested in patient safety champions.
- The delivery of reliable care is central to quality and we are using our electronic patient record to enhance this
- Working in true partnership with patients and their families is our ambition and we have introduced the concept of care partners – an opportunity for families and carers to work in partnership in delivering care. We see families as another set of eyes to leverage for safety and we welcome their involvement in care where appropriate.

*(See appendix one for detail of actions)*

### **NHS Outcomes Framework (2012)**

Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes the NHS should be aiming to improve. For each domain, there are a number of overarching indicators and improvement areas which they focus on improving health and reducing health inequalities:

**Domain 1** - Preventing people from dying prematurely;

**Domain 2** - Enhancing quality of life for people with long-term conditions;

**Domain 3** - Helping people to recover from episodes of ill health or following injury;

**Domain 4** - Ensuring that people have a positive experience of care; and

**Domain 5** - Treating and caring for people in a safe environment; and protecting them from avoidable harm.

The Trust has also considered Monitor's Quality Governance Framework which sets out key principles for Boards to ensure they are aware of the standards for caring for patients and that they are routinely upheld. Boards must scrutinise data and be confident that the data is meaningful and trustworthy. Boards need assurance that the processes for the governance of quality are embedded throughout the organisation. The guidance emphasises the need for fundamental standards and measures of compliance and an enhanced role for all clinical staff in organisational leadership and culture.

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

A handwritten signature in black ink, appearing to read 'Jane Tomkinson', with a stylized, flowing script.

**Jane Tomkinson, Chief Executive**

# ***Listening to Our Patients and Families***

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LHCH is recognised for the delivery of excellent patient and family experience through results in the national survey and internal measurement in line with the six steps of our Patient and Family Experience Vision.

Truly listening to patients and families is a key recommendation of both the Francis and Berwick reports; the way we listen to patients and families include:

## **Shadowing**

Shadowing facilitates a committed individual to follow and observe a patient and/or a family member throughout a selected care experience, to gain insight on the experience. This information is used improve the patient and family experience.

To date, 179 members of staff have undertaken a shadow; our ambition is increase on this over the course of this three year plan with the inclusion of 3rd year student nurses and medical students.

## **Patient and Family Experience Engagement Events**

The Trust facilitates four corporate patient and family engagement events each year which are designed to capture feedback on patient and family experience of the hospital either as an outpatient or during a stay in hospital. The aim of engaging with our patients and families is to enable us to truly understand their experience and to identify improvements.

The events are supported by representation from the Executive team, Non-Executives, Governors and clinical staff. In addition, service leaders within the Trust carry out regular engagement events where they listen and learn from feedback from patients and families who have experienced care within their speciality.

## **Surveys and Feedback**

On each ward we ask our patients and families to feed back on their care experience by collecting their views weekly using electronic surveys. This includes the Friends and Family Test plus other questions to give us a rich picture of the experience of care. This feedback is collected in real time to allow our ward leaders to act on this without delay.

In addition we also receive national patient survey results which allow us to receive feedback that we analyse and implement improvements from. Family care is a key part of our strategy therefore we ask families and carers each month to feedback in real-time their experience of care in our hospital. We support this by carrying out an annual family survey which allows us to triangulate this feedback with the local information we receive to ensure we are constantly listening, learning and improving.

# ***Our Strategic Objectives and Quality Goals***

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**Our quality objective in support of our vision ‘to be the best’:**

**“To deliver the highest quality, safest and best experience for patients and their families by providing reliable care.”**

The diagram below highlights how the vision and strategic objectives for the Trust are cascaded through ward to Board.



This quality strategy supports the key corporate objectives agreed by the Board of Directors and provides a vehicle for delivery of the Vision for LHCH which is “to be the best integrated cardiothoracic healthcare organisation in the country”.

Our Trust mission is to provide excellent, compassionate and safe care to every patient every day, this supports the domains of quality and sets clear demonstrable outcomes to support their delivery.

## **LHCH Quality Goals**

It is fundamental that LHCH has a clear Quality Improvement Strategy.

The quality outcomes LHCH will deliver by 2019 are:

- To reduce upheld clinical care complaints by 50%



- Deliver harm free care by 2019 in relation to avoidable falls, infections, avoidable pressure ulcers, VTE and ensuring medicines are administered safely and timely
- To achieve a 20% reduction in mortality and implementing enhanced mortality review processes
- Be within the top 10% of hospitals for overall patient care
- Achieve 97% harm free care as per the safety thermometer (falls, pressure ulcers, venous thromboembolism and catheter associated urinary tract infections).
- To enhance clinical outcomes by service line
- To achieve consistent improvements in the friends and family test.

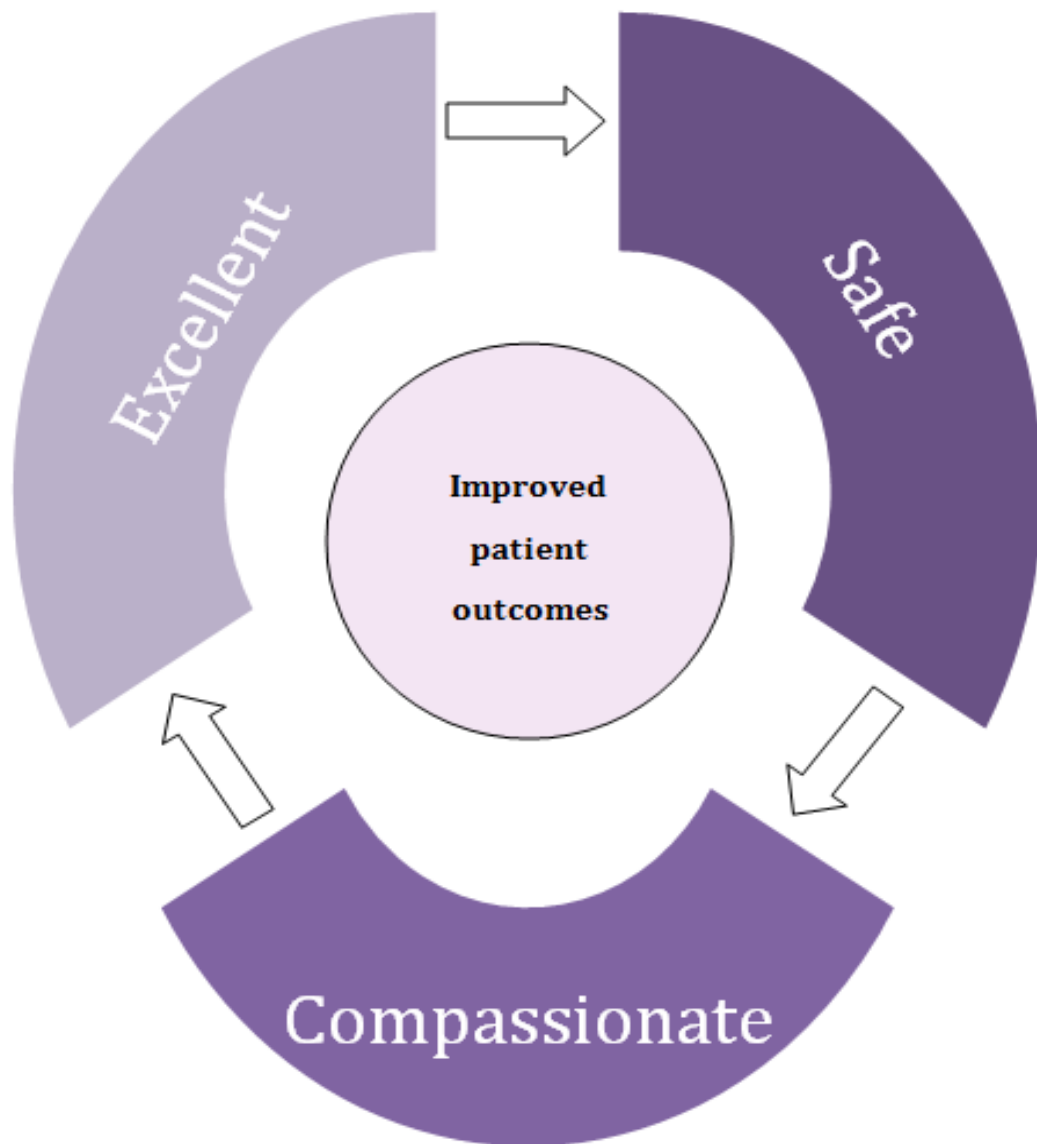
This quality improvement strategy sets out our quality improvements that will support us in achieving our overarching quality goals.

## ***Key Quality Improvements for 2014 – 2017***

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Liverpool Heart and Chest Hospital has developed a quality circle of improvements to greatly improve the patient and family experience and outcomes.

There are eighteen areas for improvement which will significantly improve patient and family experience and outcomes over the next five years and will deliver our mission of excellent compassionate and safe care to every patient and their family every day:



# ***Our Quality Improvements for 2015/16***

## **Excellent**

- Developing an open and transparent culture
- Improve the discharge process
- Improve the reliability of care
- Ensure our staff have the skills and competencies to deliver excellent care

## **Compassionate**

- Ensure our staff undertake shadowing to enhance their understanding of the patient and family experience
- Improving the involvement of families/carers in care
- Ensure our staff have the essential skills and awareness to care for patients with dementia and other vulnerable groups
- Deliver open and honest care to drive improvement.
- Use the friends and family test and engagement events as a means for listening to our patients to improve their experience

## **Safe**

- Reduce mortality incidences by 20% by 2019 and improve mortality review processes
- Delivering harm free care using the Safety thermometer
- Reducing the incidence of avoidable falls
- Reducing all avoidable grade two and above pressure ulcers
- Reducing the incidence of sepsis
- Reducing medication errors
- Achieve zero MRSA bacteraemia and maintain the trusts low incidence of C-difficile and other healthcare associated infections
- Implement the national medications safety thermometer
- Implement our actions from the sign up to safety campaign

# ***Excellent***

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## **Developing an open and transparent culture**

In order to encourage staff to raise concerns LHCH has signed up to the Nursing Times 'Speak Out Safely' campaign which aims to outline the importance of staff raising concerns about patient care and safety and providing them with safe ways of doing so. The purpose of the campaign is to reach out to staff to encourage them to highlight any concerns they have regarding patient care and safety. The Trust formally launched this campaign in April 2014.

### **What we are trying to achieve?**

LHCH has signed up to the Speak out Safely campaign which shows a commitment to support staff who want to raise concerns in a safe and open way without fear of reprisal and to develop an open and transparent culture. We will do this by;

- Working with staff to encourage them to raise concerns safely
- The introduction of an anonymous reporting line through to the risk management team
- Putting in place clear processes to report back to staff following a concern/incident being raised
- Strengthening the directorate governance groups to facilitate learning from concerns and incidents
- Looking to increase incident reporting and to share feedback from incidents reporting on Trust bulletin and at governance groups.
- Revising our Trust website to promote openness and transparency
- Using e-mail to capture concerns that people may wish to escalate in real time reporting directly into the risk management department
- Working with an external patient safety organisation to undertake a Trust wide culture survey to enable us to understand where we need to focus our improvements in relation to culture.
- CEO pledge to encourage speaking out and protection from any subsequent harm.
- Daily safety huddles with members of staff trust wide led by the Chief Executive.

### **When**

The campaign commenced in April 2014.

### **Why**

An organisation that has a robust and accessible incident reporting system where concerns are raised has been shown to be a safer organisation. Staff must be able to raise concerns and feel supported to raise concerns regarding any aspect of patient care or behaviour of individuals.

## **Delivery**

The Trust will build on the objectives set in 2014 to further enhance the speak out safely culture across the Trust. In addition in 2014 the Trust implemented a daily safety huddle trust wide led by the Chief Executive where leaders from wards and departments attend to highlight any patient or staff safety issues. The themes from these huddles are shared via team brief and communications Trust wide. A raising concerns hotline has been introduced so staff can leave a message if they want to raise a concern. In addition to the new hotline, new methods for reporting incident are being introduced, such as email reporting to the risk team, and increased training on web based reporting will be rolled out across all areas. We will also review our incident reporting systems and will have in place a more user friendly system by March 2015.

## **Improve the discharge process**

### **What are we trying to achieve?**

In our national patient survey results our patients told us we had improved our discharge process. Despite this we are aware we need to make further improvements and improve the patient and family experience when going home. We would like all our patient to be clear when they will be going home and be aware of their planned date of discharge, their discharge to be occur so that they are at home for lunch and for their discharge to be seamless without unnecessary delays in waiting for medications and any support required for their aftercare.

### **When**

April 2016

### **Why**

We are aware that discharge for our patients can be improved – we have listened to the feedback from our patients therefore we have set this a priority to improve.

### **Delivery**

Our clinical staff highlighted the need for a discharge lounge and through our processes of Listening in Action (LIA); clinical staff highlighted the need for this to assist in the safe transition of care from hospital to home.

In order to provide a safe quality driven discharge process the Trust has invested in the provision of a discharge lounge which will be open in September 2015. The lounge will facilitate a comfortable sitting area for patients prior to leaving the hospital.

Our patients want to be home timely when they are discharged from the hospital; our aim is to ensure all patients on the day of discharge will be home for lunch

time. This will mean patients will have time to rest at home and have time to readjust back in to their home environment with ease.

Our staff highlighted through LiA the need for our patients to have a seamless safe discharge with the Trust investing in a dedicated care support team to ensure are patients can be home for lunch.

## **Deliver and improve the reliability of care and the development of 'always' events**

### **What are we trying to achieve?**

Too often healthcare improvement efforts focus on what is wrong rather than building on what is done well and doing it consistently. Reliability science can help health care providers redesign systems to make sure patients receive all the elements of care they need. Delivering reliable care is a key priority for the Trust.

### **When**

April 2016

### **Why**

The learning from Berwick, Keogh and Francis highlights that when care breaks down, these results in a poor experience for patients. The development of an "always" bundle will ensure that all patients receive the care that they require.

### **Delivery**

- During 2015/16 we will further develop the bundle of always events and monitor compliance setting targets for improvement. During 2014/15 we will develop a system through our EPR system to monitor the delivery of a reliable care bundle.

We will audit the use of this bundle which will enable clinicians to identify where care has not been given reliably and to improve upon this. This will enable the development of improvement cycles that we will work through and embed in practice.

The reliable care bundle will consist of a set of always events these will be

- All patients will be reviewed by a senior clinician, Registrar or Consultant or Advanced Nurse Practitioner each day Monday to Friday and where clinical condition necessitates during weekends and this review will be clearly documented.
- The patient (and their family where appropriate) will be fully aware of their plan of care



- The patient will always be aware of the name of the consultant responsible for their care and the name of the nurse caring for them on each shift which is highlighted on a board above their bed.
- The patient will always receive their medications safely and on time
- All the patients risk assessments will be completed within six hours of admission and be reviewed as necessary
- The modified early warning score will be recorded when each set of observations is recorded, calculated correctly and where necessary escalated to a senior clinician to review the patient and there will be clear documentation to support that this has been done
- There is clear documentation when a patient is transferred to another ward or home of the information shared on transfer/discharge
- All patients have a planned and recorded date for discharge within 6 hours of admission to hospital and are discharged in line with this date (unless there are exceptional circumstances)
- Comfort checks – will be carried out as a minimum hourly at night and as required during the day with a minimum of 2 hourly.
- The patient's family member/carer will have been given the option of being involved in care delivery if this is the patients' wish.
- Safety huddles are carried out at commencement of each shift on all wards and units

**Through the delivery of the Certificate of Fundamental Care for HCAs and support workers, we will ensure our staff have the right skills, values and competencies to deliver excellent care.**

### **What are we trying to achieve?**

The Trust has now successfully mapped its internal HCA development pathway to the Certificate of Fundamental Care. This has allowed the Trust to evidence that HCA staff meet the standards for care delivery and competence. The intent for 2015/16 is to ensure all new HCA staff that complete the HCA Development Programme, can evidence portfolio completion and attain a Certificate of Fundamental Care. Whilst there is no national requirement to support existing staff who have already undertaken the HCA development pathway to achieve the new standards, additional training packages will be available to credit them towards gaining the full certificate.

### **When**

The first cohort of newly appointed HCAs will undertake the fully mapped HCA Development Pathway in September 2015. Existing staff who have previously undertaken the HCA Development Programme will be supported with training workshops no later than early 2016.

## Why

In the wake of the Cavendish Review (2013) and following the identification of serious challenges in some other health and social care settings, it was acknowledged that the preparation of healthcare assistants and social care support workers for their roles within the care setting were inconsistent. As such, in March 2015 Health Education England launched the Certificate of Fundamental Care, which sought to reflect those values in care, compassion and quality. LHCH has now mapped these core values and behaviours to its HCA pathway alongside those values reflected at LHCH.

## Delivery

All newly recruited HCAs will undertake the revised HCA Development Pathway and successfully achieve the Certificate of Fundamental Care

We will support existing HCA staff to complete the Certificate of Fundamental Care requirements.

**Via full implementation of the LHCH Cardiothoracic Degree Programme, we will develop the specialist skills and competencies of our clinical staff to support the delivery of reliable, safe care.**

## What are we trying to achieve?

Since the introduction of the LHCH BSc Cardiothoracic Practice pathway, LHCH has continued to develop its remaining modules. Alongside those modules run in 2014, the Trust plans to fully develop and run HEA3130 Developing Innovation in Practice, HEA3131 Patient & Family Centred Cardiothoracic Care and HEA3132 Safe from Harm. These modules will complete the full BSc Cardiothoracic Practice pathway and continue to address the national requirements for cardiothoracic and critical care alongside capitalising on the knowledge and skills of the clinicians leading this practice within the North West of England.

## When

Following recruitment to the programme over the summer months, the modules will commence as follows;

- September 2015 - HEA3130 Developing Innovation in Practice (10 credits)  
HEA3131 Patient & Family Centred Cardiothoracic Care (10 credits)
- February 2016 - HEA3132 Safe From Harm (10 credits)

## Why

In response to recent reports (Nicholson, 2013; Berwick, 2014 and Keogh, 2014), the focus of each of these modules seeks to provide staff with the skills and

knowledge to promote the delivery of reliable care, implementing changes through innovative practice and reflecting their holistic approach to patient care.

## **Delivery**

All modules as part of Cardiothoracic Degree Programme will be delivered in 2015/2016, with the predicted cohort sizes below,

<b>Module Name</b>	<b>Start Dates</b>	<b>Anticipated Cohort Size</b>
HEA3245 Principles of Cardiothoracic Care	<b>Sept 15</b>	<b>20</b>
	<b>March 16</b>	<b>20</b>
HEA3033 Cardiothoracic Critical Care	<b>Sept 15</b>	<b>10</b>
HEA3172 Management of Cardiothoracic Critical Care Events	<b>March 16</b>	<b>10</b>
HEA3130 Developing Innovation in Practice	<b>Sept 15</b>	<b>20</b>
HEA3131 Patient & Family Centred Cardiothoracic Care	<b>Sept 15</b>	<b>20</b>
HEA3132 Safe From Harm	<b>Feb 16</b>	<b>20</b>
<b>Total number of staff expected to start on modules 15/16</b>		<b>120</b>

**Providing undergraduate student experiences of the highest quality will contribute to high quality care delivery whilst building our workforce of the future.**

## **What are we trying to achieve?**

LHCH will continue to provide high quality cardiothoracic placements to undergraduate students from all professions. We will seek to continually improve undergraduate learning experiences and the quality of our learning environments through directly involving our students as ‘fresh eyes and fresh ears’ as part of this Quality Strategy. This will be achieved through targeted work in the following areas.

## **Final Placement Students**

We will continue to review the opportunities to increase the quantity of final year nursing students undertaking placements within the trust, recognising the potential to recruit these students into substantive nursing posts on successful completion of their programme. To support this, we will seek to maintain and increase where required, the number of final year placement mentors.

## **Practice Education Quality Assurance**

As a regional benchmark of the quality of undergraduate student placements, we will seek to improve the Health Education North West (HENW) Practice Education Outcome Score year on year. As part of our three year approach, we will increase our score year on year.

### **When**

Increased numbers of final year sign off placements will be evident from April 2015. Workshops designed to support mentors becoming final year placement mentors will be in place from April 2015.

HENW Practice Education Outcomes scores are monitored annually and reported in Q4.

### **Why**

To support our cardiothoracic workforce, sign off students are those future newly qualified nurses. Through increasing the capacity of sign off students and improving in the quality of the practice learning environment, we can secure our future workforce.

### **Delivery**

Maintain and increase real time evaluation of student experience through the implementation of our Student Friends and Family Test App.

Direct involvement of student quality ambassadors on quality reviews, walk arounds and patient engagement events.

Improving our recruitment strategy of final year students through co-ordinated recruitment events.

Improving our partnership working with HEIs and other care providers in developing our students of the future evidenced through improved Practice Education Outcomes

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# **Compassionate**

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## **Ensure our staff undertake shadowing to enhance their understanding of the patient and family experience**

### **What are we trying to achieve?**

Patient and family shadowing is a fundamental element of the 6 steps outlined in the Patient and Family vision and underpins Patient and Family centred care across the trust. The overall aim is for all patients and their families to experience a level of care that is personalised to their needs and delivered professionally with compassion.

Shadowing encourages staff to find innovative solutions and to feel positive about changes, and helps them challenge their perceptions about what is important to patients and their families. It enables staff to discover examples of exemplary and compassionate care that are not easy to explain, and helps develop relationships between patients, families and staff by allowing them to emotionally engage with patients' and family experiences.

Most importantly 'shadowers' can develop an insight into patients and families care experiences which promotes compassion and a deeper understanding of people's needs. A sense of urgency is created where the shadower feels desire to inspire and create change from what they are able to see from both the patient and family perspectives.

- Deliver shadowing training once per month.
- Ensure that two members of staff from each ward and department undertake a shadow within their clinical area
- Ensure that all staff trained to date set time to undertake a shadow.
- Support and guide staff
- The Head of Nursing for patient and family experience will collate the feedback to ensure we have clarity regarding the areas for improvement to improve the patient and family experience
- We will encourage our student nurses and medical students to undertake a shadow.

### **When**

**2015- 16**

### **Why**

- Can inspire staff to re-define a problem, find creative solutions and feel positive about changes.

- Allows staff to challenge their assumptions about what they feel is important to patients and families.
- Enables staff to develop an insight into patients' experiences, and reveals aspects of exemplary and compassionate care that are not easy to define.
- Helps develop relationships between patients, families and staff by enabling staff to emotionally engage with patients' experiences.

## **Delivery**

The Lead Nurse for Patient Experience is the named lead.

Training and education will be delivered monthly along with on the preceptorship programme and junior doctor induction as well as the HCA development programme

## **Improving the involvement of families/carers in care by ascertaining what level of involvement they would like in care – Our Care Partner program**

### **What are we trying to achieve?**

The care partner programme involves staff asking family members/carers if they would like to be involved in the care of their relative, with the patients consent, and which aspects of care they would like to take part in. We currently have four wards that are part of the care partner programme. In 2015/16 we will:

- Implement the care partner programme across all wards and clinical areas
- Ensure that the care partner will be identified as appropriate on the EPR system to facilitate audit of this in practice
- Monitor the effectiveness of the programme via the discharge survey and patient and family shadow
- Ensure all patients will be offered the opportunity to involve family members in care

### **When**

2015/16

### **Why**

This is a fundamental part of our patient and family experience vision and is one of the ways in which we are articulating to patients our ambitions for them and their families to be partners in care with us.

### **Delivery**

- Monitor the effectiveness of the programme via the discharge survey and patient and family shadowing



## **Dementia - Ensure our staff have the essential skills and awareness to care for patients with dementia**

### **What we are trying to achieve?**

LHCH is committed to delivering better outcomes for patients with dementia. Managing the care of people with dementia is a significant part of the work of our staff. In order to ensure that these patients and their care partners receive good quality care.

- Recognise which patients may be affected by dementia by ensuring that we assess all relevant patients on admission.
- Ensure that staff are appropriately trained to manage those patients who are affected.
- Ensure that all new starters will receive dementia friends training
- Identify our key leads in all wards and departments for dementia.

### **When**

**2015/16**

### **Why**

To ensure that all patients and families with dementia are supported during their stay.

### **Delivery**

- Have mechanisms in place to support staff caring for patients with dementia, for example using the “This is me document ” and “care partner” document to ensure that staff have access to key information with regard to the individual, and further developing this with the new patient and family electronic portal.
- Improve contacts with the wider community via dementia action alliance Liverpool and local health watch groups to enable safe discharge by providing easy access to care, support and advice
- Provide good quality information for patients and carers diagnosed with dementia, via the development of a resource pack for wards and clinical areas
- Deliver the CQUIN dementia standards to drive quality improvement and innovation through screening, assessment and referral

## **Open and honest care – Driving Improvement**

### **What are we trying to achieve?**

LHCH is one of 19 Trusts who are being open and honest with the care that we are providing by reporting harms in relation to falls, pressure ulcers, VTE and catheter associated urinary tract infections. We are currently delivering 97% harm free care with ambition to improve.

### **When**

#### **During 2015/16 we will:**

- Continue to publish harms as part of the transparency project
- Consistently increase the rate of harm free care we deliver to our patients.
- Publish our data in line with the data set
- Publish a patient or family story alongside the improvement narrative
- Support and encourage other Trusts to take part in the study.
- Further look at how we can link the study to patient choices website.

### **Why**

The transparency project measures the quality of nursing care delivered together with patient and staff experience in the area where harm occurred. The incidence of harm is published monthly together with the action taken to prevent a recurrence of harm.

Through this collaborative work it has been identified that pressure ulcers and falls as areas where improvements could be made. The data is published to bring a stronger focus to patient safety improvement and engage staff and patients in open, honest conversations about the quality of the care delivered and experienced.

The focus on patient safety and improvement has built from this work to develop Open and Honest Care: Driving Improvement

### **Delivery**

We will review all harms for falls, pressure ulcers, incidence of venous thromboembolism and catheter associated urinary tract infections on one day each month in all clinical areas and publish and share this data nationally.

## **Friends and Family Test - Use the Friends and family test as a means for listening to our patients to improve their experience**

### **What are we trying to achieve?**

Our results are currently achieving a net promoter of 90-92. Our ambitions are to continue to meet this high score and to work to consistently improve noting that the results will be monitored in percentages in 2015/16

### **When**

#### **In 2015/16 we will:**

- Improve upon the number of surveys completed in inpatient wards from the current 30% to 40% and include patients from across the clinical areas - this total currently excludes day case patients and outpatients.

### **Why**

- The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience.
- The implementation of the FFT across all NHS services is an integral part of Putting Patients First, NHS England's Business Plan for 2013/14 – 2015/16, and is designed to help service users, commissioners and practitioners.
- Within LHCH we also use a friends and family test solely for families/carers so we can listen to their feedback on their experience.

### **Delivery**

The results of the test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback. It will highlight priority areas for action, which will support and supplement the national requirements of the Friends and Family CQUIN and will demonstrate continued service improvement

- We will submit the results of patient feedback on both negative and positive comments obtained through the Friends and Family test.
- We will demonstrate active engagement with patients, carers and staff to publicise the Friends and Family Test - internally and externally.

The Trust has a named champion to lead the programme. The Director of Nursing and Quality has Board level responsibility. All survey results and recommendations are documented and discussed with the Board and appropriate committees.

# Safe

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## **Reduce Mortality by 20% by 2019 and improve mortality review processes**

### **What are we trying to achieve?**

The Trust has an established mortality review process. The role is to provide independent medical and nursing review of every death. The group looks for patterns and errors and areas of individual and organisational improvement. This group is multidisciplinary, with members of medical, nursing, physiotherapy and palliative care staff in attendance. The learning is fed back for presentation and discussion at audit days and via hot topics to the Directorate groups and the Clinical Quality and Patient and Family Experience Committee. The committee has been evolving over the last 3 years and has become widely accepted by all staff as an invaluable tool in our ambition to reduce mortality in the Trust.

In addition to seeking system contributors to mortality rates, focus will be on the requirement for individual practitioners to perform to nationally acceptable standards. These are set by the Royal Colleges for medical and surgical staff. We will review risk adjusted mortality for specific procedures at the Clinical Quality Committee every 6 months. Should problems occur, the committee will seek assurance that any problems are rapidly and appropriately addressed.

Risk adjusted global mortality has seen a decline over this period, and this requirement for continuous improvement is a key philosophy for the Trust quality improvement strategy.

### **When**

#### **In 2015/16 we will;**

- Continue to strengthen the process by ensuring a multi-disciplinary approach is used when reviewing the total care pathway of any inpatient death, this ensures all learning is captured from both medical and nursing review
- All reviews will be completed within a twenty eight day timeframe this ensures timeliness of learning and practice changes where appropriate can be embedded and prevent reoccurrence of incident
- In addition, the feedback and sharing of the learning will be strengthened, by ensuring that all review information is shared at the Governance Committees within the divisions.

### **Why**

Evidencing learning and changing practice is fundamental in ensuring patient safety. The Trust will ensure by the instigation of review, action taken and risk

mitigation following each inpatient death review, patient safety will continue to be the Trusts' main focus.

## **Delivery**

An independent review of in hospital deaths that focuses on learning and changing practice has been developed to incorporate nursing care perspectives. These changes will ensure a detailed and holistic view of the patient's pathway and journey thus providing further analysis of the care given and received. Timely reviews will ensure changes in practice occur thus preventing any identified failings in the management of care throughout the patient's journey.

## **Delivering harm free care using the Safety Thermometer**

### **What are we trying to achieve?**

The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care.

### **When**

#### **In 2015/2016 we will:**

Measure the percentage of patients unharmed and our aim to have 97% of patients harm free from pressure ulcers, catheter associated urinary tract infection, venous thromboembolism and harm from falls within the Trust.

The safety thermometer tool will be used to detect and track harm over time.

The nursing staff will ensure that they assess all patients on one day per month to actively assess if a patient has been harmed. This will happen in line with national submission dates.

- Maintain a low incidence of catheter associated urinary tract infections by auditing our practice annually
- Carry out a root cause analysis for any incidence of venous thromboembolism
- Achieve zero grade three avoidable pressure ulcers
- Reduce avoidable grade 2 pressure ulcers by 30%
- Reduce avoidable falls by 50%
- Maintain the trusts low incidence of C-difficile infections
- Achieve zero MRSA

The safety thermometer focuses on four harms:

1. Pressure ulcers
2. Falls
3. VTE

#### 4. Catheter associated UTI

##### **Why**

These four harms were selected as the focus by the Department of Health's QIPP Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care.

##### **Delivery**

Patients are assessed in their care settings. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The accuracy of data depends on the competence and diligence of frontline staff in interpreting and applying the definitions of harms and then recording patient harms.

#### **Reduce the incidence of avoidable falls**

##### **What we are trying to achieve?**

The Trust is continuously reviewing the processes for predicting risk and reducing patient falls.

##### **When**

A reduction of 20% of avoidable falls has been set for 2015/16 with continuous improvement through the remaining years of this plan.

##### **Why**

This is a priority as patients who suffer a fall are often affected psychologically and experience a reduction in confidence when mobilising which can lead to further falls.

##### **Delivery**

A review of the assessment processes for predicting patient falls risk is underway. A scoping meeting now takes place with the Governance and Safety Lead, Ward Manager and the staff who were caring for the patient when they fell. All patients who fall have a patient story taken to describe how the fall has affected their confidence. Innovative ways to help prevent patient falls are discussed in the bi monthly falls group.

#### **Reduce avoidable hospital acquired pressure ulcers, grade 2 and above**

##### **What we are trying to achieve?**

Our aim will be to eliminate avoidable grade 3 pressure ulcers and achieve a 30% reduction in grade 2 pressure ulcers.



The Tissue Viability Service wants to ensure that the Trust continues to move forward towards preventing *all* avoidable pressure ulcers.

### **When**

Over the next 12 months (2015/16).

The service will aim to sustain improvements beyond this.

### **Why**

It is widely written that pressure ulcers are associated with negative patient outcomes, affecting quality of life, morbidity, and mortality; and also increased hospital cost. They have been cited as 1 of the 5 most common causes of harm to patients.

The tissue viability service believes that pressure ulcer prevention should be an integral part of every patient's care, to this end the service delivers regular training and education sessions and updates with HCAs and Support Workers and maintains a visible presence on all wards and clinical areas.

### **Delivery**

- Continuing pressure ulcer scoping meetings following the development of a hospital acquired pressure ulcer, grade 2 or above. This is a specific forum led by the Tissue Viability Service and supported by senior nurse managers, to ensure that grade 2 pressure ulcers follow the same process as higher grade pressure ulcers; and for specific and measurable actions to be planned, implemented and evaluated.
- Continuing education and training and HCA/Support Worker review meetings. This includes a full days training as part of the Preceptorship programme.
- 100% of our clinical staff will have completed basic e-learning assessment in pressure ulcer prevention (now mandatory training).
- Encouraging new staff to spend time with Tissue Viability nurses to raise awareness and improve knowledge and skills; and for all Tissue Viability link nurses to spend 2 days with the service (link nurse rotational programme) and completion of competencies.
- New pressure ulcer campaign and launch of updated Trust pressure ulcer prevention and management guideline (May 2015) and promotion of national STOP pressure ulcer campaign November 2015.
- Trust wide audit to be completed by Tissue Viability (twice yearly April/September) and more frequent ward audits where areas for improvement are identified. Audits are to monitor compliance with Trust Pressure Ulcer Guideline and NICE (2014) recommendations. Information to be fed back and actions planned/evaluated where needed.
- Regular contact and continued close working with Critical Care Area and Cedar Ward, our highest risk area for new pressure ulcer incidence.

## Reducing Sepsis

Severe Sepsis following cardiac surgery is uncommon, the incidence quoted as between 0.5 and 2%. However, when it does occur the mortality rate is high, ranging between 17 -65% depending on co-morbidities.

The Trust has in place a nationally defined response mechanism to ensure patients with sepsis are managed promptly and effectively. However, the frequent change in junior medical staff, combined with the implementation of the electronic patient record have led to concerns over poor or incomplete compliance with the sepsis response within the trust.

As a result the infection prevention team will implement a refreshed sepsis campaign.

This will include the following components:

1. Refreshed and updated sepsis bundle on EPR
2. Production of a new training video which will be used in the education and training of medical and nursing staff
3. Production of promotional material such as poster and aid –memoire cards for distribution around the Trust
4. We will measure the time from prescription of sepsis antibiotics to administration as a key performance indicator which will be audited bi-monthly and presented at the Infection prevention committee for review. The national target for this is 1 hour.

The sepsis campaign will start in May 2015. We will measure compliance with the sepsis bundle which will be discussed monthly at the quality groups.

## Reduce medication errors

### What are we trying to achieve?

- To implement the Medication Safety Thermometer process using EPR. This process addresses the review of potential harms occurring as a consequence of suboptimal use of four high risk medications; anticoagulants, opiates, intravenous or subcutaneous sedatives, or insulin. This process will be established by June 2015.
- To establish a baseline measure of the harm associated with the suboptimal use of these four high risk medications by September 2015.
- To reduce the prevalence of harm associated with the suboptimal use of these medications by 20% by March 2016.

## **When**

**2015/16**

## **Why**

The Safer Medicines Committee, which reports to the Patient Safety group in addition to forming part of the Trusts' governance structure, reviews all incidents involving medication reported via the Trusts' risk management processes. This Committee also provides feedback to the Drug and Therapeutics Committee to enable that group to take a lead in encouraging and fostering a greater awareness of the safe and effective use of medicines throughout the Trust. The Committee's role is likely to become more significant as one of the Trusts priorities is the accurate measurement and ultimate reduction of medication errors, which is integral to patient safety.

The Medication Safety Thermometer is a national initiative. This work represents our Trusts opportunity to take part.

## **Delivery**

The Safer Medicines Group already reviews:

- Medication incidents within each division:
- Identify trends
- Develop action plans as appropriate
- Alert the Trust via the Drug and Therapeutics Committee plus Patient Safety Committee to serious drug incidents.

The Medication Safety Thermometer will provide monthly reports of progress. This data will report quarterly to the Committee but will also be reviewed monthly at Patient Safety Group. This new information will complement our established measure of medication safety incidents reported via our risk management system.

## **Achievement of zero MRSA bacteraemia and a sustained reduction in healthcare associated infections**

### **What are we trying to achieve**

- To ensure that effective organisational processes are in place to maintain high standards of infection prevention and control.
- To prevent all preventable health care associated infections.
- To assist with the wider public health agenda to prevent the development and transmission of antibiotic resistant organisms

## **When**

2015 /2016

## **Why**

Effective infection prevention and control is essential to ensure that patients receive safe and effective care. Healthcare associated infections can increase morbidity and mortality. Outbreaks of infection could impact on the capacity of the Trust and could also damage the Trust's reputation.

## **Delivery**

- Ensure a robust surveillance programme is in place to monitor the incidence of “alert” and highly resistant organisms and to take prompt action if any outbreaks occur
- Ensure relevant policies are in place and reviewed and updated as required
- Ensure an audit programme is in place to monitor key policies
- Ensure the environment is clean and appropriate, and facilitates infection prevention and control
- Provide training to staff on infection prevention and control
- Ensure antibiotics are prescribed appropriately and that there is an effective antibiotic stewardship programme
- Undertake frequent hand washing audits
- Improve and enhance the surveillance programme in order to measure progress and inform future developments
- Ensure an effective water safety management plan is in place
- We will measure this by our reporting of performance at the Infection Prevention committee and by our monthly quality report which details infections incidence

# ***Our Continuous Quality Improvements***

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**There are five areas of continuous quality improvement that we will focus on over the next three years these are:**

- Using technology and information to drive quality improvements
- Patient and Family Centred Care
- Clinical Audit
- Research

## **Using technology and information to drive quality**

Utilisation of IT to deliver high quality care is recognised by all key leaders as a major enabler to both advancing quality but also to meet the wider challenges of the NHS. In the “5 Years Forward” policy documents, “utilising the information revolution” is listed as the fourth major method in the “how we will achieve this” chapter.

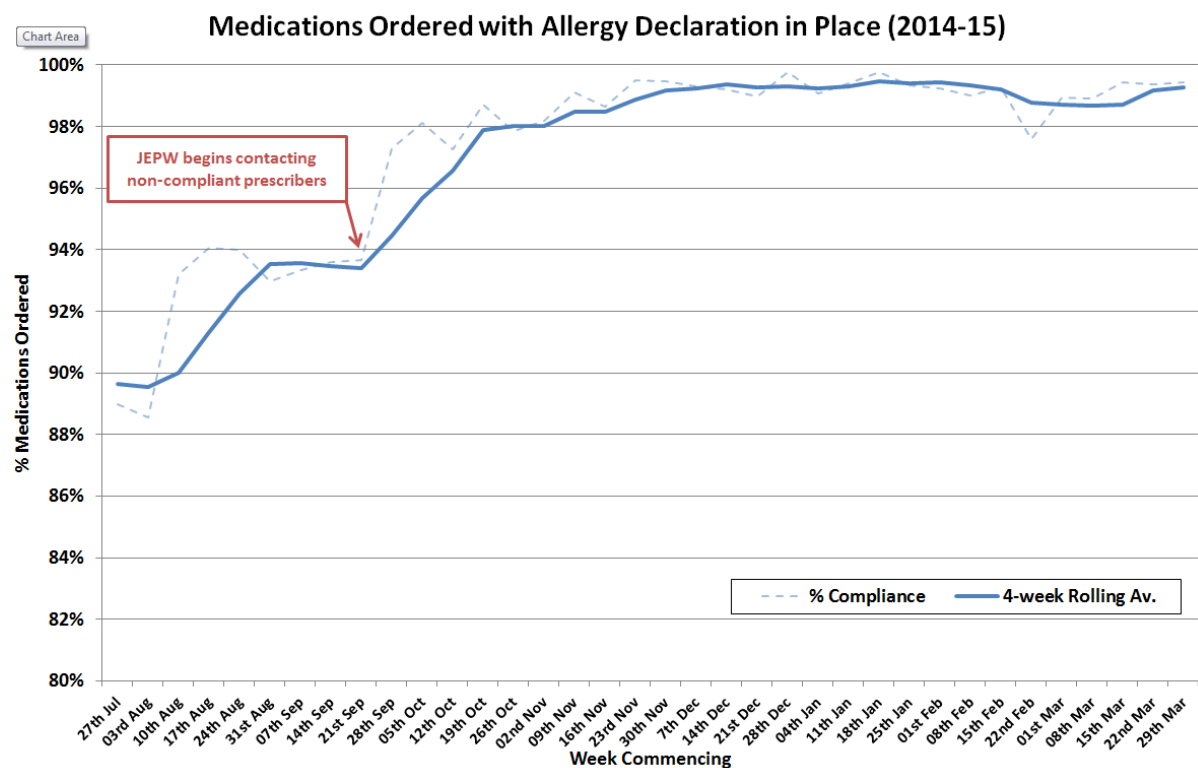
LHCH began its IT refresh program and EPR program 5 years ago and successfully went live with a comprehensive EPR on 26<sup>th</sup> June 2013. During this time, a clear strategy around how to utilise IT to support high quality care has emerged. The key principles are:

- Paperless by design
- Data captured once, and then validated and re-utilised as often as appropriate
- Utilise the immediate access to care documentation, with details regarding when and by whom data was entered, to drive up care quality and create a culture of support and education but accountability in clinical end users
- Support this process with quantitative reporting from the EPR and other clinical systems
- Focus on appropriate care documentation with a minimum of duplication and transcription. In particular the aspiration is to interface or electronically transfer data wherever possible to avoid transcribing errors.
- Create a clinical systems estate that meets the needs of end users for high quality care
- It is acknowledged that while this strategy has not been deviated from, progress against it has not been as effective as had been the aspiration. A major barrier to that has been poor adoption and engagement by the wider organisation of the EPR solution. This has reflected competing pressures and the challenge of the simple magnitude of organisational change delivered on the 26<sup>th</sup> of June 2013.

The introduction and subsequent optimisation and development of the EPR allows comprehensive electronic data collection that allows direct analysis and reporting. Examples of this has been the development of the “EP Procedure” note

that was implemented into the EPR in April 2014. It allows discreet data capture of specific data within the clinical workflow and removes the duplication of documenting the data in 2 separate systems. The processing of the raw data by the Information team is now available and has been sent to the Consultants for validation. The Trusts aspiration is to replicate this process for other national audits, such as cardiac devices.

There are multiple isolated examples where the organisation's EPR has allowed the management of improvement in quality. The most documented and systematically reported of these is compliance with organisationally approved methods of recording allergy status. This had been running at 88-94%, but with a brief period of direct intervention from the CCIO this rapidly rose to >98%. It continues to be managed through a report and consistently maintains compliance levels of over 99%. The improvement is shown in the graph below.



The importance of this example is that it utilised a comprehensive strategy to deliver effective change:

- Available training (a 5 minute training video was made)
- Use of “front end” data (i.e. logging in to the live EPR system) to identify individuals who needed support in delivering high quality care
- Personal intervention by a clinical leader
- Supported by system reporting

In summary therefore, there is clear “proof of concept” of the potential for the transparent access to relevant metrics of end user care quality afforded by the Trusts Clinical Systems to drive up quality of care.

Areas of success against previous report include an NHS England funded project to deliver automated data transfer direct in to the EPR from nursing observation machines. This project will not only remove the requirement for nurses to transcribe data in to the EPR (an important source of potential error) but will also include an automated alerting of the Outreach team by text and email for patients who are showing early signs of deterioration in clinical state (the so called MEWS, or Medical Early Warning Score).

Facility Boards are a key feature of the EPR. They allow the visual display of key metrics of care quality in a live manner. Extensive work has been undertaken to deliver these, and making these live is planned for coming months. This will support the reliable care work that the organisation is working towards, identifying for example that medical reviews, vital signs and risk assessments are carried out in the correct time frame.

Finally, direct electronic documentation of critical care observations was the sole area of “roll back” at EPR go live. The Clinical Current Activity Systems team have worked with the Clinical Lead for Critical Care and other leaders to progress the re-launch of this important process for the organisation.

## Patient and Family Centred Care

The Trust launched the Patient and Family Experience vision in April 2013 setting up the six steps of the patient and family journey and our measures using the net promoter. Our ambition is to consistently exceed the expectations of our patients and families.



Listening to patients and families and understanding their experience is important. We commit to do this by:

- Work to embed the care partner programme – ensuring that all our families/carers are asked if they would like to be involved in care and what aspects of care they would like to be involved in.
- Develop our staff in understanding dementia and the care of vulnerable patients.

- Focus on the delivery of reliable care supported by robust documentation and the delivery of always events at ward level.
- Continue to embed shadowing across the trust encouraging our staff to truly see care through the patients eyes
- Focus on the discharge process for patients and families and how this needs to improve to ensure that great care continues when patients are discharged and patients and families are confident when they leave the hospital.



# Clinical Audit and Effectiveness

The Trust has in place a comprehensive clinical audit & effectiveness strategy which determines the priorities for the selection of audits and subsequent improvements in any given year. Currently, the priorities and associated resource

uses are:

% share of resource	Key inputs	Level of audit	Key outputs
34%	<ul style="list-style-type: none"> <li>Professional registries and societies</li> <li>NICE</li> <li>Department of Health</li> <li>Care Quality Commission</li> <li>NHS Litigation Authority</li> </ul>	<ul style="list-style-type: none"> <li>National</li> <li>Heart disease and Cancer audits (NCAPOP)</li> <li>National Service Frameworks</li> <li>NICE</li> <li>National Confidential Enquiries</li> <li>CQC quality and safety regulations and outcomes</li> <li>NHS Litigation Authority risk standards</li> </ul>	<ul style="list-style-type: none"> <li>Annual</li> <li>Clinical Audit &amp; Effectiveness Report</li> <li>Quality Account</li> </ul>
10%	<ul style="list-style-type: none"> <li>CQUIN</li> <li>NHS Acute Trust Contract</li> </ul>	<ul style="list-style-type: none"> <li>Regional</li> <li>Advancing Quality</li> <li>SHA</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly</li> <li>Directorates Governance</li> </ul>
15%	<ul style="list-style-type: none"> <li>Strategic Objectives</li> </ul>	<ul style="list-style-type: none"> <li>Local</li> <li>Corporate – assurances for Board Assurance Framework</li> </ul>	<ul style="list-style-type: none"> <li>Audit Committee</li> </ul>
34%	<ul style="list-style-type: none"> <li>Service Improvement Prioritisation</li> <li>Patient safety</li> <li>Risk management</li> <li>Complaints / Claims</li> <li>Patient experience</li> <li>Council of members</li> </ul>	<ul style="list-style-type: none"> <li>Directorate service lines</li> </ul>	<ul style="list-style-type: none"> <li>Clinical Quality Committee</li> </ul>
5%	<ul style="list-style-type: none"> <li>Staff, patient, carer or stakeholder</li> </ul>	<ul style="list-style-type: none"> <li>Other multi and uni-disciplinary audit</li> </ul>	<ul style="list-style-type: none"> <li>Clinical Audit &amp; Effectiveness Group</li> <li>Best Practice Newsletter</li> <li>LHCH Intranet</li> </ul>

From these directives, an annual clinical audit forward plan is built which is consulted on widely with relevant stakeholders before being presented to the Trusts Audit Committee for final sign off. Delivery of the plan is then monitored in

year through reporting to the Directorates. Comprehensive support is available to staff undertaking audits to ensure a quality outcome to the work.

The Trust also has in place a process for responding to NICE guidance. New guidance is reviewed by the Clinical Audit & Effectiveness Group timely, and an assessment made on its relevance to the Trust given its specialty status. A gap analysis is undertaken by an appropriate clinical member of staff for relevant guidance and gaps are action planned through the Directorates. Regular reports of compliance are made to commissioners. This process ensures the Trust delivers the latest evidence based care to its patients.

The Clinical Audit & Effectiveness Group also has the responsibility for overseeing the introduction of new technology.

New technology in this context is technology which represents a significant development of existing technology, or technology that is new to Liverpool Heart and Chest NHS FT. The group ensures that adequate training, models of consent and clinical audit processes are in place to ensure patient safety in the context of delivery of aspects of a patient's treatment that are new, but are not being delivered in the setting of a formal programme of research.

## Research

'Today's' research is tomorrow's care'.

Research is a great enabler for improving the quality of care for a number of reasons:

- As a research active organisation, LHCH can offer treatments which are truly innovative as part of clinical trials; research brings new therapies and methods which otherwise would not be available to our patients.
- Research is the source of evidence for improvements and innovation. The Trust wishes to be at the forefront of implementing evidence-based practice. Implementing our own research findings will improve the quality of care for our patients.
- Research highlights best practice and identifies areas for improvement. The "enquiring mind" that comes with a research provides the right sort of environment and culture to challenge current models of care and seek improved solutions.
- Interacting with other researchers (internal and external) as part of the research process provides opportunities to learn from others and bring high quality care to our Trust.
- Staff training; our staff are up-skilled as they become involved in research, resulting in a more competent workforce.
- Research links directly with the Patient & Family Experience Vision; all steps of the vision are covered by the research process, from reputation to the after stay, with dedicated follow up care.

The Trust has a comprehensive strategy for research and innovation recently refreshed for 2015/16 to 2017/18. The objectives for the strategy are:

- Promote research & innovation in our priority areas
- Build a culture that promotes supports and values research and innovation activity
- Develop capacity and capability for research and innovation
- Maximise opportunities for our patients to take part in research
- Maximise opportunities for research and innovation collaborations with external partners
- Ensure effective governance of the research & innovation function

Taken together, the research & innovation strategy complements the quality strategy as an agent for improving quality of care.

## Commissioning for Quality Improvement (CQUIN) 2015/16

The Trust has committed to deliver CQUIN both to continue to improve the quality of care for our patients in accord with national, regional and local priorities.

Improvement Area	Ambition
National Priority: Acute Kidney Injury	<ul style="list-style-type: none"> <li>• Effective detection of new diagnoses using clinical coding and EPR</li> <li>• Ensuring the transmission of key management information via the discharge letter regarding stage of AKI, evidence of a medicines review having been undertaken, type of blood tests required on discharge and frequency of blood tests required on discharge for monitoring.</li> </ul>
National Priority: Sepsis	<ul style="list-style-type: none"> <li>• Compliance with the sepsis order set and timeliness of appropriate treatment.</li> </ul>
National Priority: Dementia	<ul style="list-style-type: none"> <li>• Continue to develop the Find, Assess, Investigate and Refer process to ensure timely referral of potential new dementia patients to general practice.</li> <li>• Dementia training for staff.</li> <li>• To ensure that carers of people with dementia and delirium feel adequately supported.</li> </ul>
Regional Priority: Advancing Quality	<ul style="list-style-type: none"> <li>• Continued monitoring of the compliance with the acute myocardial infarction and coronary artery bypass grafting bundles.</li> <li>• Improvement in the use of bundle elements resulting in improved appropriate care score.</li> </ul>
<ul style="list-style-type: none"> <li>• Local Priority: Clinical Digital Maturity</li> </ul>	<ul style="list-style-type: none"> <li>• Trust to commit to engaging with identified Informatics Merseyside lead on a monthly basis to review progress against agreed clinical digital maturity milestones.</li> <li>• Continued engagement with the iLinks Transformation Programme via CIAG and on-going representation on relevant subgroups</li> <li>• Undertake review of IT estate against the digital maturity indicator.</li> </ul>

# ***Quality Account Priorities for 2015 – 2016***

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## **Priority One: Timeliness of in-patient discharge**

### **Category: Patient Experience**

#### **What**

Improve the Timeliness of in-patient discharge from hospital

#### **Why**

Timely discharge for our in-patients to ensure they have everything in place for a safe and timely return to their place of discharge by 12 mid-day. This gives the patients and their families a focus when leaving the safety of a hospital setting. Patient experience is vital to us delivering a safe and quality service to meet our patient and their family's needs. Feedback from our patients suggests discharge delays have occurred due to not having their medications ready to enable them to leave the hospital early in the day.

Chosen via the Stakeholder Group

#### **How**

Our aim is to have 10% of our patients discharged before 12mid day.

#### **When**

March 2016

#### **Who collects the data**

The Electronic Patient Record and our patient administration service will be used to collect the data.

#### **Monitoring of Data**

The Quality and Patient Family Experience Committee will monitor the progress made.

#### **Current Position**

Less than 5% of our inpatient discharges are currently taking place before 12mid day.

## **Priority Two: Family and Carers to Be Offered the Opportunity to Be a Care Partner**

### **Category: Effectiveness**

#### **What**

Promotion and involvement of our patient's families and carers in the care delivered to our patients during their in-patient stay.

**Why**

This aspect of care is pivotal to ensuring engagement with our patient's carers and families through sometimes the most difficult of times. Our vision is to enhance our relationships with our patient's carers and their families by providing them with the right level of support and to provide aspects of care to their loved ones whilst in hospital.

Chosen via the Stakeholder Group

**How**

Our aim is to evidence through the EPR record that 40% of our patient's families and carers are offered the opportunity to be involved as a care partner

**When**

March 2016.

**Who collects the data**

The electronic patient record needs to be developed so we can collect this data.

**Monitoring of Data**

The Quality and Patient Family Experience Committee will monitor the progress made.

**Current position**

Base line data needs to be established to inform the improvements needed.

**Priority Three: Patients, families and carers to be able to speak out safely**  
**Category: Safety****What**

We want to encourage all our patients, their families and carers to speak out in a safe and comfortable environment when they feel there is a need to do so.

**Why**

It is important for us to recognise that our patients, their families and carers may on occasions want to speak out safely regarding aspects of care, or certain situations they are not happy with. We want to ensure our patients, families and carers are supported and encouraged to do this. As a learning and patient and family centred hospital we want to know when we do not get things right, so we can change, and adapt to make the experience for our patients families and carers a positive and good experience when in the hospital.

Chosen via the Stakeholder Group

**How**

We want to display on all our in-patient areas the process for speaking out safely this will be **Report, Escalate, and Talk, (RET)**. This process will inform all our patients, families and carers how to openly discuss their concerns. We want to collect all concerns raised through the implementation of a telephone SOS phone line, a dedicated e-mail address and the opportunity to speak to a senior nurse face to face.

**When**

March 2016.

**Who collects the data**

The administrator for the phone line and e-mail communication or via a face to face conversation.

**Monitoring of Data**

The Quality and Patient Family Experience Committee will monitor the progress made.

**Current position**

This is a new concept therefore we will need to introduce this to our clinical areas in quarter one and roll out to all clinical areas by the end of March 2016.

**Priority Four: Safe Quality Care for our vulnerable groups of patients****Category: Clinical Effectiveness****What**

Identifying and ensuring our vulnerable in- patients receive the best in quality safe care in accordance with their needs.

**Why**

It is important to us to recognise that some of our patients have specific care needs due to their vulnerable clinical conditions. We would like to ensure that all specific care needs have been identified and acted upon, and that the identified specific care is always delivered.

**How**

We want to add into our EPR system a flow chart that captures the specific vulnerable clinical condition and identifies the care required proportionate to the specific need of the patient.

Chosen via the Stakeholder Group

**When**

March 2016.

**Who collects the data**

The Electronic Patient Record.

**Monitoring of Data**

The Quality and Patient Family Experience Committee will monitor the progress made.

**Current position**

Base line data needs to be established to inform the improvements needed.

## ***Identified Quality Improvements for 2016 and Beyond***

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This quality improvement strategy will be reviewed annually and our ambitions to improve quality will be prioritised.

Identified improvements that will be considered for 2016 onwards will be:

- To establish baseline measurements for ventilator acquired pneumonias
- Wound infections (including surgical site infections) – to look at compliance with care bundles.
- Review of the care bundles in place and compliance and setting improvement targets as necessary
- Review the readmission data for critical care to outline any areas for improvement
- To examine the re sternotomy rates within the Trust and look at how we might improve them
- To review the response rates both in and out of hours to deteriorating patients and how we might improve them



## ***How will we Measure Progress?***

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Progress against the quality improvement targets will be measured through the Trusts' governance systems. The clinical quality and patient and family experience committee will be responsible for monitoring progress and against the set quality priorities and will provide assurance to the Quality Assurance Committee and the Board of Directors on progress. Progress against the priorities is also presented to the Council of Governors.

The Trust's Operational Board will monitor exceptions to achievement of the quality priorities and the directorate 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 Foundation Trust. This quality improvement strategy confirms our commitment to ensure this is achieved.

## Appendix 1

### Francis, Keogh and Berwick

Recommendations/Actions	Trust progress on Actions	Exec Lead Date	Date for next review	Date of Completion
<b>Preventing Problems</b>				
<p>Culture and Patient safety – (F)</p> <p>Use of mortality review to prevent avoidable deaths (K)</p> <p>Use of early warning scores to identify patients who may be deteriorating (K)</p> <p>Effective teamwork between all disciplines (F)</p> <p>Patients aware of Consultant and Nurse responsible for care (F)</p> <p>Regular ward rounds (F)</p> <p>Administration of medicines (F)</p>	<ul style="list-style-type: none"> <li>• (F) Agreed to implement speak out safely campaign from April 2014 TBA at Board- This will form part of the QI strategy for 2014/19. Other considerations are safety briefings and the benefits of these</li> <li>• Patient safety group in place - focus on reducing pressure ulcers and safety and medications</li> <li>• Weekly harm reports to exec meeting</li> <li>• Detailed quality report to the BOD meetings commenced January 2014 replacing the IPR</li> <li>• MRG in place – review of this will be carried out as part of quality objectives to strengthen including MDT in process for 2014/15</li> <li>• EWS, ward rounds, medicines administered safely and overseen by nurse in charge, named nurse and consultant responsible for care are part of reliable care bundle – quality objectives 2014/15</li> </ul>	Director of Nursing and Quality/CEO/MD	April 2015	Completed

<p>Openness Transparency and Candour (F)</p> <p>Make demonstrable progress towards reducing avoidable deaths in hospital (B)</p> <p>Be open and honest with serious incidents with patients and families (K)</p> <p>Compliance with being open policy (K)</p> <p>Transparency (K)</p>	<ul style="list-style-type: none"> <li>• (F)All serious incidents are reviewed and being open policy used – review of process to be articulated</li> <li>• Mortality review process – to be strengthened to include nursing 14/15</li> <li>• (F)Trust is part of transparency project</li> <li>• Review of website pertaining to quality and how we can be more transparent regarding complaints data etc. to be undertaken in 14/15</li> <li>• Speak out safely campaign to commence April with launch trust wide and exploration of feedback mechanisms and sharing of learning trust wide</li> </ul>	Director of Nursing and Quality/MD	April 2015	Completed
<p>Listening to patients (F)</p> <p>Patients, Carers and the public will feel like they are being treated as equal partners. They need to be confident that their feedback is listened to and see how this is impacting on their own care and the care of others (B)</p>	<ul style="list-style-type: none"> <li>• (F)Gap analysis of the recommendations from Clwyd and Hart report underway</li> <li>• Review of patient association recommendations on complaints management underway</li> <li>• Patient and family engagement programme in place</li> <li>• Friends and family test in place</li> <li>• Real-time feedback to be ascertained from April 201</li> <li>• Senior nurse walk rounds monthly</li> <li>• Monthly senior nurse visits at weekends and</li> </ul>	Director of Nursing and Quality	April 2016	Completed

<p>Look more in depth at complaints (F)</p> <p>Ensure patients are aware of methods of registering a complaint (F)</p> <p>Real time feedback (K)</p> <p>Relationships with health watch (K)</p> <p>Patient and public engagement (K)</p>	<p>night</p> <ul style="list-style-type: none"> <li>• Feedback of complaints and the learning to be included on website 14/15</li> <li>• Non Exec review of complaints in progress</li> <li>• Bedside folders will be in place for April 2014 information on how to register a complaint</li> <li>• Ward entrance monitors – information about the ward</li> </ul>			
<p>Safe Staffing (F)</p> <p>Evidence based tools will be used to determine appropriate staffing levels. Boards will sign off staffing levels every six months with assurance on the impact on quality of care and patient experience. Awaiting guide by the national quality board. (B)</p> <p>Supervisory ward managers (K)</p>	<ul style="list-style-type: none"> <li>• Review of nursing workforce using AUKUH and Professional Judgement carried out 6 monthly for the previous two years</li> <li>• Work underway to provide reports for governance ,Patient and Family Experience Committee and the Board of Directors on staffing required and actual staffing from June 2014 inclusive of patient safety incidents and quality issues</li> <li>• Critical care staffing in place according to national guidelines – recent agreement no increase in staffing</li> <li>• All ward managers supervisory</li> </ul>	Director of Nursing and Quality	April 2015	Completed

<b>Detecting Problems Quickly</b>				
<p>CQC inspections to look more closely at records (F)</p> <p>Patients and Clinicians will have confidence in the quality assessments made by the CQC and they will be part of the inspections (B)</p>	<ul style="list-style-type: none"> <li>• Governance review 7<sup>th</sup> February by CQC – minor concern – Outcome 16 – this has now been resolved following a re-inspection now compliant</li> <li>• Review of governance systems internally at present and review of BAF</li> <li>• ESQS has been reviewed to include review of documentation</li> <li>• Quality objectives for 14/15 to include review of reliable care using EPR to review standard of documentation</li> <li>• Review of new CQC structure to ensure we are prepared for future inspections</li> </ul>	Associate Director of Corporate Affairs/Head of Governance	April 2015	Completed
Fundamental standards and enhanced quality standards (recruitment) (F)	<ul style="list-style-type: none"> <li>• Review of recruitment process using values and behaviours</li> </ul>	Director of HR	April 2016	
Working Together (F)	<ul style="list-style-type: none"> <li>• Mortality review group in operation since – review of terms of reference to include MDT and nursing care from April 2014</li> </ul>	Director of Nursing and Quality/MD	April 2015	Completed
Speak out safely (F)	<ul style="list-style-type: none"> <li>• Trust to join the nursing times speak out safely campaign from April 2014</li> <li>• Review of whistleblowing policy – to be re-launched April 2014</li> </ul>	Director of Nursing/Director of HR	April 2015	Completed
Clear Strong Governance – Role of Boards (F)	<ul style="list-style-type: none"> <li>• Review of BAF</li> <li>• Governance Review</li> <li>• Further development and integration of</li> </ul>	Associate Director of Corporate	April 2015	Completed

	<p>Governors into the quality agenda</p> <ul style="list-style-type: none"> <li>Develop relationships with healthwatch, CQC and Governors</li> </ul>	Affairs/Head of Governance		
<b>Taking Action Promptly</b>				
<p>Clear and meaningful ratings(F)</p> <p>How data is used by the board (K)</p> <p>Quality account needs to be more comprehensive and balanced assessment of quality (K)</p>	<ul style="list-style-type: none"> <li>Quality report on Board agenda and circulated each month Board briefed on any serious harms and full root cause analysis presented</li> <li>Quality account work underway currently</li> </ul>	Director of Nursing and Quality	April 2015	Completed
<p>Clear risk based interventions (F)</p> <p>Boards and Leadership of organisations will be confidently and competently using data and other intelligence to improve quality (B)</p>	<ul style="list-style-type: none"> <li>Systems in place to monitor concerns – harm report to execs, quality report to clinical quality and Board</li> <li>Harm reports to exec</li> <li>Quality report to the board</li> <li>Quality indicators presented alongside workforce reviews</li> </ul>	Director of Nursing and Quality	April 2015	Completed
<b>Ensuring robust accountability</b>				
Levels of accountability	<ul style="list-style-type: none"> <li>Nursing structure review to complete by October 2014</li> </ul>	Director of Nursing and	April 2015	Completed

	<ul style="list-style-type: none"> <li>Review of exec portfolios</li> </ul>	Quality/ CEO		
Holding to account	<ul style="list-style-type: none"> <li>Leadership training evaluation next steps to be agreed</li> </ul>	Director of Strategy and OD	April 2016	
High Professional standards/professional regulation (F)  Nursing revalidation (K)	<ul style="list-style-type: none"> <li>Nursing revalidation – await NMC feedback</li> <li>Appraisal process review underway</li> <li>Medical revalidation in place</li> </ul>	Director of Nursing and Quality/Director of HR	April 2016	
Internal scrutiny and challenge	<ul style="list-style-type: none"> <li>Quality Impact assessments undertaken by the medical director and director of nursing and quality on all cost improvements identified</li> <li>Review of governance underway</li> </ul>	Director of Nursing/Medical Director	April 2015	Completed
<b>Ensuring staff are trained and well-motivated</b>				
Staff engagement (F)  Understand the positive impact that happy and engaged staff have on patient outcomes – this needs to be a key part of any quality improvement strategy (B)  Using Junior Doctors in	<ul style="list-style-type: none"> <li>Annual surveys completed</li> <li>Team brief now open to all staff</li> <li>Staff friends and family to be implemented in April 2014</li> <li>Executive walkabouts</li> <li>Senior nursing walkabouts</li> <li>Review of induction undertaken</li> <li>People and OD strategy</li> </ul>	Director of HR/Director of Nursing and Quality	April 2015	Completed

training (B)				
Tap into the talent of student nurses and junior doctors (K)				
Use innovative ways of engaging staff (K)				
Education and Training	<ul style="list-style-type: none"> <li>Cardiothoracic training in conjunction with Edge Hill University – commence February in critical care</li> </ul>	Director of Nursing and Quality	April 2015	Completed
Support workers and HCA training	<ul style="list-style-type: none"> <li>HCA programme in place</li> </ul>	Director of Nursing and Quality		Completed
Leadership culture (F)	<ul style="list-style-type: none"> <li>Review of leadership priorities to be undertaken</li> </ul>	Director of HR	April 2016	
Leadership at every level (K)				
Compassionate care	<ul style="list-style-type: none"> <li>PFCC in all education programmes</li> <li>Dementia awareness and training – dementia strategy</li> <li>Shadowing in place</li> </ul>	Director of Nursing and Quality		Completed
Value based recruitment (F)	<ul style="list-style-type: none"> <li>Review of recruitment to incorporate values and behaviours being undertaken</li> </ul>	Director of HR	April 2016	
Recruit for values and behaviours (K)				