Excellent, lifelong, integrated care

Southport & Ormskirk Hospital NHS Trust

Quality Improvement Strategy 2016-2019

An integrated care organisation

WHAT DO WE WANT TO ACCOMPLISH?

This strategy will build on the work outlined in the Trust's previous quality strategy and will focus attention on projects that will reduce harm and mortality, improve patient and staff experience and make the care we deliver to our patients more reliable and grounded in evidence based care.

We will do this by delivering a programme of quality improvement projects which will help staff make changes to ensure that we provide high quality, personal care to every patient, every time. Our efforts will be focused on a targeted portfolio of projects which we believe will have a significant impact on unintentional harm and mortality.

These projects are described in the document, as are the measures we will use to determine the success of the programme of projects.

We predict that this programme of work will help us to achieve significant improvements in clinical quality over the next three years, will build on the strengths of the organisation, improving both patient and staff experience.

We will need to learn and embed a range of quality improvement methods at all levels within the organisation and our clinicians and managers will have to demonstrate a determination to stick to this agenda despite internal and external challenges. We aim to create a culture within the organisation where quality improvement becomes second nature.

Our goal is to become an organisation in which every member understands their role in delivering clinical quality, learns from the experience of others and feels empowered to act to drive improvements and works towards that goal every day.

Simon Featherstone
Director of Nursing and Quality

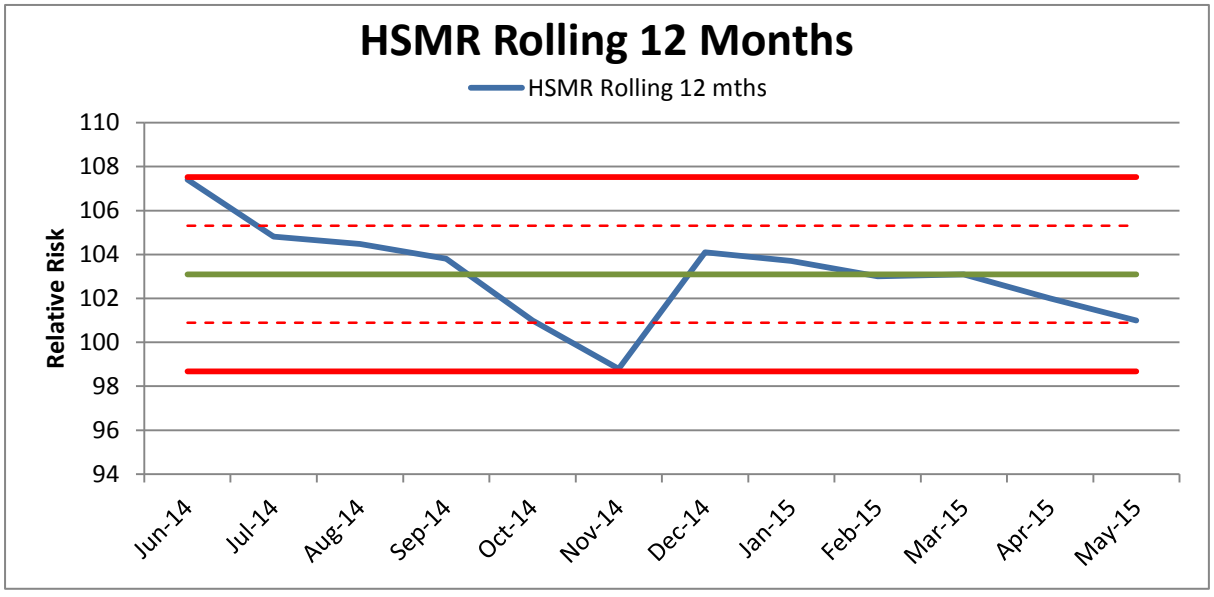
MORTALITY

REDUCING HOSPITAL MORTALITY (risk adjusted mortality)

Hospital mortality will remain one of the prime drivers of the strategy. Hospital mortality refers to the number of patients who die in hospital, however because every patient admitted to hospital with the same condition does not have the same risk of death, observed mortality rates alone are not a good means of comparing the quality of care delivered by different hospitals. For example, it would be surprising if a healthy 60 year-old patient died following hip replacement surgery. In contrast, it would be less surprising if a 93 year-old patient with multiple health problems died following that same surgery (Mayo Clinic 2001-2011).

HSMR compares an organisation's actual number of deaths with their expected (or predicted) number of deaths. The prediction calculation takes into account factors such as the age and sex of patients, their diagnosis and whether the admission was planned or an emergency. Standardisation of the ratio allows valid comparisons between different hospitals and their different populations. A HSMR above 100 means that more patients died than would be expected; a HSMR below 100 means that fewer patients died than was expected.

Fig 1



Through a number of workstreams, Southport & Ormskirk Hospital Trust has been working hard to reduce HSMR over the last three years and as can be seen in fig 1 above, this has seen a gradual reduction in the figure for the Trust. The work included in this strategy aims to see this figure reduce further and this strategy sets out a proposed trajectory for improvement which will see the organisation deliver improvements year-on-year over the next three years.

HSMR Trajectory Targets 2016 - 19

Date	2016-17	2017-18	2018-19
12 Month Rolling HSMR Target	100	98	95

The trajectory set will see an annual 2-3 point reduction in 12 month rolling HSMR from the current Q4 position in 2015-16 to a position in 2018-19 which would move the Trust's benchmarked position for HSMR in all acute Trusts from the current bottom 40% performance to top 30% performance.*

**It should be noted that however as we and others improve, the baseline will also change because of these improvements.*

To achieve this reduction in HSMR, the focus of work in the first year of the strategy will be to reduce mortality linked to pneumonia, which currently has the highest condition-specific HSMR within the organisation. The focus on pneumonia will address a condition where the volume of patients is high and mortality is significant. Additionally, there is significant evidence to support what is optimal care.

The work on pneumonia in the first year of the strategy and will use the IHI Breakthrough series Collaborative model, with a strong focus on improving the reliability of care delivered to patients with pneumonia. The current patient safety collaborative on the deteriorating patient will be extended and refocused to address this issue, with the use of a proxy outcome of cardiac arrests.

The work currently underway on sepsis and our ability to recognise and appropriately respond to patients with sepsis will continue throughout the life of this strategy and we will aim for 95% compliance with the sepsis bundle by March 2017. Current performance against the sepsis bundle indicates that this would represent a 24% improvement in compliance.

MORTALITY REVIEW PROCESS

The ability to review and gain learning from all hospital deaths is recognised as having significant benefit in terms of our understanding of improvement needs. Currently the mortality review process covers a relatively small proportion of the patients who die within the Trust. This process will be refreshed and relaunched as part of this strategy to ensure that the notes of all patients who die whilst receiving care at the Trust are reviewed within two weeks of notification of death. This will enable us to gather information which will help us to better understand our processes and practices and improve the care we deliver.

TARGET: 100% of patient deaths reviewed within two weeks by October 2016.

This is recognised as best practice within the NHS and will bring the Trust into line with a number of Trusts regionally and nationally.

REDUCING HARM

WHAT DO WE MEAN BY HARM?

Hospital acquired infections, medication errors, surgical infections, pressure sores and other complications are examples of harm which are commonplace. Despite the extraordinary hard work of healthcare professionals, patients are harmed in hospitals every day. Fortunately catastrophic events are rare but we must acknowledge that unintentionally a significant number of our patients experience some harm.

Harm within a healthcare setting is defined in many ways but the common belief is that harm is 'unintended injury resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice) that requires additional monitoring, treatment or extended stay in hospital'.

Simply, this is suboptimal care which reaches the patient either because of something we shouldn't have done or we didn't do something that we should have done.

MEASURING HARM

Traditional efforts to detect harm have focused on voluntary reporting and tracking of 'adverse events'. However, research has shown that only 10 to 20 percent of errors are reported through adverse event reporting systems and, of those, 90 to 95 percent cause no harm to patients. We have some understanding of where unintentional harm occurs, through our examination of adverse events, however we need a more effective way to identify events that do cause unintentional harm to patients, in order to select and test changes to reduce harm.

This strategy proposes that we use the NHS Acute Trigger Tool, an online casenote review system, to accurately identify unintentional harmful events. This tool is used by clinical auditors within the organisation to review a randomly selected set of patients' records. The review identifies 'triggers' or clues as to whether an adverse (sub optimal) event has occurred and whether this actually caused the patient any harm. Harmful events are then categorised as to the extent of harm.

By examining 20 randomly selected clinical records per month, for a three month period, using the IHI Global Trigger Tool we will be able to demonstrate a baseline adverse event rate. From this we will be able to set realistic annual reduction targets to achieve an overall harm reduction target over the next three years.

NHS SAFETY THERMOMETER

In addition to the use of the NHS Acute Trigger Tool to identify currently unrecognised harm, the Trust will use data gathered through the use of the Safety Thermometer tool developed by the Department of Health. The Safety Thermometer was designed in order to detect and track harm over time and gathers data on four

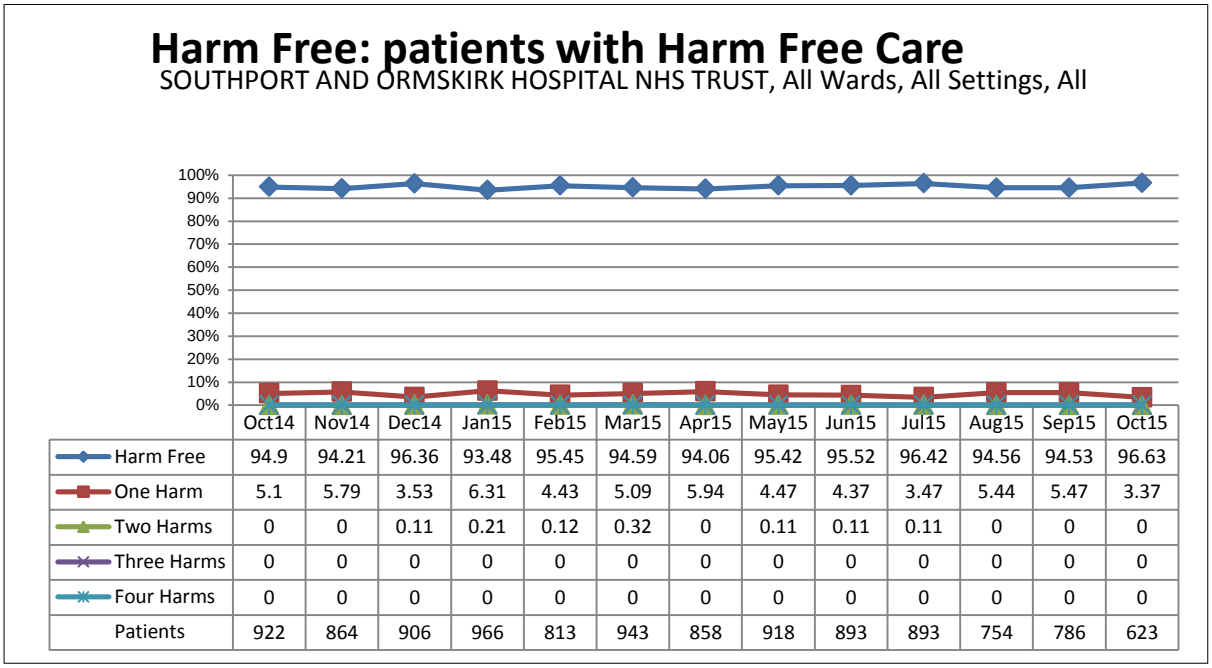
areas of harm on all patients within the organisation on a designated day every month. The specific harms monitored using this tool are pressure ulcers, falls, catheter associated urinary tract infections and venous thromboembolism.

Safety Thermometer data has been collected across the Trust for a number of years by a small number of senior nurses. This data collection has recently transferred to senior ward-based nurses and as such, applies a consistent approach to the identification of harm as well as embedding a greater perceived ownership of the causes of harm at a local level.

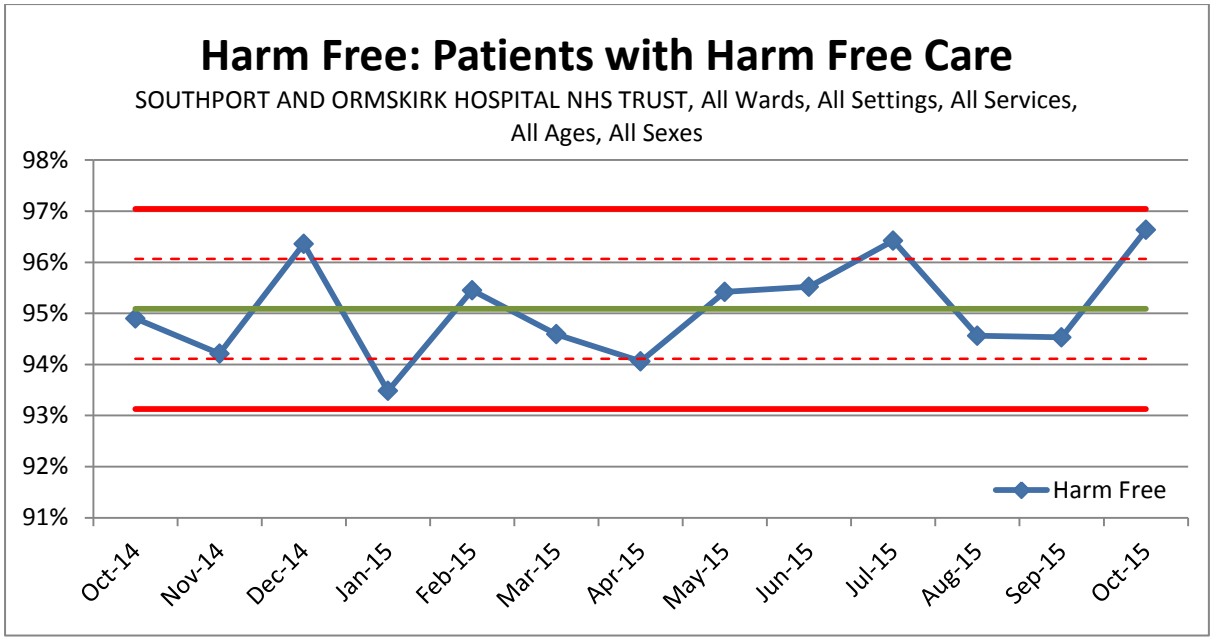
As well as measuring harm from the four individual named harms, the Safety Thermometer also measures the percentage of patients that received 'harm free care' – defined by the absence of harm from all four of the measured harms. The current Trust target for Harm Free Care is 95%, which is consistently achieved, and this will be increased to 98%from the launch of this strategy. Our current performance in respect of harm free care can be seen below.

TARGET: 98% of patients unharmed from pressure ulcers, catheter associated urinary tract infection, venous thromboembolism and falls by March 2017

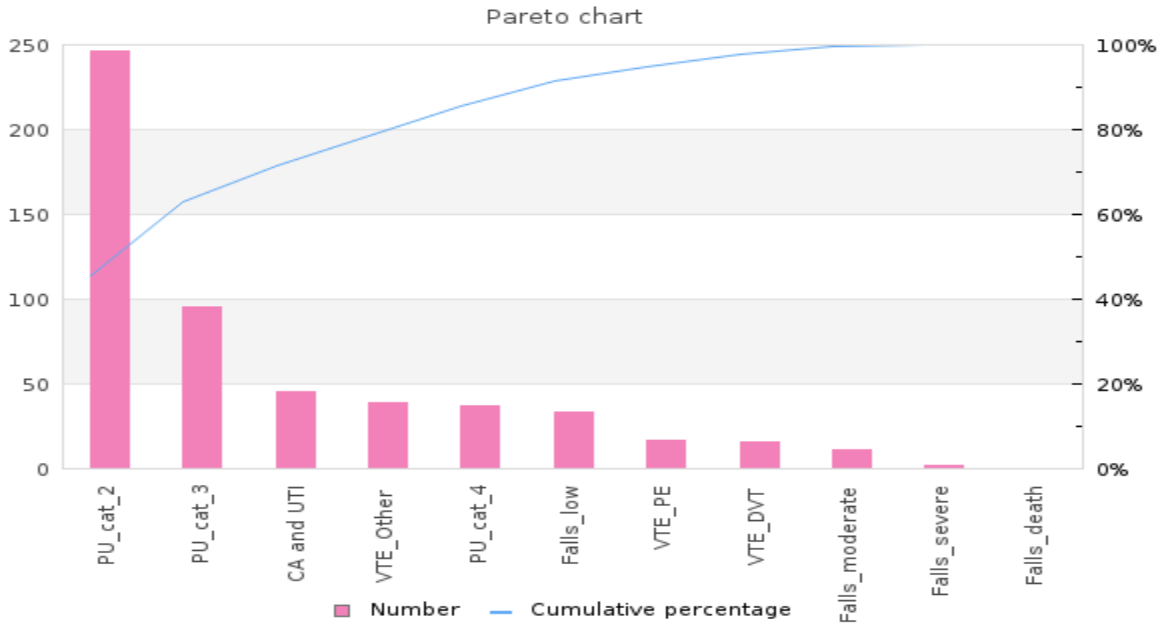
This represents 3% target increase for the Trust and will match best practice within the NHS



	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15
Harm Free	94.9	94.21	96.36	93.48	95.45	94.59	94.06	95.42	95.52	96.42	94.56	94.53	96.63
One Harm	5.1	5.79	3.53	6.31	4.43	5.09	5.94	4.47	4.37	3.47	5.44	5.47	3.37
Two Harms	0	0	0.11	0.21	0.12	0.32	0	0.11	0.11	0.11	0	0	0
Three Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	922	864	906	966	813	943	858	918	893	893	754	786	623



The pareto chart of the safety thermometer harms indicates the relative degree of harm from the four key harms measured by the national safety thermometer and this will be used to determine the order of focus on harm during the three years of this strategy. It can be seen from the chart that pressure ulcers have the greatest harm impact on patients receiving care from the Trust, followed by catheter associated urinary tract infections, venous thromboembolism and falls.



WHAT WILL DRIVE CHANGE?

The improvements we seek will not happen by themselves. The key outcomes of the strategy (reducing mortality and avoidable harm and improving patient and staff satisfaction) will be facilitated through the four key, interdependent drivers of: Quality Initiatives, Measurement, Workforce Capability and Leadership and Culture.

QUALITY INITIATIVES

The quality improvement project in this strategy will focus on key identified areas. These areas will form the mainstay of the quality improvement work over the next three years, but will be augmented as the organisation, through the work of the Acute Trigger Tool, develops a greater understanding of factors which contribute to patient harm.

The initiatives to reduce harm will be approached in two phases, driven by priority and available resource within the organisation. Reducing the HSMR for the Trust will be a priority in phase 1, alongside harm from pressure ulcers and the ongoing work on improving the Trust's response to sepsis. The two quality improvement phases, the rationale for inclusion and associated targets are set out below.

PHASE 1 PROJECTS 2016-2018

Reducing Mortality from Pneumonia

Why: Pneumonia currently has the highest condition-specific HSMR within the organisation at 124.24. This places the Trust 134th out of 137 acute Trusts nationally. The focus on pneumonia will address a condition where the volume of patients is relatively high and mortality is significant. Additionally, there is significant evidence to support what is optimal care.

How: The project will be executed through a Breakthrough series Collaborative approach. The current patient safety collaborative on the deteriorating patient which commenced in July 2015 will be extended and refocused to address this issue, with the continued use of a proxy outcome of cardiac arrests.

Target: Reduction in cardiac arrest rate by 50% by December 2017

Reducing Harm from Pressure Ulcers

Why: Pressure ulcers constitute the highest level of harm to patients within the Trust, both in the community and acute setting. Although some pressure ulcers are inevitable we know from our own investigations that many can be avoided. Pressure ulcers have a negative impact on the quality of life for our patients; they are

unpleasant to live with and can be very painful and the Trust is committed to reducing this harm.

Pareto analysis indicates that harm from pressure ulcers is the most significant of the safety thermometer harms within the Trust.

How: The project will be executed through a Breakthrough series Collaborative approach. The patient safety collaborative focused on pressure ulcers commenced in July 2015 and will conclude in April 2016.

Target: By July 2016, Community –reduction in grade 2 pressure ulcers by 30%; Acute – reduction in grade 2 pressure ulcers by 25%; elimination of grade 3 and 4 pressure ulcers across the Trust.

Improved Reliability with Sepsis

Why: The UK Sepsis Trust notes that in the United Kingdom alone, around 37,000 patients die each year from sepsis. To put this into perspective, this means that more people die annually from sepsis than from lung cancer, or from bowel cancer and breast cancer combined. Reliable early delivery of basic aspects of care has been demonstrated to significantly reduce mortality significantly and the United Kingdom Sepsis Trust has developed the concept of a sepsis bundle- a set of tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring- to be instituted within designated times following admission by non-specialist practitioners at the front line.

The delivery of the Sepsis bundle has been demonstrated nationally to reduce the risk of death from 44 percent in the non-compliant group to just 20 percent.

How: The Trust has had a multi-disciplinary sepsis task and finish group in place since March 2015 and is working towards improved reliability in the delivery of the sepsis bundle. Current performance against the sepsis bundle for Q3 2015 is 69.1% against all aspects of the bundle.

Target: 95% reliability with all aspects of the sepsis bundle by March 2017.

PHASE 2 PROJECTS 2017 – 2019

The timetable for phase 2 projects will be submitted for Board approval in 2016.

Catheter Related Urinary Tract Infections

Why: Nationally, catheter associated urinary tract infection (CAUTI) is the most common hospital acquired infection and is believed to account for up to 40% of all cases. Left untreated the infection can lead to urosepsis and death. The Trust

currently monitors catheter insertion as well as episodes of catheter associated urinary tract infections and cases of urosepsis, however confidence around the data is limited. Work is ongoing to ensure compliance with NICE guidance on catheter insertion and the Trust will run a patient safety collaborative focused on catheter associated UTI in 2016.

How: We will work with specialist medical, nursing and other colleagues to ensure the data are reliable and to build the project plan and measurement systems. This work will take place during 2016 to allow us to commence a collaborative in 2017.

Target: The targets around CAUTI will be developed once the Trust's benchmarked position is confirmed and will be submitted to the Board for approval prior to the commencement of the collaborative.

Medicines Management

Why: Medication errors account for a significant portion of the harm that exists in healthcare. The work around improving our systems and processes around medicines management will focus on three key areas:

1. High risk medications; Medications such as anticoagulants, insulin and opiates are known to place patients at particularly high risk and we will focus on the administration and use of these three high risk medications.
2. Known allergies and prescribing, with a specific focus on penicillin based antibiotics. The Trust experiences a number of incidents every year relating to the prescribing of penicillin based antibiotics to patients with a known penicillin allergy.
3. Medicines reconciliation; medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. In the acute setting, NICE guidance indicates that medicines reconciliation should take place within 24 hours of admission and the Trust compliance with this is currently approximately 85% Monday to Friday, but lower for weekend admissions.

How: We will work with pharmacy, medical and nursing colleagues to design data collection tools, capture baseline data and build a project plan and measurement system.

Target: The targets around medicines management will be developed once the benchmarked positions are confirmed and submitted for Board approval prior to the commencement of the focused work.

Acute Kidney Injury

Why: Acute kidney injury (AKI) is seen in 13–18% of all people admitted to hospital, with older adults being particularly affected. These patients are usually under the care of healthcare professionals practising in specialties other than nephrology, who may not always be familiar with the optimum care of patients with acute kidney injury. The number of inpatients affected by acute kidney injury means that it has a major impact on healthcare resources.

The Trust's condition specific HSMR for AKI is relatively good at 92.7 with good levels of assurance around the accuracy of the data, however the work will focus on the assessment and prevention of AKI amongst vulnerable patients and compliance with NICE guidance on AKI. Further data collection is required to allow the Trust to gain a clearer view on assessment and prevention.

How: The work on AKI will be executed using a patient safety collaborative approach and will commence in 2017.

Target: The targets around AKI will be developed following data collection and analysis and will be presented for Board approval prior to the commencement of the patient safety collaborative.

Venous Thromboembolism

Why: Venous thromboembolism (VTE) is a term that covers both deep vein thrombosis and its possible consequence, pulmonary embolism. A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg and if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a potentially fatal blockage, known as pulmonary embolism (PE).

The Trust currently monitors the incidence of venous thromboembolism through the safety thermometer and through Datix submission. Data submission on VTE for the Safety thermometer indicates that the Trust's performance is within statistically expected norms and the assessment of inpatients for VTE prophylaxis is reliable at >95%, however work is ongoing to gain clarity around the source of VTE from Datix submissions (acquired or admitted with), with this work being led by Trust medical clinicians. Once clarity is gained around this data, the Trust can gain a view of its performance relative to other providers and determine what improvements are required.

How: Once clarity is gained around the data, the Trust will establish a task and finish group to ensure reliability around the correct VTE prophylaxis, as recommended by NICE guidance.

Falls

Why: There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. However, there is much that can be done to reduce the risk of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay in hospital.

Data from the Royal College of Physicians National Audit of Inpatient Falls 2015 indicate that the Trust has the lowest rate of falls in the North West at 3.71 per 1000 occupied bed days (OBD) and benchmarks well nationally for falls with moderate and above harm from falls at 0.13 per 1000 OBD.

Trust data on falls rate per 1000 OBD indicates performance above the reported RCP rate at 4.5 per 1000 OBD. This level of performance would place the Trust as having the second lowest rate of falls amongst Trusts in the north west. Notwithstanding this, it is recognised that patients do continue to fall within the Trust and occasionally suffer significant harm as a result. In response to this we will run a patient safety collaborative in 2017/18 to build on the work of the falls group and further reduce harm from falls.

How: The project will be executed through a Breakthrough series Collaborative approach.

Target: Our benchmarked position on falls will be assessed closer to the time of the collaborative and reduction targets agreed with the Board prior to the commencement of the collaborative.

Breakthrough Series Collaborative Approach

The Trust has recently embarked on two quality improvement projects aimed at reducing harm from pressure ulcers and to improve our recognition of and response to patients at risk of acute deterioration. The projects are modelled on the Institute for Healthcare Improvement's Breakthrough Series Collaborative Model (BTS) and it is proposed that this becomes the primary (although not exclusive) methodology for driving quality improvement in clinical care in this strategy.

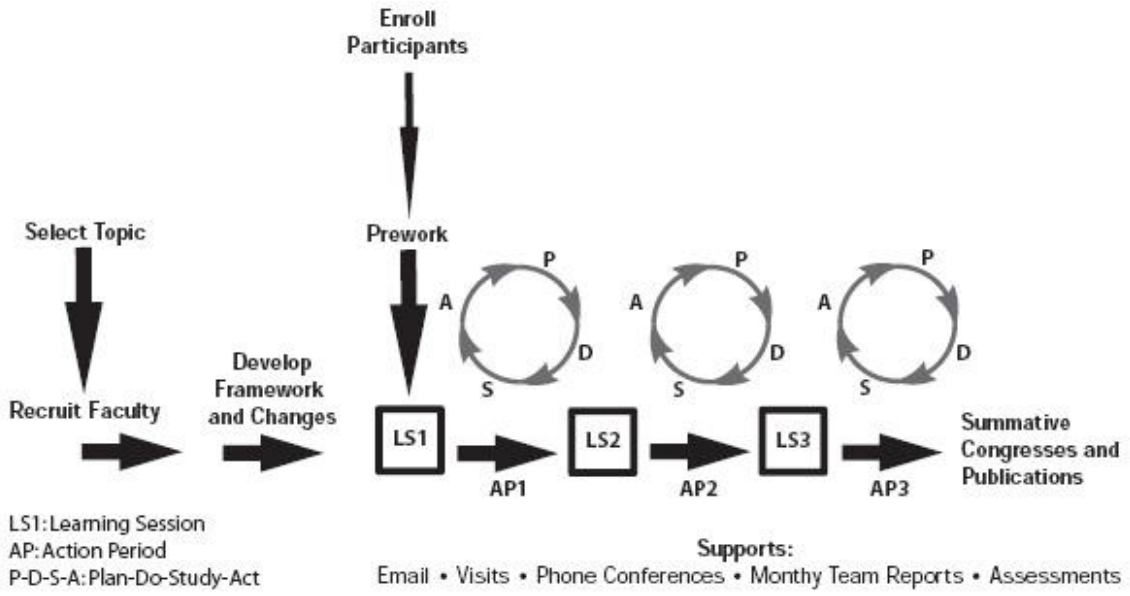
The breakthrough series collaborative (BTS) model is a proven intervention in which wards and departments can learn from each other and from recognized experts around a focussed set of objectives. The key to success is engagement, alignment and collaboration. Subject matter experts work with improvement experts who help organisations select, test and implement changes on the front line of care. Systems are redesigned from the bottom up using small tests of change.

A BTS collaborative provides a framework to optimise the likelihood of success for improvement teams. It works best when there is a deficit in quality which can be

identified by teams as ‘unacceptable’ and where there are pockets of excellence which can be used for learning. Critical success factors include leadership support; patients at the helm; a clear aim; focus on measurement; an agreed time frame and clinical engagement. Teams commit to working together over a fixed period and attend three 2 day learning sessions. In between learning sessions there are ‘action periods’ where teams test changes.

Learning sessions provide instruction in the theory and practice of improvement and feedback to senior leaders, focusing the organisation’s learning. Each team reports on their methods and results, lessons learned and provide social support and encouragement for making further changes. During the intervening action periods participating teams have direct access to specialist improvement advisors and one another via, regular conference calls, online dialogue, frequent written updates and supportive ward visits.

The BTS collaborative ends with a quality summit where teams present their findings and agree on a bundle of interventions which have been demonstrated to improve quality in that particular care area. This bundle is then applied across the organisation during a ‘scale-up and spread’ phase to ensure that the learning is understood and utilised Trust-wide.



HOW WILL WE MEASURE OUR SUCCESS?

Measurement is an important part of improvement. If we do not measure then we have no way of assessing whether what we are doing is having the desired effect. The strategy will incorporate the development of a number of indicators and dashboards which will give a clear indication on progress against the success criteria for each of the projects in the strategy.

Each patient safety collaborative will have its own, unique target and progress against that target will be monitored through the Trust Quality and Safety Committee and presented at Trust Board.

The strategy will include building an understanding at all levels within the Trust of the display of data, using statistical process control charts where appropriate.

Corporate Indicators

A set of corporate indicators will be developed and reviewed by Board through the IPR on a monthly basis. These indicators will give a view of clinical outcomes and satisfaction and will be mirrored at both CBU and ward/department level so that performance can be understood at different levels within the Trust. From this, Board will be able to review how the strategy is impacting on outcomes with regard to shifts, trends and variation.

Board Dashboard	
Clinical Outcomes	**HSMR** **Harm** • **Pressure Ulcers** • **Falls** • **VTE** • **Catheter UTI** **Sepsis Bundle Compliance** **Cardiac Arrest Rate** **Medicines related incidents** **Maternity Dashboard**
Satisfaction	**Patient** **Staff**

Ward Level Indicators

The strategy will include a revision of ward-level data to enable a greater local understanding and ownership of performance. These data will be reviewed at CBU level and discussed at sub-Board level through the Trust's Quality and Safety Committee.

The ward-level quality indicators will act as 'smoke-signals' for the senior nursing team, enabling them to more readily spot wards which might be struggling from a quality perspective. Indicators will have tolerance limits set against them and will be benchmarked across the organisation. All data are currently available, but will be pulled into a single, monthly ward-specific report.

LISTENING TO PATIENTS

In addition to the set of quality initiatives, we will also develop a system whereby patients and families are provided with an opportunity to flag concerns to designated hospital staff if they feel we are not listening to them.

It is recognised that patients and families are often best placed to know when they or their loved one are becoming unwell. They live with their diagnoses and treatments and so are better able to pick up on changes in the way that they are feeling. The system will facilitate patients and their families accessing a second clinical opinion if they feel it is necessary with the aim of improving the quality of care and reducing harm.

The work will mirror a successful system introduced in a number of Trusts in the NW and we will work with appropriate ward teams to test this locally. This will include:

- Promoting the system to inpatients and staff members
- Monitoring whether issues are being addressed in an acceptable manner and timeframe
- Learning from the content of the calls about what issues are most concerning to patients and their families and work to address these

This initiative will be commenced in 2016 and expanded across the organisation to all areas of the hospital once testing is complete.

LEARNING FROM INCIDENTS

The Care Quality Commission's State of Care report states that the differentiating factors between Trusts that are rated outstanding and those rated inadequate are their ability to monitor and act on issues that are identified and how well they share the learning from incidents.

Reporting Rate

The Trust has an established incident reporting system and all reported incidents are reviewed to ensure that we learn when things go wrong. Numbers of reported incidents have risen however reporting numbers place us only in the mid quartile compared to other Trusts.

A high reporting rate with below average levels of harm demonstrates that staff feel supported to report incidents and that we take action to prevent future harm for patients. The Trust will therefore aim to demonstrate the development of a safety reporting culture by increasing our incident reporting numbers to achieve top quartile benchmarked performance.

TARGET: Top quartile performance in incident reporting by March 2017

Dissemination of Learning

The successful identification of learning from incidents and the dissemination and embedding of learning will be a key focus in 2016. Processes will be developed to reliably provide contemporaneous feedback on lessons learned from incidents and structures will be developed to ensure that the learning from incidents is understood at a local level throughout the organisation.

Serious Incident Process

The serious incident review process will be revised and relaunched as part of this strategy to ensure that the most serious incidents which occur in the Trust are investigated in a manner which draws the maximum learning from the incident and develops a culture of understanding and learning at all levels within the Trust. The revised process will include a senior review and sign off of every serious incident which occurs within the organisation and will launch in January 2016.

Ward Accreditation Programme

The strategy will include the implementation of an accreditation programme which will give a greater understanding of, and set clear standards around ward level performance. The system has been developed internally using understanding gained from a number of NHS organisations in the NW and will run as an ongoing programme.

The Southport & Ormskirk Nursing Accreditation Scheme (SONAS) framework is based on the Trust's 'Care as Care Should Be' approach to service delivery and provides evidence for the Care Quality Commission's Fundamental Standards of Care, the 6Cs of Care, Compassion, Communication, Competence, Courage and Commitment (NHSCB, 2012) and our own Trust SCOPE values.

The SONAS assessment framework is modelled around the CQC five domains of Safe, Effective, Caring, Responsive and Well Led and the corresponding Key Lines of Enquiry (KLOE). It is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. The programme will commence in November 2015.

WORKFORCE CAPABILITY, LEADERSHIP AND CULTURE

Central to the success of the strategy is the requirement to have the right number of staff, with the requisite skills and motivation to drive the projects. There is a recognised strong correlation between high levels of staff satisfaction and positive patient outcomes.

We believe that our staff, patients and the public need to feel assured that our clinical departments and areas are adequately staffed to provide the safest possible care. We need to have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage off shifts meeting planned safe staffing levels.

Workforce capability, leadership and culture are the key drivers of the revised Organisational Development strategy and as such, the quality improvement strategy should be viewed alongside the organisational development strategy for the organisation.

COMMUNICATION AND DELIVERY

The Trust capacity for delivering targeted quality improvement is dependent on the availability of skilled individuals with change management and quality improvement skills.

The Trust has been fortunate to have had assistance from the TDA quality improvement team to help develop and deliver the first two patient safety collaboratives, but will need to build in-house capacity to run future events.

To this end the Director of Nursing has begun developing the skills of key individuals within the Trust quality and PMO teams and will continue to build QI capability within

the organisation. As the process becomes embedded within the Trust the ability to plan and deliver patient safety collaboratives will become easier. Key to the success of the strategy will be the appointment of a key individual with significant quality improvement skills to lead and develop the QI team.

Project infrastructure

All projects will be managed by project managers from within the current quality team managed by the Director of Nursing. Projects will be scheduled according to the framework of the BTS model and may last up to 18 months dependent on complexity and content. Each project will have an accompanying scale up and spread strategy. Each project will determine the best means for effective patient involvement.

1. **Preparation** – during the preparation phase the project champion will be identified by the Director of Nursing and Medical Director. They will work with the project managers to identify specialist subject advisors and organise the expert meeting and timeline. Information will be gathered and a best practice framework developed by a small team. Pre-work will commence on measurement, data collection and materials. The project initiation document will be completed in draft format.

2. **Expert meeting** – the expert meeting is convened to bring together subject matter experts who have skills and experience to complement each other and who are passionate about improvement. They agree the content of the programme and the project plan in the project initiation document.

3. **Project initiation document** – this is a detailed description of the background, aim, measures, changes and timescales. It will be presented to the board prior to commencement of the project and will be used to determine whether the project is running to schedule.

4. **Learning session** – see project framework (above).

5. **Summit / scale up** – the summit is an opportunity for teams not in the innovation community to learn about the changes tested in the collaborative. The spread strategy will be formally discussed at the summit and the agreed change package will be presented.

Internal Communications

The Quality Improvement Strategy will be promoted using existing internal communication channels as well as being a test area for developing new channels. Some of these include: QI featuring on the agenda of the Grand Round, QI session at Trust induction, development of an online introduction to QI, use of screensavers for specific campaigns, and a dedicated area on the internal website.