University Hospital Southampton NHS
NHS Foundation Trust

Our Quality Improvement Framework 2018 – 2019

The UHS Way

The QIF is a tool to engage and communicate with staff and patients about transformation projects to improve the quality of care planned for 2018/19. The priorities have been chosen to reflect areas that are important to our patients and staff that need transformational change and enhanced focus to realise improvements by year end.

- The QIF is not designed to replicate the detail in the trust strategy and annual plan or cover all of the key performance indicators and work streams for quality.
- The safety strategy, patient experience strategy and the clinical strategy contain detail on the plans and processes to maintain and improve quality for patients at UHS.
- It forms part of the annual quality account where each year we report on progress against last year's priorities and set priorities for the following year
- Looking after people is at the centre of everything we do and because of this, and the busy, challenging environment we work in, we recognise that supporting caring for and developing our staff is crucial to delivery of the QIF

Our Quality Improvement Framework 2018 – 2019

The UHS Way

Well Led	• Embedding our values • Best use of resources
Safe	• Recognition and management of the deteriorating patient • Deliver the national safer maternity strategy
Responsive	• Embedding SAFER bundle and improving experience of discharge • Keeping patients eating, drinking and moving
Effective	• Every outpatient encounter adds value • Antimicrobial resistance
Caring	• Shared decision making • Improving end of life care

University Hospital Southampton NHS
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Quality Improvement Framework for patients

2018 - 2019

Well -Led				
Aim	Drivers	Measure	Executive and Operational Leads	Monitoring Group
Embedding our values	• Every member of staff has an appraisal that is meaningful and inspires us to be better at living our values every day. • Taking time out to speak to patients and gain genuine insights into their experience within the Trust • Develop the research capability of our hospital to its full strength in order to make things better for our patients • Staff at all levels are willing and able to actively participate in quality improvement to ensure we consistently deliver outstanding patient care • Embedding values in training and education	• 92% of staff receive an appraisal including a wellbeing discussion and a personal development plan (PDP) • Patient feedback including FFT and national patient survey • Number of patients offered clinical trials • Staff satisfaction from staff survey	Gail Byrne/ David Young/ Ellis Banfield/Christine McGrath/Kate Pryde/Claire Fountain	Talent and leadership Board

Well -Led				
Aim	Drivers	Measure	Executive and Operational Leads	Monitoring Group
Best use of resources	• Using our resources to provide clinical services that operate as productively as possible with an improved focus on better quality, sustainable care and outcomes for patients. • For UHS to be proportionate, minimising regulatory burden, and draw on existing data collections where possible • To be clear what 'good' looks like – using data from the Model Hospital and Insight Dashboard to help guide improvement in the use of resources and focusing on quality. • To promote good practice to aid continuous innovation and improvement. • Using our workforce to maximize patient benefit and provide high quality care • Effectively using clinical support services to deliver high quality, sustainable services for patients • Effectively managing corporate services, procurement, estates and facilities to maximize productivity to the benefit of patients	• GIRFT • Weekly NHSI reporting against agency rules • Pay bill • Staffing reviews • medicines spend and savings • Procurement costs • The Use of Resource domain of our next CQC inspection will achieve a rating which is reflective of the organisations' achievements.	Paul Goddard/Matt Barker/Serena Gaukroger- Woods	TEC

Safe				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Recognition and management of the deteriorating patient	• Roll out an automated electronic alert system • Recognise sepsis rapidly and manage sepsis appropriately • Ability to track deterioration more precisely. • Whole systems approach to deterioration, escalation and response. • Standardisation of NEWS 2 across Trust. • Ability to facilitate early detection, diagnosis and escalation. • Share key patient information • One tool across Trust for adult patients (excluding paediatrics and obstetrics). • Seamless language from community to acute hospitals and back out. • Ability to track patient's deterioration. • Collaborative pan pathway system. • Evidence based prioritisation of resources. • Seamless transitions of care. • Align hospitals within UHS and region. • Close working with Wessex Academic Health Sciences network to develop this community of practice.	• Outreach calls • Cardiac arrest calls • Early warning scoring events • Accuracy of observations • % of patients who had sepsis screening • Time to IVABs for patients with sepsis • Mortality rates • Avoidable high harm/death • Reduction in safety errors. • Better outcomes for patients – reduction in higher scoring acuity levels. • Research and audit associated with whole systems deterioration.	Gail Byrne/ Derek Sandeman/ Karen Hill/Jules Kause/Julian Sutton	ROAR

Safe				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Deliver safer maternity care strategy	• Promoting professional cultures that support teamwork, continuous improvement and service user engagement. • Implementation of evidence-based best practice. • Clinical professionals with expertise in safe care practices. • Standardised approach to reviews and investigations. • Timely, good quality data.	• The Saving Babies Lives Care Bundle. • The Perinatal Mortality Review Tool. • Each Baby Counts Programme • Maternal deaths from direct or indirect causes related to pregnancy. • Developing an action plan to ensure monitoring and deliver of all of the separate elements highlighted within the November 2017 Safer Maternity Care National Maternity Safety Strategy Progress and Next Steps Report, including the 10 criteria for the CNST discount	Gail Byrne/Suzanne Cunningham	Women & Newborn Risk and Patient Safety group

Effective				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Every outpatient encounter adds value	• Advice and guidance • E-referral • Referral Support Service • Standardised referral pathways with structured templates Increased tier 2 capacity	• Number of ‘saved referrals’ • % of e-referrals / ASI rates • % secondary care referrals % community referrals • Specialty waiting times • FFT	Derek Sandeman/Becky Gough	Outpatient Board

Effective				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Antimicrobial resistance	• Education - antimicrobial choice, course lengths, prompt review • Enhanced antibiotic reporting • Supporting prescriber choices • Supporting clinical review of patients on antibiotics	• The percentage of UHS patients who receive a dose of antibiotics on any given day will have decreased further and the prescription of ultra-broad spectrum antibacterial agents without appropriate indication will have stopped. • 90% of UHS patients will have had a documented antibiotic review within 72 hours and the percentage of UHS patients who receive a dose of an antibiotic on any given day will have dropped to 40%. • Standardised mortality for pneumonia, urinary tract infections and septicaemia will all continue to fall. • Compliant with the 2018/19 CQUIN	Derek Sandeman/ Julian Sutton/ Kieran Hand/ Hayley Wickens	Antimicrobial stewardship committee

Responsive				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Embedding SAFER bundle and improving experience of discharge	• Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions. • All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. • Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am. • Early discharge. 30% of patients will be discharged from base inpatient wards before midday. • Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mindset. • Red to Green days as a visual management system to assist in the identification of wasted time in a patient's journey.	• SAFER audits • Red2Green days • Stranded patients • HB4L data	Andrew Asquith/Angie McClarren	SAFER steering group

Responsive				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Keeping patients eating, drinking and moving	• Use of specially trained volunteers to assist in mobility • Roll out of modified MUST tool and care plans	• Number of trained volunteers • Number of patients dressed in own clothes where appropriate • % patients with MUST score • % of patients with Nutrition care plan • Improved reports of patient satisfaction • Reduced length of stay • More timely admissions for other patients • Reduced laundry costs where hospital gowns/pyjamas are used	Gail Byrne/Sasha Smith	EDM project group Nutrition and Hydration steering Group

Caring				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Shared decision making	• Carry out the Shared Decision Making CQUIN for two years, with year one focusing on transcatheter aortic valve implantation (cardiology) and neuro-oncology teams. • Increase patient access to digital self-management material • Increase the quality and amount of information available to patients and practitioners	• Agree on which parts of the pathway (decision nodes) present different treatment options and review tools. • A team building and training plan for staff in 2 pilot sites. • Test and evaluate the use of our Shared Decision making (SDM) tool and further develop it to meet shared patient and service needs. • Number patients participating is peer support • Number of patients discharged from secondary care or to PIFU • Increase in confidence scores • Increase in knowledge scores	Derek Sandeman/Paul Grundy/Becky Gough	Outpatient Board

Caring				
Aim	Drivers	Measure	Executive and Operational Lead	Monitoring Group
Improving end of life care	• Promoting formal and informal mechanisms to engage with and hear the voice of patients and families, including families who have been bereaved. • Staff at all levels working to provide an individualised approach to every patient's care at the end of life. • Every member of staff supported to be able to communicate effectively with patients and families at the end of life including conversations relating to uncertainty and dying. • Staff educated to be able to deliver excellent care for patients approaching the end of life.	• Feedback from complaints • Survey of bereaved families' experience. • Adherence to NICE Quality Standards 144 "Care of dying adults in the last days of life." • Each patient will have an agreed individual plan of care to include food and drink, symptom control and psychological, social and spiritual support. • Audit quality of Individualised End of Life Care Plans • Increase in numbers of staff trained in end of life care. • Appropriate end of life care anticipatory prescribing • National Audit of Care at the End of Life 2018/19 indicators	Gail Byrne/Carol Davis/Mark Cawley	EOLC Steering Group