St Helens and Knowsley Teaching Hospitals NHS Trust

# STHK Clinical & Quality Strategy


## April 2018-2021

## Acknowledgement

We are particularly grateful to external partners who were consulted in the development of this strategy: St Helens GP Federation & St Helens CCG, Halton CCG, Knowsley CCG, Healthwatch St Helens, Healthwatch Halton, Healthwatch Knowsley, Halton GP Federation, Halton Heath & Wellbeing Board, Knowsley Health & Wellbeing Board, Alder Hey Children's Hospital, Aintree University Hospitals, Liverpool Heart & Chest Hospital, Northwest Boroughs Partnership, Royal Liverpool & Broadgreen University Hospitals, Southport & Ormskirk Hospitals, Warrington & Halton Hospitals and the Cheshire & Merseyside Health & Care Partnership (STP). We would like to offer particular thanks to the following people who gave up their time to contribute: Councillor Derek Long, Leader of St Helens Council, David Fillingham and colleagues from AQuA, Stephen Brown on behalf of NHSI, Dr Kieran Murphy on behalf of NHSE, David Valentine, Medical Director of Bridgewater Community Healthcare, Brian Finney patient representative, Sarah James, patient representative, the group that included: inpatients, outpatients, visitors, parent & toddler groups, community café, Dementia friends & carers; and many STHK staff.

## Executive Summary

In 2012/13, after extensive consultation with a wide range of stakeholders, St Helens & Knowsley Teaching Hospitals NHS Trust (**STHK**) Board launched its 5-year clinical & quality strategy.

The strategy proved to be highly successful, with sustained clinical and financial achievement, a transformed relationship with our lead commissioner and a plethora of national awards. Whilst emergency access has proved challenging, we have consistently achieved national performance targets, including referral to treatment targets and national cancer targets (best in England at the time of writing).

Not only was STHK care rated Outstanding by Care Quality Commission (CQC) and patient experience rated the best in the NHS, but the organisation was rated a top 100 employer by the Health Service Journal, best in the NHS on every domain of the 2017 Patient Led Assessment of Care & Environment (PLACE) and top NHS Staff Survey results 2018, but more importantly, safety and clinical outcomes improved, health inequalities narrowed and healthcare experience was excellent.

The health and care environment is changing rapidly. Sustainability & transformation partnerships have emerged, integrated care systems offer contiguous local health and social care; and integration with and of providers offers an opportunity to tackle the twin challenges of demand and clinical & financial sustainability.

Locally, deprivation, unemployment, smoking, drug and alcohol misuse remain high, health outcomes are still poor relative to more affluent areas, health inequalities

persist and emergency attendances and admissions to hospital are amongst the highest in England.

Much has been achieved……. but much remains to be achieved.

There is consensus within our local community that it is only by working together towards our common goals that we will achieve health & wellbeing for our public.

At STHK, our aspiration is simple: to provide best quality (5-star) patient care.

## Aim

The aim of this Clinical Strategy is to promote a culture of continuous value improvement, underpinned by robust systems and processes and individual and collective accountability.

## Ownership

The Clinical Strategy is held by the Board, but co-created and co-owned with our workforce and our external partners. It informs and is informed by local plans and our broader collective strategic goals. The Board is clear: sustainable safety and value, good health outcomes and a positive healthcare experience remain our priorities and underpin all trust activities.

## Background

For much of the last decade, the NHS has focussed successfully on continuous quality improvement – and rightly so. The NHS has to manage a widening gap between cost and income and we believe the time has come to draw greater attention to the concept of ***value*** (where value = quality/cost). Quality must improve, but we must be mindful of cost. Our approach will be to continue to drive quality improvement but simultaneously clinicians and managers will focus more attention on efficiency and productivity; our aim is to shift the dialogue to '*continuous value improvement*' without detriment to patient experience, to make best use of limited resources to enhance the health and wellbeing of local people. Quality must be safeguarded, however, and we will remain vigilant and never allow normalisation of poor care or outcomes despite the NHS financial challenge.

Informed by work with Institute for Health Improvement (IHI), our last Clinical & Quality Strategy focussed on 20 or so key performance indicators that were surrogates for the quality improvement we sought (and achieved). The present strategy focusses more on promoting and developing our underpinning vision, our culture, distributed leadership for improvement at every level and the capability,

behaviours, systems, processes and accountability that are the hallmark of successful organisations.

We are describing a transition from improvement projects to an embedded culture of improvement; from our central QI team (that ensures that we employ a relatively consistent, systematic and structured approach to quality improvement) to alignment of the aspirations, behaviours and approach of *all* of our staff to our value improvement agenda. Though both are important, we transition from prioritising our compliance dashboard (how we compare to others) to our transformation dashboard (are we on track to deliver our aims).

We will we accelerate transformation of our culture by *demonstrating* our priorities (actions speak louder than words): what gets board attention and reward; how are we are seen to react to critical incidents, complaints, litigation and organisational crises; how are we're seen to prioritise resources (and praise), role modelling, teaching, coaching and what we're seen to prioritise when we recruit and promote.

We will take a fresh look at our systems of governance that have served us well since their refresh in 2012; we will strengthen the golden thread of assurance and delegation board to ward to board and refresh the work plan for councils and groups, with enhanced focus on evidence of action beyond the committee level; our minutes will continue their transition from 'aide memoire' to 'assurance audit trail'.

Our organisation and the health and social care economy in which it sits have matured and so must our approach to our Clinical Strategy.

We have appointed some 5000 quality leads because every member of the organisation from the car park attendant to the chief executive is responsible for co-delivering our 5-star vision.

## 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 struggled to keep pace with the needs of an ageing population, the changing burden of disease and rising patient and public expectation.

NHS health outcomes are the best they've ever been, but national performance targets are not being met, cancer outcomes can be improved; inequalities persist, workforce planning needs to improve and there are very major clinical and financial sustainability challenges.

As a self-critical, learning and sharing organisation, the NHS still has much to improve.

## The Local Context

The CCGs, the Local Authorities (LAs) and the Trust serve a relatively deprived population of some 360,000 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.

In recent years, CCGs, LAs and Trusts have increasingly worked collaboratively to break down organisational barriers that hamper timely, efficient and effective care and instead offer an increasingly integrated health and care system focussed on prevention, timely intervention and care closer to home.

## Joint Strategic Needs Assessments (JSNAs) and stakeholder engagement

Our JSNAs and extensive stakeholder engagement prioritise improved life expectancy and better health by:

- giving every child the best start in life
- better supporting young people
- tackling obesity, smoking and alcohol-related harm
- detection and effective intervention in mental health problems, including dementia and parity of esteem for mental health problems.
- prevention, early detection and effective management of long-term conditions
- prevention, early detection and effective management of cancer
- increasing physical activity and building community resilience
- better unplanned care, with a ‘left-shift’ to improve timeliness of local care delivery and prevention of unnecessary hospital attendance and admission
- better end of life care

## Clinical priorities

From the JSNAs come our clinical priorities:

- safe and harm-free care
- improved health and quality of life
- prevention of premature ill-health and death
- improved recovery from ill-health
- a positive patient/user experience
- Clinical & financial sustainability

## Implementation of Clinical Priorities

The goals of the Peoples Board, 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.

| | |
|---|---|
| **STHK Vision** | 5-Star Care |
| **STHK Values** | Kind & Compassionate, Respectful & Considerate, Listening & Learning, Friendly & Welcoming, Open & Honest |
| **STHK** | Safe, Timely, Healthy, Kind |

## SAFE CARE

Safety is our first concern. Our aim is to make our hospital a safer place and to prevent harm and potential harm. Indeed, during our consultation NHSI proposed that we aim to be the safest hospital in England. We accept this challenge.

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

1. Prevent problems
2. Detect problems quickly and be open about them
3. Take prompt action when problems occur
4. Ensure robust accountability
5. Ensure staff share and learn and 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 attempts to eliminate 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

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.

## HEALTHY

Every patient is an individual and should receive care tailored to their individual needs and circumstances, but unwarranted 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 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.

We will promote good health and prioritise wellbeing and prevention wherever we can.

## 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.

**Realising the STHK 5* Vision: Our 10 Priorities**

1. We will continue to build on our ambition to ensure that every patient contact, including end of life care, results in a 5* experience, best possible outcomes and best value.

2. We will continue to value our staff, not only by rigorously adhering to our ACE behavioural standards ('An ACE Place to Work'), but also by prioritising learning and development (including new ways of learning). We will actively promote retention and timely succession planning, aligned to the Trust's strategic direction. We are already a top 100 employer; can we become a top 10 employer?

3. Horizontal Integration: we will work with and within our STP to transform the Merseyside & Cheshire Health & Care environment to one that is clinically and financially sustainable and free from unwarranted variation and health inequality without compromising our 5* aspirations.

4. Vertical Integration: we will collaborate with commissioners and other local health and care partners, most notably stronger collaboration & partnership with patients & public, families & carers and the 3rd Sector to realise our collective vision of an integrated, PLACE-based system that prioritises prevention, supports self-care and offers timely intervention and value for money.

5. We will review and refresh our structure and systems of governance to embrace our widening responsibilities within our local health and care community, to refresh its purpose and to strengthen the golden thread

between board and ward….clinic…. community care setting…. and primary care practice.

6. We will refresh and systematise learning and sharing from deaths, near-misses, serious incidents, complaints, litigation….and good practice across our wider footprint (and beyond).

7. We will simultaneously strengthen our culture of openness and candour that promotes learning and quality improvement with a greater focus on individual and collective accountability that helps learning embed and achieve traction.

8. We will strengthen our systems for patient and public engagement, stakeholder involvement and public accountability.

9. We will increase, celebrate and capitalise on diversity within our workforce and within our workplace, whilst simultaneously eliminating unwarranted variation to improve the richness of our offer and the consistency of our experience and outcomes.

10. We will ensure that our care environment remains the best the NHS can offer and that our buildings, equipment and facilities enable our staff to realise our collective 5* culture.

## Recognising Success

How will the Board (and relevant external stakeholders, for example the NHSI, NHSE and local elected representatives and commissioners) know STHK has achieved its strategic priorities?

The organisation already monitors (and is monitored on) 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, HENW, GMC and trainee feedback, response to national reports, national safety thermometer and much more within the integrated performance report and is held to account by local commissioners and health and social care partners (including the People's Board) and national regulators.

## SMART Assessment

Each year, working with the Executive Directors and the Board, the Deputy Medical Director, Deputy Director of Nursing, Deputy Director of HR and Deputy Director of Operations will draw up a **SMART action plan** with KPIs that will be monitored by Quality Committee for the Board.

**Timetable for Implementation**

| Action | Lead | Comments | Status |
|---|---|---|---|
| Write first draft of revised strategy for presentation to Exec Dirs by 10/5/18. | **MD** | Shared by email 10/5/18. | |
| Comments from Exec Directors collated by CEO by 17/5/18 | **CEO** | Bulleted list for MD to be emailed by CEO by 17/5/18. Nil received exc from DoF. | |
| Create 2nd draft of revised strategy incorporating comments by 24/5/18 | **MD** | Feedback from DOF incorporated. | |
| Share 2nd draft with external stakeholders by 30/5/18 for comments (2 week turnaround). | **MD** | 2nd draft shared via email. | |
| Create 3rd draft of revised strategy incorporating comments by 20/6/18 | **MD** | | |
| Final draft of revised strategy to Board 27/6/18 | **CEO** | MD on A/L. On agenda√ **Approved** | |
| Final version of Strategy incorporating Board comments by 4/7/18 shared with 4 deputies. | **MD** | | |
| DMD, DDoN, DDoOps, DDirHR to draw up 2018-19 Action Plan and present to Exec Committee 2/8/18 | **DDoN** | | |
| Quarterly Reports to Quality Committee, starting 11/18. | **DDoN** | | |
| Annual Board Update, March 2019. | **MD** | | |