Clinical & Quality Strategy
2014 - 2018
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EXECUTIVE SUMMARY

In Spring/Summer 2013, following consultation with a wide range of stakeholders, St Helens & Knowsley Teaching Hospitals NHS Trust Board approved its 5-year Clinical & Quality Strategy.

Subsequently, as part of its work developing an integrated business plan for Foundation Trust status, the Trust Board decided it would be helpful to rationalise, modernise and integrate the 5-star corporate objectives (‘the star chart’) and the Clinical & Quality Strategy.

Progress has been made in improving the performance of the NHS in recent years, but much remains to be done. Not only are UK clinical outcomes poorer than in some other wealthy countries, but shortfalls in care quality at Mid Staffordshire Foundation Trust described in the Francis Report have shocked the nation and prompted a radical rethink of the delivery, monitoring and regulation of care.

Locally, deprivation and unemployment are high, smoking, drug and alcohol misuse are high, health outcomes are relatively poor, health inequalities are wide and emergency attendances and admissions to hospital are amongst the highest in England - and growing.

There is consensus within our community that it is only by working together towards our common goal of improving the health and wellbeing of local people that we will achieve our objectives.

The aim of this Clinical & Quality Strategy is to present St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) Clinical and Quality Priorities in the context of the strategic priorities of the wider NHS and our health and social care community.

Our aims are simple: to provide best quality care. To the wider public, 5-star has become synonymous with best quality, so we describe our aspiration as 5-star care.

The 5-stars represent the qualities that will help us deliver our care goal, namely: compassion, communication, courage, commitment and competence.

To monitor progress delivering our strategy, we describe 24 key performance indicators (KPIs) and major drivers to successful delivery of these KPIs.

A Clinical & Quality Action Plan describes in detail how the Clinical & Quality Strategy will be operationalised, how goals will be realised and how performance towards these goals will be monitored and managed.

The Clinical & Quality Strategy is owned by the Trust Board and informs our Integrated Business Plan (IBP) and the Longterm Financial Model (LTFM). The Trust Board is clear: safety and quality, good health outcomes and a positive healthcare experience are its priorities and underpin all Trust activities.
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THE WIDER CONTEXT
Major progress has been made in improving the performance of the NHS in recent years, but against a backdrop of significant national financial challenge, the current health and social care system has failed to keep pace with the needs of an ageing population, the changing burden of disease and rising patient and public expectations.

Despite falling death rates, the UK has the second highest rate of mortality amenable to health care among 16 high-income nations (Nolte & McKee 2011); there are 10,000 premature cancer deaths (Department of Health 2011), 24,000 avoidable deaths in people with diabetes (National Audit Office 2012) and up to 1,500 excess deaths in children with asthma and pneumonia (Wolfe et al. 2011).

Striking health inequalities persist (Marmot 2010) and about 1 in 10 hospital admissions leads to harm (House of Common Health Committee 2009). Moreover, people admitted to hospital at weekends are more likely to die (Dr Foster 2012), and more than half of acute hospitals inspected by the Care Quality Commission recently failed to deliver basic standards of dignity and nutrition for older people (Care Quality Commission 2011).

Up to 29% of hospital bed-days are taken by patients whose admission might have been avoided if their care was better managed.

Nearly two thirds (65%) of people admitted to hospital are over 65 years old and people over 85 years old account for 25% of bed-days (up 22% over the past decade). Indeed, over the past 10 years, there has been a 65% increase in secondary care episodes for those over 75 years, compared with 31% for those aged 15-59 years. The average length of stay for acute care in UK hospitals in 2010 was 7.7 days, higher than the Organisation for Economic Co-operation & Development (OECD) average of 7.1 days and significantly in excess of Australia (5.1), Netherlands (5.8) and USA (4.9) days. People over 85 years spend around eight days longer in hospital than those aged under 65 – 11 days as opposed to three.

There has been a 37% increase in emergency admissions in the past 10 years with emergencies accounting for 35% of all hospital admissions, costing £11 billion per year.

Emergency admission rates at weekends are around 25% lower than during the rest of the week, but 30-day mortality rates amongst those admitted at weekends are 2-3 fold higher (Royal College of Physicians, 2012).
2
THE LOCAL CONTEXT
The Clinical Commissioning Groups (CCGs), the Local Authority and the Trust serve a relatively deprived population of 350,000 whose standardised mortality rate is 15% above the English average. Unemployment is twice the national average, one third of children live in one-parent families, over half the population is overweight or obese and take up of elective care is low.

Much of the local population has historically viewed the hospital as a first port of call during acute illness and A&E attendances and emergency admission rates are amongst the highest in England.

For the past decade, the acute hospitals and the former PCTs have focussed on organisational priorities at the expense of more joined-up collaborative working and with insufficient integration with social care. With the transition to new health and social care arrangements, the emergence of clinically led CCGs and the pre-eminent role of the new Health & Wellbeing Boards, there has been a transformational change in the local health and social care environment and a collective commitment to collaborative working that is already translating into improved health and social care for local people.

Against this backdrop the priorities for our NHS are clear and how they map to local health community and hospital strategic priorities is shown below:
Using Joint Strategic Needs Assessments (JSNAs) and extensive stakeholder engagement our community has identified local priorities to deliver NHS goals:

**St Helens H&WB Priorities**
1. Give every child the best start in life
2. Support young people
3. Tackle alcohol misuse
4. Tackle obesity & excess weight
5. Promote good mental health and wellbeing
6. Early detection and effective management of long term conditions
7. Reduce unnecessary hospital admissions
8. Support people with dementia

**St Helens CCG Priorities**
1. Early detection and effective management of long term conditions
2. Reduce unnecessary hospital admissions and readmissions
3. Reform of mental health services
4. Reform of urgent care services
5. Reform of integrated high quality community care
6. Development of sustainable high quality primary care services
7. Ensure delivery of evidence based care
8. Ensure all patients are treated with care and dignity

**Halton H&WB Priorities**
1. Prevention and early detection of cancer
2. Improved child development
3. Reduction in the number of falls in adults
4. Reduction in harm from alcohol
5. Prevention and early detection of mental health conditions

**Halton CCG Priorities**
1. Continuous improvement of the health and wellbeing of the people of Halton
2. Meaningful engagement with local people and communities
3. Clear and credible plans which continue to deliver improvements in local health services and the Quality, Innovation, Productivity and Prevention (QIPP) challenge within financial resources, in line with national outcome standards and the local Joint Health and Wellbeing Strategy (JHWS)
4. Ensure robust constitutional and governance arrangements, with the capacity and capability to deliver all our duties and responsibilities, including financial control, as well as effectively commissioning all the services for which we are responsible
5. Establish and sustain collaborative arrangements for commissioning with other CCGs, Halton Borough Council and the NHS Commissioning Board (NHS CB)
6. Appropriate, affordable and effective external commissioning support
7. Achieve and maintain authorisation without conditions from the NHS CB

**Knowsley H&WB Priorities**
1. People living longer, healthier lives in Knowsley, getting closer to national average and gap in average length of life closing within Knowsley
2. People are well prepared when choosing to become parents
3. Health conception, Pregnancy & Birth
4. Children are ready for school physically, emotionally and developmentally
5. Children make a positive transition between primary and secondary school
6. Young people have the skills and resources to make a positive transition to adulthood
7. Adults able to manage their own health & wellbeing and have a good quality of life
8. People are able to maintain independence for as long as possible
9. People are able to die with dignity and respect

**Knowsley CCG Priorities**
1. A better start in life
2. Increasing life expectancy
3. Reducing alcohol related harm
4. Unplanned care services
5. Mental health
6. Dementia
7. End of life care

**STHK Hospitals Clinical Priorities**
The goals of the Health and Wellbeing Boards, Clinical Commissioning Groups and STHK mirror the NHS Outcomes Framework. We share a common vision and hospital care typically starts and ends in the community with outcomes and experiences of inpatient and outpatient hospital care inextricably bound up in social care and the overarching community context.

<table>
<thead>
<tr>
<th>NHS Outcomes Framework</th>
<th>STHK High Level Aims</th>
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<tbody>
<tr>
<td>Prevent premature death</td>
<td>Safe, timely, highly effective, kind care</td>
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<td>Quality of life in longterm conditions</td>
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<td>Improve recovery from ill health</td>
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<td>Deliver positive patient experience</td>
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<tr>
<td>Provide safe and harm-free care</td>
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**STHK High Level Aims**
- Safe, timely, highly effective, kind care
3

CARE
SAFE CARE

“Do no harm and be kind”

Safety is our first concern. Our aim is to make our hospitals a safer place and to prevent harm and potential harm.

Our approach can be summarised in a DH 5-point plan:

1. Prevent problems
2. Detect problems quickly
3. Take prompt action when problems do occur
4. Ensure robust accountability
5. Ensure that staff are trained and motivated

We will use better information systems and sound judgement to share good practice and to identify care failure. Where we find poor care, we will acknowledge it swiftly and fully, we will apologise and we will tackle it. We will release our clinicians from the burden of unnecessary bureaucracy to allow them to focus on what's important – our patients; and we will promote a robust safety culture that does not tolerate avoidable harm.

Safety for our patients, carers (and staff) includes: safe (harm-free) care, preventing healthcare associated infections, falls, pressure ulcers, hospital acquired venous thromboembolic events and medication errors.

TIMELY CARE

“Right care, right time”

Contemporary society places emphasis on timeliness and expects its healthcare to be delivered promptly.

Where there is a tension between speed and safety or best health outcomes, we will be measured in our approach, but where we can we will strive to deliver care in a timely manner, whether that be initial assessment and investigation, admission to hospital or other treatment, an outpatient appointment or operation or discharge from hospital or clinic. Moreover, we will endeavour to communicate about care, planned and delivered in partnership with patients and carers, by timely and preferably electronic means.

HIGHLY EFFECTIVE CARE

Every patient is an individual and must receive care tailored to their individual needs and circumstances, but unnecessary variation leads to poor care.

Respecting the needs of the individual, we will increase standardisation of (inter)nationally recognised best quality, evidence-based care by strengthening our use of and adherence to NICE (and other) best practice guidance and Quality Standards. We will expect variance from these standards to be minimised and to be explained as a matter of course.

We will promote QIPP and we will work with commissioners and others to eliminate waste to ensure that we are able to deliver best quality, best value health outcome focussed care locally to local patients – ensuring that care is delivered by an appropriately trained, qualified and experienced clinician in the most appropriate setting.
KIND CARE

Much has been written in the Francis Report about a lack of kindness. Arguably, society’s preoccupation with individualism and a pressure to deliver a myriad of externally imposed and strenuously performance managed objectives at any cost has undermined kindness.

Kindness in times of ill health or stress (and indeed for fellow staff) is a basic human right and not something we dispense when we’re not too busy. We will promote a culture of kindness, not least through our ACE Behavioural Standards, and we will take steps to ensure that assessment for and of kindness forms part of the selection processes we use to appoint and promote our staff.

Kindness includes: listening to and working with our patients and carers to be more accessible and deliver best healthcare in partnership and in an environment of trust and mutual respect; it means being ever conscious of the impact of ill health and healthcare on quality of life for the individual and their loved ones and taking all available opportunities to understand and improve that quality of life; it means doing what we can to promote and improve basic care and dignity at every opportunity – ensuring patients have access to and can get food and drink (no more out of reach jugs of water or trays of food left before a frail elderly patient who cannot feed themselves) and responding immediately to requests for the toilet; it means better care for those with dementia and those who lack capacity; it also means better understanding and use of the Mental Capacity Act and Deprivation of Liberty arrangements, better safeguarding (for adults and children) and better care and support for patients nearing the end of their lives and their families and carers.

Strategy versus Operation

The detailed plans required to deliver our strategy (Clinical & Quality Action Plan) are described in a separate document informed by clinical teams at the coalface who are best able to operationalise plans within their departments and within their areas of clinical expertise. Unlike this Clinical and Quality Strategy which is informed by frontline staff and stakeholders (including users and carers) within and outside the organisation, but is led and owned by the Trust Board (with oversight from the NHS TDA and ultimately Monitor), the operational plan is ‘bottom-up’ and led and owned by clinicians and their departmental management colleagues at the healthcare interface with our patients.

Recognising Success

How will the Trust Board (and relevant external stakeholders, for example the NHS TDA/Monitor, NHS England and local commissioners) know it has achieved its strategic aims of safe, effective, timely, kind and health outcome focussed care?

The organisation already monitors and will continue to monitor many national, local and internal performance measures, including: national benchmarks, CQUIN, NHS R&D & CRN reports, complaints monitoring, serious untoward incidents and never events, patient and staff feedback, national, regional and local clinical audits, CAS alert monitoring, NCEPOD reports, QIPP monitoring, workforce metrics, NHSLA reporting, Deanery and trainee feedback, response to national reports, national safety thermometer, national quality dashboard and much more.

Our 4 key objectives (STHK: Safe, Timely Highly effective & Kind) will be tracked via 24 key performance indicators (KPIs).
Health care quality measurement has been described in three dimensions: structure, process and outcome with outcomes as the ultimate validators of the effectiveness and quality of clinical care. We would add ‘User & Carer Experience’ as a crucial fourth dimension: “Quality of Care is as important as Quality of Treatment.”

Our ‘Clinical & Quality Action Plan’ includes metrics related to structure and process because it is by having appropriate structures and processes in place that high quality evidence based effective outcomes and a positive user and carer experience are delivered, but for our high level strategy, outcomes and experience are our principal metrics.

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<tr>
<th>Our Vision</th>
<th>5-Star Care</th>
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<tr>
<td>Our Values</td>
<td>Compassion</td>
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<td>Communication</td>
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<td>Courage</td>
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<td>Competence</td>
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<td>Our Priorities</td>
<td>Safe</td>
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<td>Highly effective</td>
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<td>Kind</td>
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<td>Our Metrics</td>
<td>24 Key Performance Indicators</td>
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1. SAFE
- Prevent Harm
- Hospital acquired Infections
- No Never Events
- Grade 3/4 Pressure Ulcers
- VTE Assessments
- Medication Errors

2. TIMELY
- Elective Care
- A&E time to Assessment
- Cancelled Operations
- ICU Discharges
- eDischarge Summaries
- Cancer Care

3. HIGHLY EFFECTIVE
- Overall Mortality
- Weekend Mortality
- Avoidable Mortality
- Emergency Readmissions
- Consultant Care
- Standardised Care

4. KIND
- Friends & Family Test
- Embedded PPI
- Safeguarding
- Basic Care & Dignity
- Better Dementia Care
- Better End of Life Care
5-Star: Key Performance Indicators (KPIs)
1. Increase safe (harm-free) care
Metric: Safe (harm-free) care
Source: NHS Safety Thermometer
5yr Target: Increase mean to >99/100
Executive Lead: Director of Nursing, Midwifery & Governance

2. Reduce hospital acquired infections
Metric: MRSA & C.difficile
Source: Integrated Performance Report
5yr Target: Zero MRSA & C.diff <in-Year National Target
Executive Lead: Director of Nursing, Midwifery & Governance

3. Prevent Never Events
Metric: Never Events
Source: STEIS
5yr Target: Zero
Executive Lead: Medical Director

4. Reduce hospital acquired grade 3/4 pressure ulcers
Metric: Pressure ulcers
Source: Integrated performance report
5yr Target: Reduce avoidable to zero
Executive Lead: Director of Nursing, Midwifery & Governance

5. Increase VTE screening
Metric: VTE Assessments
Source: Integrated Performance Report
5yr Target: Increase to >98%
Executive Lead: Medical Director

6. Reduce medication errors
Metric: Prescribing errors causing serious harm
Source: Datix - monthly report by Pharmacy
5yr Target: Zero
Executive Lead: Medical Director

7. Improve timely Elective Care
Metric: 18-week Referral to Treatment
Source: Integrated Performance Report
5yr Target: Upper quartile performance in every speciality
Executive Lead: Director of Operations

8. Improve timely assessment
Metric: A&E time to first clinical assessment
Source: Integrated Performance Report
5yr Target: Median time to clinical assessment to 15 min

9. Improve timely treatment
Metric: % Cancelled Operations
Source: Integrated Performance Report
5yr Target: Reduce to ≤0.2%
Executive Lead: Director of Operations

10. Improve timely discharge
Metric: Delayed discharge from ICU
Source: ICNARC
5yr Target: ≥95% patients discharged from ICU ≤4 hr

11. Improve timely communication
Metric: eDischarge summary GP
Source: Integrated Performance Report
5yr Target: >95% discharge summaries dispatched ≤24 hr of IP discharge

12. Improve Cancer Care
Metric: Timely Cancer Care
Source: Integrated Performance Report
5yr Target: Upper quartile performance for all tumour groups
Executive Lead: Director of Operations
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<tr>
<td><strong>Metric</strong></td>
<td>SHMI</td>
<td><strong>Metric</strong></td>
<td>HSMR for patients admitted on Saturday &amp; Sunday</td>
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<tr>
<td><strong>Source</strong></td>
<td>National reporting system</td>
<td><strong>Source</strong></td>
<td>Dr Foster</td>
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<td><strong>Syr Target</strong></td>
<td>Reduce SHMI to &lt;1.0</td>
<td><strong>Syr Target</strong></td>
<td>Admitted-weekend HSMR = weekday HSMR</td>
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<td><strong>Executive Lead</strong></td>
<td>Medical Director</td>
<td><strong>Executive Lead</strong></td>
<td>Medical Director</td>
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<tr>
<th>17. Consultant care</th>
<th>18. Standardised Care</th>
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<tr>
<td><strong>Metric</strong></td>
<td>Consultant care</td>
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<tr>
<td><strong>Source</strong></td>
<td>Internal rotas &amp; job plans</td>
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<tr>
<td><strong>Syr Target</strong></td>
<td>Named consultant attending all acute wards 7/7</td>
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<td><strong>Executive Lead</strong></td>
<td>Medical Director</td>
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<tr>
<td><strong>Metric</strong></td>
<td>Friends &amp; Family Test</td>
<td><strong>Metric</strong></td>
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<tr>
<td><strong>Source</strong></td>
<td>Integrated Performance Report</td>
<td><strong>Source</strong></td>
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<tr>
<td><strong>Syr Target</strong></td>
<td>Better than national average performance</td>
<td><strong>Syr Target</strong></td>
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<td><strong>Executive Lead</strong></td>
<td>Director of Nursing, Midwifery &amp; Governance</td>
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<th>22. Basic Care &amp; Dignity</th>
<th>23. Better Dementia Care</th>
<th>24. Better End of Life Care</th>
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<tr>
<td><strong>Metric</strong></td>
<td>Food, Drink &amp; Toileting Questions</td>
<td><strong>Metric</strong></td>
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<tr>
<td><strong>Source</strong></td>
<td>Monthly Bespoke or National Questionnaire</td>
<td><strong>Source</strong></td>
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<tr>
<td><strong>Syr Target</strong></td>
<td>50% improvement at Yr 5 c.f. baseline</td>
<td><strong>Syr Target</strong></td>
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<tr>
<td><strong>Executive Lead</strong></td>
<td>Director of Nursing, Midwifery &amp; Governance</td>
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<th>Director of Nursing, Midwifery &amp; Governance</th>
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<tr>
<td><strong>Metric</strong></td>
<td>TBC nationally - successor to LCP</td>
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<tr>
<td><strong>Source</strong></td>
<td>Internal Report</td>
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<tr>
<td><strong>Syr Target</strong></td>
<td>Maintain or exceed evolving national target</td>
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<tr>
<td><strong>Executive Lead</strong></td>
<td>Director of Nursing, Midwifery &amp; Governance</td>
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6
MAJOR DRIVERS
The Trust Board believes the following major drivers will be pivotal to that Action Plan:

**Workforce**

**Information Management & Technology (IM&T)**

**Medicines Optimisation**

**Communication, Engagement & Working with Partners**

**Governance**

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**WORKFORCE**

- **Ward Nurse Staffing**
- **Annual Appraisal**
- **Mandatory Training**
- **7-day Consultant Working**
- **Annual Job Planning**
- **Staff Wellbeing & Attendance Management**

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**WORKFORCE**

Safe, effective inpatient and outpatient care and a positive experience are critically dependent on having the right numbers and balance of staff in the right place and doing the right things.

- **Ward Nurses**: major review of ward nurse staffing levels has suggested a need for more nurses and a different skill mix in some areas. Some details of this review are still to be finalised, but the Trust Board expects to make a significant investment in ward nurses to facilitate delivery of this strategy, not least through the Chief Nursing Officer’s (6Cs): care, compassion, commitment, competence, courage and good communication. It is likely following a fuller response from the government to the second Francis Report that there will also be significant changes to training, appraisal and revalidation of nurses.

- **7-day Consultant Working**: for decades inpatient hospital care has revolved around a model of care where activity is focussed on Mon-Fri, largely 8-6, not least because of reluctance on the part of the NHS as a whole to invest in more out of hours care. In recent years, society has changed, weekend working is increasingly the norm and public expectations of hospital care have shifted. In addition, recent evidence suggests that people admitted to hospital at the weekend (elective and non-elective) have higher subsequent mortality and weekend discharges are disproportionately low. For many years, consultants have worked at the weekend, but this work has largely been focussed on timely review of emergency admissions and not the routine care of existing inpatients on the wards. Our aim is to provide consultant care on all relevant wards 7-days per week and a consultant presence on the emergency assessment units 12-hours per day, seven days per week. To make this care effective will not only involve changes to consultant job plans and consultant expansion, but also an expansion of relevant supporting services. Increasingly, the hospital will function similarly at weekends to during the week.
IM&T developments are focused on delivering more effective information and real-time clinical systems capturing once and using many times to provide clinicians with improved tools for making informed decisions.

The current reliance on the EDMS Health Record for clinical information will shift to a structured Electronic Patient Record (EPR). EDMS will integrate into the core EPR systems and be superseded in many aspects by the use of real-time clinical systems such as order communications, eMEWs, ePrescribing, direct data entry/clinical decision support, and wrapped with a single sign on patient context Clinical Portal.

This will see a focus on integration, blurring the identities of individual systems and working toward providing a single, individually customisable environment, through which interaction with the information is achieved. Information of the highest quality is essential to providing high quality, efficient, effective, and safe patient care.

- **EDMS**: enhancements for structured direct entry of data at the point of care and eforms within EDMS starting with real-time data input in outpatient setting, and fully paperless outpatient clinic. - Integrate EDMS with key trust clinical systems, providing patient context. Enhance EDMS to support access via mobile devices.
• **e Communication:** improved electronic communications, within hospital, between hospitals, community and primary care professionals. Solutions include; Order Communications, ePrescribing, eReferrals, A&E summaries, eDischarge. This will move the correspondence elements of information exchange to an electronically communicated structured message. These systems will support significant improvements in timeliness, to real-time in some cases, between clinical stakeholders due to greater interoperability and agility of patient information.

• **e Prescribing system:** electronic ePrescribing system to replace existing manual process of recording a patients drug transactions on various paper forms with an electronically structured patient-centric record aids the choice, administration and supply of medicines through decision support and provides ‘real time’ electronic recording of medicines administration, clinical pharmacy and medicines management activities.

• **Mobile communications:** the integrated use of mobile devices, including the use of personal devices employees bring to work (BYOD), to improve access to information, digital communication and collaboration inside and outside the Trust via a strategy to minimise risk, increase productivity and accessibility of information. Uses a combination of Trust issued and user owned devices to guarantee access to personal communications.

• **e Modified Early Warning Scores (eMEWS) System:** undertake real-time electronic capture of clinical observations to provide comprehensive monitoring, including dashboards, review and audit with the automatic ability to notify patient deterioration based on pre-set triggers and escalate by automatically notifying the next level (team or individual) via a predetermined protocol. Enables capture of clinical observations and interactions. Data recorded electronically at the bedside on mobile devices.

• **Support Services:** to provide a service that is fit for purpose, that clearly understands and meets the definition, delivery and support of IM&T solutions in the context of mission critical 24/7 paperless clinical environment. Provide and ensure cost effective use of available resources and with these constraints ensure systems are fast and reliable, data is managed without loss and remedial activities are undertaken in a professional and timely way. A customer focused attitude is central to all activities which prioritises business continuity and security.

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**MEDICINES OPTIMISATION**

- ePrescribing & Medicines Administration
- 7-day Pharmacist Working
- Personalised Treatment
- Transfers of Care

• **e Prescribing & Medicines Administration:** current, paper-based systems for the prescription and administration of medicines are based on a model established in the NHS over 40 years ago. Since then medications have grown in number and
• complexity, with a resulting greater risk to patients. Electronic prescribing & medicines administration systems offer the opportunity to reduce clinical risk and also to enable innovations such as decision-support for prescribing and support for timely administration of medicines. To maximise this opportunity a robust infrastructure is essential to support the building of decision making rules, links to guidelines/pathways, maintenance of databases, reporting, audit etc. Evidence has emerged recently that a reduction in missed doses supported by an e prescribing system has correlated with reduction in patient mortality.

• 7 Day Pharmacist Working: to support comprehensive 7-day care of patients within the Trust it is necessary to provide suitably extended supply services and also clinical pharmacy services to wards. Historically, pharmacy services have been configured to provide full pharmaceutical care, including clinical pharmacy from Mon-Fri 8am to 6pm. Reduced service is provided at weekends, mostly restricted to dispensary/supply services. The importance of timely medicines reconciliation after inpatient admission is emphasised by NICE and the NPSA. Clinical pharmacy at weekends will reduce delays in correcting errors and omissions on prescriptions at weekends which would otherwise not be identified until the following Monday. Gaps in current weekday clinical pharmacy service to wards need to be addressed to ensure that there is a consistent minimum level of service to all inpatients.

• Personalised treatment: medicines optimisation is a more patient-focussed approach to getting the best from medicines. Focussed on the patient and their experience, it can help more patients take their medicines correctly, reduce waste of medicines, avoid patients taking unnecessary medicines and improve medicines safety. Ultimately it can help patients to take more ownership of their treatment. Clinical pharmacists will document when they have conducted a medicines optimisation review with each inpatient to identify and address issues raised e.g. needs blister pack, has problems opening medicines bottles, cannot swallow big tablets, cannot use inhaler correctly etc.

• Transfer of Care: the likelihood that an elderly medical patient will be discharged on the same medicines on which they were admitted is less than 10%. Adverse drug events occur in up to 20% of patients after discharge and it is estimated that 11-22% of hospitalisations for exacerbations of chronic disease are a direct result of non-compliance with medication. The risk of an adverse event post discharge has been reported at 4.4% for every drug alteration. Improving the transfer of information about medicines across all care settings will reduce avoidable harm to patients and medicines-related admissions & readmissions to hospital. The implementation of electronic discharge documentation is an important step forwards. However, there is a need to identify patients who will benefit from specific post-discharge follow-up. Pilot schemes such as the New Medicine Service (NMS) for community pharmacists offer a funded opportunity to provide this follow-up. Clinical pharmacists will utilise the opportunity to refer consenting patients for follow up under the NMS.
Patients & Carers: improved communication and engagement with patients and carers, including but not confined to improved patient & public involvement and engagement with the Governing Body, is critical to the successful achievement of the Trust Board’s strategic aims.

Board to Ward to Board: to deliver best quality evidence-based care, superior outcomes and the positive patient experience described in this Clinical & Quality Strategy requires exemplary communication between the Trust Board and workers at the front line, the ‘ward’. Not only must the Trust Board communicate its vision and the direction of travel to the ward, but the Trust Board must also be able to listen to, understand and act on in a timely manner feedback from the ‘ward’. Engagement from clinicians and others at the coalface is vital to strategic success.

Working with External Partners: this Clinical and Quality Strategy is underpinned by the belief that all relevant partners and organisations are striving for the same goals, encapsulated in the NHS Operating Framework and that organisation’s strategic and operational plans are local priorities to deliver our shared goals. To achieve our ultimate goals, we must work together and ensure that there is a tight fit between complementary organisational priorities; constant, effective communication and engagement between partners is critical.
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GOVERNANCE
In April 2013, the Trust Board approved modernisation of its Committee structure to enhance governance and facilitate its Foundation Trust application in a post-Francis NHS. The previous Governance Board is replaced with a Quality Committee and Councils reporting to this Quality Committee reflect Darzi’s domains of quality: Patient Safety Clinical Effectiveness, Patient Experience, and Workforce.

The Quality Committee and each council have revised Terms of Reference and Membership.

In addition there is a new Risk Council reporting to the Executive Group Meeting.

This section describes the rest of its governance structure to ensure there is a ‘golden thread’ running from ‘Board to Ward’ (delegation) and from Ward to Board (assurance) with robust arrangements to ensure that lessons learned in any part of the system are shared and enacted throughout the system.

Delegation, Sharing Lessons & Assurance

Using the Trust Board approved terms of reference (TORs) for the Quality Committee and each Council, and a list of all relevant quality & governance activities delegated by the Trust Board to its governance committees, activities were pragmatically re-mapped to the most appropriate Council to update an agenda for each council that reflects those activities for which it has delegated responsibility and must seek appropriate assurance; together with a bi-directional reporting structure for communicating delegated responsibilities, lessons learned and assurance as appropriate from Board (via the Quality Committee) to Ward (vertical - delegation) to Ward (horizontal - sharing lessons) to Board (vertical - assurance).

Applying the same principles, agendas from the Councils were then used to inform ‘core agenda items’ and ‘key performance indicators’ for Care Group Governance Meetings, Directorate Meetings and Ward Meetings respectively.

Quality Committee

Non Executive Director chair takes responsibility for reporting committee activities to the Trust Board (using a standardised reporting framework) i.e. although there are multiple common attendees, the NED is the critical link between QC and Trust Board.

Councils

Executive Director chair takes responsibility for reporting committee activities to the Quality Committee (using a standardised reporting framework) i.e. although there are multiple common attendees, the Executive Director is the critical link between Council and QC.
Care Group Governance meetings

Care Group Heads of Quality roles will in future be mirrored in each Care Group and will be focussed on ensuring robust delegation, assurance and lesson sharing at a Care Group level and with the Councils above and the Directorates/Wards below (in the old system there was substantial and unhelpful variation between the different Care Groups).

Although there are multiple common attendees, the Head of Quality is the critical link between the Council and the Care Group Governance meeting.

Matrons & Specialty Leads

Similarly, the roles of the Matron, which currently differs between Surgery and Medicine and have become more operationally focussed in recent years, will be harmonised and focussed primarily on the governance and quality agenda. Matrons will be present at both Care Group and Ward Meetings. Specialty leads perform a similar role between Care Group and Outpatient Specialty Teams i.e. although there are multiple common attendees, the Matron is the critical link between Care Group and the Wards and Specialty Lead is the critical link between the Care Group and outpatient based specialties e.g. Rheumatology.

Council Agendas & Reporting Structure

The section below specifies indicators and reports / activities that must be reviewed by the Quality Committee and Governance Councils to ensure the TOR approved by the Trust Board are delivered. A draft agenda for each group is included.

QUALITY COMMITTEE

Quality Indicators
- Integrated Performance Report (IPR) – all quality indicators in IPR should be reviewed by QC
- Quality Account goals
- Clinical & Quality Strategy Action Plan
- Nursing Strategy SMART Objectives

Reports to Quality Committee
- Care Group quality performance reports (using a standardised reporting framework)
- SUI RCAs and action plans
- Summary report from governance councils (using standardised framework) & escalation of issues from Governance Councils (council minutes available on request)
- NHSLA update
- CQC update
- MIAA governance reports and action plans

Other Functions of QC
- Acknowledge policies approved by Councils
- Escalate quality concerns to Trust Board
- Report back from Trust Board regarding quality issues (explicitly identify to Heads of Quality & Deputy Director of Nursing delegation’ of issues from Board to Ward)

Proposed Agenda Items
1. Review IPR (Quality) – monthly
2. Review SUI RCA & action plans monthly until closed
3. Feedback from Councils - Assurance, Escalation & Sharing Lessons – monthly
4. Feedback to Councils from Trust Board – Delegation, Escalation & Sharing Lessons - monthly
5. Note policies approved by councils - monthly
6. Quarterly:
   • NHSLA
   • CQC
   • MIAA
   • Quality Account goals
   • Clinical & Quality Strategy Action Plan
   • Nursing Strategy Action Plan
   • Reports from Care Groups

7. AOB

PATIENT SAFETY COUNCIL

Quality Indicators
   • VTE
   • HCAI
   • Falls
   • SUIs (inc. Never Events)
   • Incidents (trends)
   • Pressure Ulcers
   • Safeguarding
   • Safety Thermometer
   • CAS / Medicine alerts

Other Functions of Patient Safety Council
   • Chair to produce summary report for Quality Committee & identify issues to be escalated
   • Review & approve policies relating to safety and inform Quality Committee
   • Report back from Quality Committee & ensure messages/issues are fed back to care groups & department meetings
   • Review any other issues regarding safety that are raised at meeting

Proposed Agenda Items
1. Review Safety KPIs every month
2. Review CAS / medicines alerts every month
3. Review open SUI action plans every month
4. Identify safety issues to escalate to QC – every month
5. Feed back to council from QC and explicitly communicate to Heads of Quality / Care Group representative the key messages / lessons learned to be shared and disseminated across the Trust.
6. Policy approval - monthly
7. Quarterly:
   • Care Group safety reports (using a standardised reporting framework, care group, action plans & lessons learnt)
   • Claims
   • E4E
   • Blood transfusion
   • Decontamination
   • Medical devices
   • Tracheostomy steering group
   • Medicine management (inc controlled drugs)

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CLINICAL EFFECTIVENESS COUNCIL

Quality Indicators
• Mortality (SHMI & HSMR, including subgroups)
• Re-admission rates (including subgroups)
• AQ
• LOS
• Obstetric Trauma
• Stroke performance indices
• Dementia indices
• Medicines Management Indices
• A&E performance indices
• Outpatient indices
• Daycase indices

Reports to Clinical Effectiveness Council
• Care Group reports (using a standardised reporting framework, care group to report outline on all effectiveness indicators, action plans, trends & lessons learnt)
• NICE
• Clinical Audit
• NCEPOD reports
• Drug & Therapeutics committee (medicines management -effectiveness)
• Laboratory Performance
• Resuscitation Group
• MET Group
• Improving Outcomes Group
• Clinical Outcomes Group (CRAB)
• TARN
• ICNARC
• MINAP
• R&D
• Pathology Quality Group
• Organ Donation Group

Functions of Clinical Effectiveness Council
• Chair to produce summary report for Quality Committee & identify issues to be escalated
• Review & approve policies relating to clinical effectiveness and inform Quality Committee
• Report back from Quality Committee & ensure messages/issues are feeding back to care groups & department meetings
• Review any other issues regarding clinical effectiveness that are raised at meeting

Proposed Agenda Items
1. Review Effectiveness KPIs every month
2. Review IOG reports every month
3. Identify effectiveness issues to escalate to QC – every month
4. Feed back to council from QC and explicitly communicate to Heads of Quality / care group representative the key messages / lessons learned to be shared and disseminated across the Trust.
5. Policy approval - monthly
6. Quarterly:
   • Care Group effectiveness reports (using a standardised reporting framework, care group to report on all effectiveness KPIs, action plans, trends, lessons learnt)
   • NICE
   • Audit
   • NCEPOD
   • Drug & therapeutics committee
   • Laboratory Performance
   • Resuscitation Group
   • MET Group
   • Improving Outcomes Group
   • Clinical Outcomes Group
   • TARN
   • ICNARC
   • MINAP
PATIENT EXPERIENCE COUNCIL
Note: this council currently meets bimonthly but it is proposed this is moved to monthly

Quality Indicators
- F&FT
- HOSPEDIA Survey results
- Complaints
- PALS
- HEALTHWATCH reports

Other Reports to Patient Experience Council
- Care group reports (using a standardised reporting framework, care group to report all outline of experience indicators, trends, action plans & lessons learnt)
- National Inpatient Survey (yearly but need action plan)
- PLACE
- Learning disability pathway
- Housing Pathway Group
- Dignity Champions
- Mental Capacity Act
- Supported Discharge Steering Group
- Chaplaincy Group
- Volunteers Group
- Bereavement working group
- End of Life Steering Group
- Interpreter Meeting

Other Functions of Patient Experience Council
- Chair to produce summary report for Quality Committee & identify issues to be escalated
- Review & approve policies relating to patient experience and inform Quality Committee
- Report back from Quality Committee & ensure messages / issues are feeding back to care groups & department meetings
- Review any other issues regarding patient experience that are raised at meeting

Proposed Agenda Items
1. Review Experience KPIs – monthly
2. Review annual inpatient survey action plan – monthly
3. Identify experience issues to escalate to QC – every month
4. Feed back to council from QC and explicitly communicate to Heads of Quality /care group representative the key messages / lessons learned to be shared and disseminated across the Trust.
5. Policy approval - monthly
6. Quarterly:
   - Care Group experience reports (using a standardised reporting framework, care group to report on all experience KPIs, action plans, trends, lessons learnt)
   - PLACE
   - Learning disability pathway
   - Housing Pathway Group
   - Dignity Champions
   - Mental Capacity Act
   - Supported Discharge Steering Group
   - Chaplaincy Group
   - Volunteers Group
   - Bereavement working group
   - End of Life Steering Group
   - Interpreter Meeting
7. AOB

7. AOB

- R&D
- Pathology Quality Group
- Organ Donation Group
WORKFORCE COUNCIL

Quality Indicators
- Appraisal
- MT
- Sickness
- CRB
- Staff survey

Other Reports to Workforce Council
- Health & Safety / Non-clinical Risk Group
- L&D steering group
- Valuing our People Steering Group
- Clinical Education Board
- HR Policy Sub Group
- Equality & Diversity Steering Group
- Joint Negotiating Group
- Local Negotiating Group
- Lead Employer Group
- Medical Revalidation Steering Group
- Medical & Dental Professional Standards Group
- Nursing & Midwifery Professional Standards Group
- AHP Professional Standard Group

OTHER FUNCTIONS OF WORKFORCE COUNCIL
- Chair to produce summary report for Quality Committee & identify issues to be escalated
- Review & approve policies relating to workforce and inform Quality Committee
- Report back from Quality Committee & ensure messages / issues are fed back to Care Groups & department meetings
- Review any other issues regarding workforce that are raised at meeting

Proposed Agenda Items
1. Review Workforce KPIs monthly
2. Review annual staff survey action plan - monthly
3. Identify workforce issues to escalate to QC – monthly
4. Feed back to council from QC and explicitly communicate to Heads of Quality / Care Group representative the key messages / lessons learned to be shared and disseminated across the Trust.
5. Policy approval - monthly
6. Quarterly:
   - Care Group workforce reports (using standardised reporting framework, Care Groups to report on all workforce KPIs, action plans, trends, lessons learnt)
   - Health & safety group report
   - L&D group report
   - Value our People Steering Group
   - Clinical education group
   - HR policy group
   - Equality & Diversity group
   - JNCC, LNC, Lead employer Group
   - Medical revalidation Group
   - Professional standard Groups

CARE GROUP, DEPARTMENT & WARD AGENDAS
Ensuring Board to Ward (delegation) and Ward to Board (assurance) and Ward to Ward (horizontal) sharing of lessons requires conformity of governance meetings across Care Groups, wards and departments.

This necessitates each Care Group to have a core governance meeting responsible for monitoring and reporting key quality indicators and for ensuring sharing of lessons and consequent changes to practice. Likewise, wards and directorates must have the same set quality agenda items on their monthly meeting agendas. Agendas will specifically require groups at all levels to identify key lessons learned and sharing of these lessons. Pivotal to the success of the proposed governance structure are the roles of the Deputy Director of Nursing,
Heads of Quality and Matrons. They will be responsible for ensuring delegation, assurance and horizontal sharing of lessons and for providing evidence regarding this.

**Proposed Care Group, Ward & Department Governance Meeting Agenda Items**

It is recognised that not all items will be relevant to every meeting every month, but, having key quality indicators as set agenda items should keep teams and Care Groups focused on core Trust targets. For all domains it is expected that trends, actions taken and lessons learned will be discussed and disseminated.

**SAFETY**
- Falls
- Pressure Ulcers
- VTE
- HAIs
- Incidents
- Safeguarding

**EFFECTIVENESS**
- Mortality
- Re-admission
- LOS
- Audit
- National standards, benchmarking, NICE
- Other effectiveness indices relevant to the area (to be agreed with Head of Quality)

**EXPERIENCE**
- F&FT
- HOSPEDIA
- Complaints
- PALS

**WORKFORCE**
- Appraisal
- Sickness
- MT
- Other training compliance

**Core Agenda Items**
- Feed back by Head of Quality (Care Group meeting), matron (ward), other leads (departments) from governance councils and explicitly communicate to staff the key messages / lessons learned from councils to be shared and disseminated across the Trust. Actions to be taken to ensure lessons to be learned are disseminated must be agreed and logged.
- Any issues requiring upward delegation to either care group governance meeting or a governance council to be identified at each meeting and logged.

The ‘golden thread’ ensuring Board to Ward to Board delegation, assurance and sharing of lessons is thus ensured by overlap between key individuals and common agenda items and reporting systems at every layer of the structure, linking the layer above to the layer below. Horizontal sharing of lessons is explicit at each relevant layer. Details of these arrangements can be found in the Integrated Governance and Risk Management Framework.

- Trust governance structure and function has just undergone a major overhaul with improved delegation and assurance; some fine tuning of this system continues. There is a recognition that the new structures must be piloted, stress-tested and reviewed in the months ahead to ensure that the enhanced arrangements are fit for purpose and capable of delivering and supporting this Clinical & Quality Strategy.
Informed by the NHS Operating Framework, local Health & Wellbeing Strategies and the Strategic Commissioning Priorities of our CCGs, the Trust Clinical & Quality Strategy defines hospital priorities to deliver the local Health & Social Care agenda.

The Clinical & Quality Action Plan describes in detail how the Clinical & Quality Strategy will be operationalised, how goals will be realised and performance towards these goals monitored and managed.

The Integrated Business Plan describes how the hospital Trust working with external partners will co-organise, co-develop and co-build its service to create a platform for delivering the Clinical Strategy and its associated Action Plan. It will describe investment in prevention, realisation of opportunities to invest and expand areas for reconfiguration and consolidation and areas for disinvestment.

The longterm financial model provides assurance that the IBP is underpinned by sound medium to longterm financial planning necessary to provide the resources to deliver the Clinical Strategy.
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STAKEHOLDERS

St Helens & Knowsley Teaching Hospital Trust Board and its Executive Team gratefully acknowledge the following stakeholders who were consulted and/or contributed directly or indirectly to the development of this Clinical & Quality Strategy.

Local people, most notably, (in alphabetical order):
- AQuA
- Governance Committees
- Halton Clinical Commissioning Group
- Halton Health & Wellbeing Board
- Halton, St Helens & Knowsley Strategic Partnership Board
- Halton & St Helens Voluntary & Community Action
- Knowsley Clinical Commissioning Group
- Knowsley Health & Wellbeing Board
- Selected former Hospital Governors
- St Helens Clinical Commissioning Group
- St Helens Health & Wellbeing Board
- St Helens & Knowsley Teaching Hospitals NHS Trust:
  - Clinical Directors & Consultants
  - Clinical Matrons
  - Ward Managers & Ward Teams
  - Care Group Heads of Governance &
  - Head of Pharmacy
  - Director of Infection Prevention & Control
  - Informatics Team
- St Helens Local Authority, Social Care & Health
- St Helens Local Involvement Network (LINKs)

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