NHS
Lancashire Care
NHS Foundation Trust

High quality care,

in the right place,

at the right time,

every time.

Motivated engaged and valued staff

People at the heart of everything we do

Quality, always being the best we can be

OUR VISION

Quality Priorities Plan 2017 / 2018

Supporting Health and Wellbeing

Contents

Introduction

Quality is our number one strategic priority.

The Trust Board have committed to this by having one single strategy for the Trust, which is quality led. This document sets out our priority areas for improvement work over 2017/18 and supports the achievement of the overarching three year Quality Plan.

Our vision sets out what we do – delivering high quality care, in the right place, at the right time, every time. I know you are all as passionate as I am for continually improving our services and making Lancashire Care the very best that we can be.

This plan sets out 16 key priority areas for Trust-wide improvement. They have been identified through a range of sources including the findings of our recent inspection by the Care Quality Commission, our quality surveillance and the learning from complaints, incidents and serious incidents. By tackling these 16 priority areas in a systematic way we will improve the safety, effectiveness and experience of our services.

Supporting these 16 priority areas is a comprehensive set of quality improvement work planned by our Support Services. This work has been developed by Support Services in collaboration with our Networks and was presented to the Board – highlighting the importance of each service truly embracing our common commitment to quality and the support provided to our front line teams.

This document does not reflect the huge amount of quality improvement work already undertaken by teams across the Trust and so it is right I acknowledge that work and the dedication of the staff involved. No one needs permission to improve quality and my team are ready to support you in this work through training, support, advice, data and encouragement.

Over the year we will embed our new quality improvement tool – Life QI. This tool will allow us to track quality improvement activity across the Trust and will help measure the impact we make.

I look forward to working with you over the next year in delivering our vision, our values and our commitment to continuous improvement in quality.

Dee Roach
Executive Director of Nursing and Quality

Our vision and quality outcomes

Our vision is *High quality care, in the right place, at the right time, every time.* This vision was developed by people who use our services and our staff. It reflects what we aspire to do every day.

The Trust Board has committed to this vision by setting one strategy for the Trust which is quality-led and is supported by a number of plans including:

- Quality Plan
- People Plan
- Estates Plan
- Health Informatics Plan.

Our vision also includes our three quality outcomes that we aim to achieve:

- People at the heart of everything we do
- Motivated, engaged and valued staff
- Always being the best we can be.

Quality improvement is key to delivering our vision and our quality outcomes. In a complex and changing NHS, the need to continually improve is essential in protecting our patients and staff, improving the experience of our patients and staff, and improving the effectiveness of our clinical services.

Our approach to improving quality

This Quality Priorities Plan for 2017/18 sets our Trust-wide 16 priority areas, along with a range of quality improvement work being undertaken by our Support Services. It does not include the full range of quality improvement work underway at a local level by teams.

We encourage and empower our staff top make improvements to quality wherever the opportunity arises and our Quality Improvement Framework provides the tools, support and guidance needed to make this happen. Our Quality Improvement Team has experiences practitioners in improvement skills and science able to support teams and our Quality Governance Team has experts in interpreting legislative, regulatory and Trust requirements along with the ability to access and analyse data.

The reason for this plan and the 16 priority areas is to ensure we deliver on significant issues that require Trust-wide improvement – by bringing together people to improve quality across the organisation and to ensure that improvement is sustained.

In 2017/18 we will build on our quality improvement learning programme in partnership with the Advancing Quality Alliance (AQuA) as part of *The Building Blocks to Effective Continuous Quality Improvement Across an Organisation* (Dr Peter Chamberlain). Not everyone needs to be expert in this approach, but everyone should understand the principles with quality improvement specialists driving, coaching and working to sustain improvement work. The principle of co-designing quality improvement initiatives involving people who use services, families and carers together with our staff is the foundation of our approach to quality improvement.

We also launched our new quality improvement software at the 2017 Quality Improvement Conference – Life QI will become our single tool for recording quality improvement activity. This new software will support staff undertaking improvement work by guiding and recording the improvement journey and will allow the Trust to see the totality of improvement work taking place which in turn helps share best practice.

For more information on our approach to quality improvement, please speak to the Quality Improvement Team or your Network Quality Governance Business Partner.

Quality Priority 1: Core Skills

Quality Priority	Core Skills

Quality Priority Lead	Ian Tegerdine

Quality Improvement Advisor	Helen Lee
Quality Governance Advisor	Jan Tipping
Management Group	People Plan Delivery Group
Assurance Committee	People Sub-Committee

Aim of the quality priority

We will ensure our workforce have the necessary core and job essential skills to deliver high quality care. We will transform our learning offer beyond traditional training.

Summary of the planned improvement work

During Q1 a recovery process was planned, developed and implemented. Significant Improvement was noted. Record keeping was reviewed and a 'single source of truth' developed. Further work commissioned to explore reasons for any continued non-compliance, Once results are known revised recovery plans, with a revised target date, taking into account new information, to be developed.

Key quality and performance indicators

85% of staff hold the recorded competence at the level appropriate to their specific role in the following areas: Conflict Resolution / Violence Reduction Training, Equality & Diversity, Fire Safety, Health & Safety, Infection Control, Manual handling, Resuscitation (BLS/ ILS), Safeguarding (Adult / Child), Mental Capacity Act, Prevent

Aligned Care Quality Commission requirements

The Trust was inspected in September 2016 by the CQC and they issued Requirement Notices mandating improvement action for the following areas:

- Compliance with basic life support and immediate life support was low.

- Not all staff had the appropriate qualifications and training.
- Not all staff received regular updated training to provide end of life care, basic life support and conflict resolution to maintain staff competencies.
- Essential training for the teams we visited was not at a sufficient level in relation to the Mental Health Act level two training, Mental Capacity Act level two and Prevent training.

In addition to the above Requirement Notice, the CQC said the Trust should:

- Ensure that staff who require core and essential training receive it in line with Trust policy.

- Ensure that compliance with mandatory training is recorded and delivered in line with Trust policy.
- Review processes in place to enable mandatory training data held at Trust level accurately reflects compliance at team level.
- Ensure learning needs are identified through the Trusts appraisal process.
- Up-skill safeguarding training from level two to level three as required (specific to the sexual health service).

Quality Priority 2: Supervision

Quality Priority	Supervision

Quality Priority Lead	Gita Bhutani

Quality Improvement Advisor	Anne Allison
Quality Governance Advisor	Jan Tipping
Management Group	People Plan Delivery Group
Assurance Committee	People Sub-Committee

Aim of the quality priority
This priority supports our overarching 3 year Quality Plan and the People Plan with the expectation that all staff have access to meaningful and effective supervision.

Summary of the planned improvement work
Supervision Policy, reviewed, agreed and embedded in organisation. Pilot of Nursing Standards in Supervision. Professional Assurance Matrix quarterly reporting and monitoring via Quality and Safety Sub-Committee. Agree and embed consistent recording system for capture of supervision compliance data.

Key quality and performance indicators
Quarterly Assurance reporting of compliance matrix to Quality and Safety subgroup Compliance with core requirement for Safeguarding training.

Aligned Care Quality Commission requirements
The Trust was inspected in September 2016 by the CQC and they issued Requirement Notices mandating improvement action for the following areas: • The model of safeguarding supervision in use did not allow for objective, critical reflection of all current safeguarding cases. In addition to the above Requirement Notice, the CQC said the Trust should: • Ensure that all staff receive regular supervision and this is evidenced as per Trust policy • Review how it engages with staff in the North Lancashire Sexual Health Team and provide further support as required.

Quality Priority 3: Appraisals

Quality Priority	Appraisals

Quality Priority Lead	Damian Gallagher

Quality Improvement Advisor	Helen Lee
Quality Governance Advisor	Jan Tipping
Management Group	People Plan Delivery Group
Assurance Committee	People Sub-Committee

Aim of the quality priority
All staff will have a meaningful appraisal that supports our vision, values, strategic priorities and shared objectives.

Summary of the planned improvement work
PDR objectives reflect the quality plan. Appraisals are monitored quarterly. E PDR to be embedded across the Trust. New appraisal and PDR process in development during 17/18.

Key quality and performance indicators
Monitoring planned. Appraisal process rolled out .

Aligned Care Quality Commission requirements/CQUIN
• Ensure that all staff receive annual appraisals and this is evidenced as per Trust policy • Will support Staff health and Wellbeing CQUIN.

Quality Priority 4: Mental Health Law

Quality Priority	Application of Mental Health Law

Quality Priority Lead	Matthew Joyes (interim lead)

Quality Improvement Advisor	Tom Swan
Quality Governance Advisor	Lisa West
Management Group	Network Mental Health Law Groups (x4)
Assurance Committee	Mental Health Law Sub-Committee

Aim of the quality priority
We will correctly apply mental health law to deliver safe and effective care.

Summary of the planned improvement work
Launch new Mental Health Law Surveillance Report. Revised and standardised terms of reference developed for Network Mental Health Law Groups. Revise Mental Health Act and Mental Capacity Act training. Strategic engagement with the police to strengthen the work of the Lancashire-wide multi-agency group and locality groups. Develop processes for anticipation of the change in law regarding the reduction of time for Section 136 detentions; from 72 hours to 24 hours.

Key quality and performance indicators
Notification to CQC of all DOLS applications. Monitor compliance of all patient information re s130D and s132A of Mental Health Act. Compliance with training for community mental health staff re community treatment orders.

Aligned Care Quality Commission requirements/CQUIN

- Patients on a community treatment order provided with information they would reasonably expect on their rights as required under s132A of the Mental Health Act
- Patients on a community treatment order provided with given information on their right to an Independent Mental Health Advocate as required under s130D of the Mental Health Act as a qualifying patient
- Patients automatically referred to a mental health tribunal in the prescribed statutory time periods
- All community patients to have legal authorisation of their treatment plan
- Ensure there is an effective system in place to allow staff to check consent to treatment documentation prior to administering medication
- Ensure that relevant professional community mental health staff are properly informed and trained in their responsibilities when working with patients on a community treatment order.

Quality Priority 5: Clinical Risk in Mental Health

Quality Priority	Mental Health Clinical Risk Assessment and Management

Quality Priority Lead	Helen Lilley

Quality Improvement Advisor	Tom Swan
Quality Governance Advisor	Caroline Waterworth
Management Group	Positive and Safe Sub-Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
We will drive improvement and consistency across clinical risk assessment and clinical risk management in mental health service, including taking forward development of the Standard and Enhanced Risk Assessment Tools.

Summary of the planned improvement work
Standard and enhanced tools review. Environmental risk reviews. Fully documented clinical risk assessment and plans in place for all patients. Improved access to appropriate care whilst awaiting in patient admission.

Key quality and performance indicators
Risk assessment in care plans. Risk register regular review and mitigation.

Aligned Care Quality Commission requirements/CQUIN
- Environmental ligature risks   - Planned relocations of in-patient services   - Reduce the number of times patients spend over 72 hours in the health-based place of safety due to shortages of beds on in patient wards.   - Mental health A&E CQUIN.
Aligned internal requirements
The Trust commissioned a clinical audit and a further specialist review into the use of the Standard and Enhanced Risk Assessment Tools, both of which identified areas for improvement.

Quality Priority 6: Care Planning

Quality Priority	Holistic and Care Planning

Quality Priority Lead	Helen Lilley

Quality Improvement Advisor	Anne Allison
Quality Governance Advisor	Ann Hall
Management Group	Clinical Records Sub-Group
Assurance Committee	Quality and Safety Sub-committee

Aim of the quality priority

We will drive improvement and consistency in care planning across the Trust, including the involvement of people who use our service, their families and carers.

Summary of the planned improvement work

Action group set up with terms of reference reflecting promoting health preventing harm objectives.

Quality improvement work testing collaborative care plans using QI Life methodology.

Key quality and performance indicators

Personalised Care Planning CQUIN.

Children and young People Transitions CQUIN.

Hearing feedback information will be in accessible format.

Aligned Care Quality Commission requirements

The Trust was inspected in September 2016 by the CQC and they said the Trust should:

- Ensure complaints material is available for patients with a learning disability or autism, and have this information in accessible formats that meets all patient's needs
- Consider a system that enables all health needs and patient risks identified at the time of assessment to have a care plan in place.
- Consider the use of a universal pain assessment tool to assess and evaluate the level of a patient's pain and the effectiveness of treatment
- Ensure that equipment provided to children and young people in the community is provided in a timely manner
- Ensure an antenatal contact is offered consistently to all pregnant women in the Trust
- Ensure that care plans clearly reflect patient views and are completed collaboratively with the patient
- Ensure that the evidencing patient's being given copies of their care plan is improved.

Quality Priority 7: Record Keeping

Quality Priority	Standards of Record Keeping

Quality Priority Lead	Patsy Probert

Quality Improvement Advisor	Anne Allison
Quality Governance Advisor	Ann Hall
Management Group	Clinical Records Sub-Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority

We will drive improvement and consistency in standards of clinical record keeping across the Trust. To inform development of the new electronic patient record system to support high quality Clinical record keeping.

Summary of the planned improvement work

Standards of Clinical Record keeping group established to review current practice /required standards.

Review of professional record keeping standards compliance.

Review compliance with Organisational Policy.

Collaborative Care planning review with QI test sites for collaborative care plans.

Ensure outputs from clinical record keeping group are integral to RIO Clinical Forum.

Key quality and performance indicators

Clinical records detail key worker identified.

Clinical records detail consent.

Collaborative care planning quality improvement tested.

Clinical records detail when a service user requires accessible information.

Yearly audit cycle for record keeping – compliance with organisational and professional standards.

Aligned Care Quality Commission requirements

The Trust was inspected in September 2016 by the CQC and they said the Trust should:

- Document in the patient record that consent has been given
- The key worker is clearly identified in the patient record and the primary reason for referral
- Response times can be regularly monitored and reviewed
- Document the time of all entries on the patient records.

- Detail why appointments are cancelled by services
- Ensure there is consistent recording of observations of patients
- Ensure that community staff properly consider and record the competence and scope of parental responsibility when patients under 16 years of age transition into the community mental health teams
- Ensure that the results of all audits are disseminated to community mental health staff to help them continuously improve and work within best practice guidelines.

Quality Priority 8: Staffing

Quality Priority	Staffing for Quality and Safety

Quality Priority Lead	Lynne Carter

Quality Improvement Advisor	Anne Allison
Quality Governance Advisor	Caroline Waterworth
Management Group	Staffing for Quality and Safety Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority

We will continue the significant improvement in the achievement of safe and effective staffing across clinical services. This priority supports our 3-year Quality Plan.

Summary of the planned improvement work

Assess all in patient and community services nurse staffing levels using validated evidence based tools which take account of acuity, dependency and activity, setting staffing levels which reflect not only numbers of staff but also competency in practice.

Ensure that professional judgement is considered on a shift by shift basis in relation to safety and quality.

Key quality and performance indicators

Exception reporting of red flags and staffing incidents with documented mitigation provided daily and monthly.

Monthly dashboard and narrative triangulating staffing resource with agreed qualitative indicators.

Full roll out of e roster

Inclusion of AHPs and Psychologists in Care Hours Per Patient Day

NB: Other indicators will be monitored via quality priorities such as reduction in violent incidents, reduction in pressure ulcers which may also be partly attributable to safe staffing.

Aligned Care Quality Commission requirements/CQUIN

- Staffing levels are sufficient to provide therapeutic assessment and input and health care assistants that continue therapeutic treatment have appropriate qualifications and training (at Longridge Hospital)
- Continue to implement the recruitment and retention drive to ensure there are enough staff to meet patients' needs
- Continue to review the staffing skill mix and provision of psychiatric cover, access to

psychology and speech and language therapy across the Trust
- Review and utilise safer staffing tools and caseload weighting tools to determine the number of staff required to safely and effectively manage nursing caseloads
- Ensure timely access to paediatric occupational therapy and speech and language therapy
- Continue to review and address safe staffing levels within the rapid intervention and treatment teams and the subsequent impact on service delivery
- Ensure staffing levels are sufficient to support the delivery of activities and leave.

Quality Priority 9: Seclusion

Quality Priority	Seclusion

Quality Priority Lead	Lynne Carter

Quality Improvement Advisor	Tom Swan
Quality Governance Advisor	Stephen Osbaldeston
Management Group	Positive and Safe Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
Seclusion practice across all mental health services will be compliant with the Mental Health Act Code of Practice.

Summary of the planned improvement work
Ensure that all staff are familiar with and demonstrate appropriate seclusion practices.

Key quality and performance indicators
Seclusion records are accurate and comprehensive.
Seclusion facilities are all reviewed and compliant with the Code of practice.
Seclusion practices are professional, appropriate and have due regard for patient needs.

Aligned Care Quality Commission requirements/CQUIN
• Ensure that the Seclusion Policy is updated in line with the Mental Health Act Code of Practice • Ensure that seclusion records clearly document the cleaning schedule • Continue to address issues relating to the provision of seclusion • Reducing restrictive practice CQUIN.

Quality Priority 10: End of Life Care

Quality Priority	End of Life Care

Quality Priority Lead	Michaela Toms

Quality Improvement Advisor	Michelle Prescott
Quality Governance Advisor	Ann Hall
Management Group	End of Life Sub-Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
End of life care will meet patient, family, carer and regulatory requirements.

Summary of the planned improvement work
All patients will have end of life care in their preferred place with appropriate care to provide pain relief, comfort measures and with the full involvement of family and friends as requested.

Key quality and performance indicators
All patients have a comprehensive end of life care plan which includes risk assessments. Regular audit takes place of peoples experience. NICE Guidelines are reviewed and adopted.

Aligned Care Quality Commission requirements
- Have an end of life care plan embedded within the services which should be used for all patients identified as approaching end of life   - Consider an audit of peoples experience when they have experienced a close death as per National Institute for Clinical Effectiveness (NICE) guidelines   - Identify adherence to National Institute for Clinical Effectiveness (NICE) guidelines for patients approaching end of life as a risk on the community health services for adults risk register   - Monitor to determine if risk assessments are completed to ensure all patient risks are identified and minimised to reduce harm, in particular for those patients who are receiving end of life care.

Quality Priority 11: Supporting Staff

Quality Priority	Supporting Staff following Adverse Events

Quality Priority Lead	Caroline Waterworth

Quality Improvement Advisor	Helen Lee
Quality Governance Advisor	Pam Wood
Management Group	Supporting Staff Task and Finish Group
Assurance Committee	People Sub-Committee

Aim of the quality priority
This priority supports our overarching 3-year Quality Plan and the People Plan in that all staff will feel supported after adverse and traumatic events. The priority will also look at building resilience across the workforce and the legal support provided to staff post-incident.

Summary of the planned improvement work
Quality Improvement plan in place and will be evidenced through Life QI.
Pilot programme for staff Psychological first aid programme underway in Mental health Network, with planned evaluation for further roll out.
Review requirements of resilience building as part of staff Training Needs Analysis work.

Key quality and performance indicators
Staff health and wellbeing CQUIN.
Evidence of staff debrief after incidents detailed in Datix reporting and serious incident investigations.
Staff reporting accessibility of support following an adverse incident.

Aligned Care Quality Commission requirements
The Trust was inspected in September 2016 by the CQC and they said the Trust should:
• Ensure that staff are always debriefed following serious incidents.

Quality Priority 12: Violence Reduction

Quality Priority	Reduction in Violence and Aggression

Quality Priority Lead	Caroline Waterworth

Quality Improvement Advisor	Tom Swan
Quality Governance Advisor	Stephen Osbaldeston
Management Group	Positive and Safe Sub-Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
Ensure staff have the skills and capabilities to prevent and management violence and aggression. Reduce violent incidents by 10% from 2016/17 baseline number.

Summary of the planned improvement work
Develop full roll out of SafeWards. Ensure staff are trained and feel competent. Ensure we close the learning loop following incidents.

Key quality and performance indicators
Violent incident data monthly by ward/team. All incidents to have completed root cause analysis. Review lone working services and develop better monitoring. Ensure all areas are safe from weapons etc.

Aligned Care Quality Commission requirements /CQUIN

- The Trust should ensure staff follow the Trusts policy of environmental health and safety risk assessment
- Review root cause analysis investigations to capture all leaning as actions on the action plan
- Action in relation to the duty of candour must be clearly identified in the root cause analysis investigation
- Improve systems for staff that are lone working in particular in the evenings
- Ensure that each locality undertakes routine fire drill testing to prepare them in the event of a fire
- Reduce restrictive practice CQUIN.

Quality Priority 13: Pressure Ulcers

Quality Priority	Pressure Ulcers

Quality Priority Lead	Michaela Toms

Quality Improvement Advisor	Michelle Prescott
Quality Governance Advisor	Ann Hall
Management Group	Pressure Ulcer Task and Finish Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
Zero avoidable, acquired pressure ulcers by 2020.

Summary of the planned improvement work
Ensure React to Red is rolled out across all teams.

Key quality and performance indicators
Number of pressure ulcers acquired. Number of pressure ulcers healed. All risk assessments are complete for all patients. Care plans are comprehensive and complete. All grade 3 and 4 pressure ulcers are reviewed by Tissue Viability Team. All staff have basic pressure ulcer training.

Aligned Care Quality Commission requirements/CQUIN
• Wound assessment/pressure ulcer CQUIN.

Quality Priority 14: Medication Safety

Quality Priority	Medication Safety

Quality Priority Lead	Cath Fewster

Quality Improvement Advisor	Michelle Prescott
Quality Governance Advisor	Caroline Waterworth
Management Group	Medications Safety Sub-Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
This priority will continue the significant improvement in reducing medication errors and medication related risks.

Summary of the planned improvement work
Reduce harm from medication errors and/or failed monitoring of effects. Reduce missed dose errors. Ensure safe prescribing. Ensure medication administration competence. Ensure safe storage of medication.

Key quality and performance indicators
Reduction in errors with harm. Reduction in missed dose errors. Reduction in adverse events. Compliance with audits.

Aligned Care Quality Commission requirements/CQUIN
- Ensure the audit of antipsychotic prescribing for people with a learning disability is fully reviewed, implemented and actioned for all patients prescribed antipsychotic medication   - Ensure there is consistent recording of monitoring of patients following the use of rapid tranquilisation   - Ensure all safe storage guidelines are adhered to.

Quality Priority 15: Physical Healthcare in Mental Health

Quality Priority	Physical Healthcare in Mental Health In-patient Services

Quality Priority Lead	Lynne Carter

Quality Improvement Advisor	Awaiting appointment
Quality Governance Advisor	Viv Prentice
Management Group	Promoting Health, Preventing Harm Group
Assurance Committee	Quality and Safety Sub-Committee

Aim of the quality priority
Ensure improvement in physical healthcare services across mental health in-patient services and the reduction in avoidable incidents.

Summary of the planned improvement work
Compliance with training and competence in physical health assessment. Roll out National Early Warning Scoring system. Continue implementation of Nerve Centre. Ensure comprehensive assessments in place for all patients. Ensure access to appropriate healthcare professionals for physical health care issues.

Key quality and performance indicators
Number of staff trained and assessed as competent in physical health care assessment. NEWs scoring monitored for accuracy. Full roll out of Nerve Centre. Audit of key assessments e.g. Waterlow, MUST.

Aligned Care Quality Commission requirements/CQUIN

Cardiovascular assessment CQUIN

Alcohol and tobacco CQUIN

Collaboration with Primary Care CQUIN

Quality Priority 16: New Professional Roles

Quality Priority	New Professional Roles

Quality Priority Lead	Patsy Probert

Quality Improvement Advisor	Anne Allison
Quality Governance Advisor	Viv Prentice
Management Group	Staffing for Quality and Safety
Assurance Committee	People Sub-Committee

Aim of the quality priority
This priority supports our overarching 3-year Quality Plan and the People Plan through introducing and developing new professional roles to meet changing clinical and workforce needs.

Summary of the planned improvement work
Professional Leadership Collaborative Forum established -Nursing , Medical , AHP, Pharmacy and Psychology leaders to agree shared approach to new roles. Collaborative working with network teams to review current roles and potential new roles i.e. Advanced practitioners / Consultant Nurses/Therapists. Professional Apprenticeships – Professional leaders to be sighted and lead on the development of professional Apprenticeships in the organisation. Workforce Planning group.

Key quality and performance indicators
Workforce planning references opportunities for new professional roles. Progression of Nurse Associates. Apprenticeship planning evidences opportunities for professional Apprenticeships .

Support Services Quality Improvement Priorities

The Quality Plan is co-produced with all Support Services teams with the aim of each team articulating through their quality plan goals and actions the ways in which they support the Networks and Clinical Teams to achieve the three quality outcomes and deliver high quality care, in the right place at the right time for people who use our services.

2017/18

This refreshed co-produced and inclusive Quality Plan reflects currently known actions to support the achievement of the outcomes.

Outcomes - 2019	If our strategy is working we will achieve these goals by 2019:	New actions	Actions timescale
People who use our services are at the heart of everything we do	**Strategy and Business Planning Team** • Quality is the leading strategic priority and this is reflected in all associated priorities across finance, workforce, estates, performance, informatics and technology.	Complete facilitation of strategy refresh and the move towards delivering high quality services in collaboration (rather than competition) with partners; present to Board in Q4	310317
		Continue facilitation of the quarterly review process, supporting EMT to hold Networks and Support Services to account against delivery of objectives to provide high quality care to people who use our services	310318
	Company secretary team	Ensure our governors are receiving the right information to enable them to fulfil their role Establish opportunities for the Board to engage with clinical services and hear from people who use our services	310318

	Property Services: • RRCS Property Services will collate feedback from those they support to inform their continuous quality improvement and effectiveness to achieve the Vision for Quality (e.g. from the FFT survey).	Property Services will collate feedback from those they support to inform their continuous quality improvement and effectiveness to support this outcome	310318
	• RRCS Property Services will actively learn from incidents, near misses and complaints and promote lessons learnt.	At Each quarterly business plan review RRCS Property Services communicate to the relevant service line the following where applicable: o Any lessons learned o Plans to continue to embed the learning	310318
	Pharmacy and Medicines Management To undertake a review of the Pharmacy and Medicines Management infrastructure required in order to deliver the right drug to the right patient at the right time ensuring good governance, safety and medicines optimisation	To develop the role of the Community Clinical Pharmacy Technician across all community mental health teams for all ages to support adoption of the Five Year Forward View for mental health in delivering the physical health care agenda and good medicines optimisation	310718
	Medical Directorate: Service user involvement in all appropriate clinical audits	Where clinical audit methodology requires service user involvement through focus groups or a questionnaire this will be built into the project.	310319

People who use our services are at the heart of everything we do	Service user participation in research	Service users to be offered the opportunity to participate in research, to build on the Trust's position as the highest recruiting MH/Community Trust in the North West in 15/16.	
	Making the Nicotine Management Policy 'business as usual'.	E-cigarette pilot Review information provided for staff and service users Reporting system to provide ward level information on progress against NMP to link to quality SEEL	310318
	Enabling service users to take control of health damaging behaviours	Updated MECC content Demonstrable increase in MECC training levels New EPR to support MECC	310318
	Established group to drive the parity of esteem agenda with clear reporting processes and an active work plan	Refine membership of Whole Person Health Group with structured agenda and annual work plan which considers all applicable risks.	
	Human Resources: • Service users and patients will be the main focus of the work we undertake by supporting and training managers in the skills to manage employees that deliver the care.	Phase 2 – Values Based Recruitment NW Streamlining Accredited internal mediation programme Implementation of TRAC to further speed up recruitment	310317

People who use our services are at the heart of everything we do	**Health Informatics** • Co-Production and Deployment of new EPR system to support improved patient care.	To continue to work with clinicians to involve them and the people who use their services in the design of the new EPR. Ensuring that the record supports clinical practices being in partnership with people who use our services.	310318
	Performance and Information • Outcomes reporting will be enabled within clinical systems	Performance metrics and trajectories achieved. LDP reporting metrics in place. Deliver regulatory and contracted measures	310318
	Finance: Finance teams will have a greater understanding of the ways in which their contributions impact upon people who us our services.	To engage in opportunities to both inform programmes and to experience the work of our frontline teams. For examples: engagement with the Frontier Framework, the Building Blocks, the 'Sit and See' programmes.	310318
	Transformation Advisory Service Consideration of people who use our services will reflected in all transformation programmes	Implement an agreed approach to leading transformation with a standard suite of tools so that the trust continues to provide excellent care Evaluate the impact of transformation on service delivery Lead and exploit technology to transform care that will provide excellent value for money in a financially sustainable way	310318

	Delivering the strategy The DTS programme associated transformations will ensure that best quality is preserved.	All DTS programmes will have a fully completed Quality Impact Assessment (QIA) in accordance with the revised procedure which clearly articulates the benefits and any risks to quality.	310318
	Networks with Nursing and Quality • Feedback from people about their experiences will match with the benchmark set by each teams 'aspirational' experience story.	To continue to work with clinical services/ teams to support the development of their own 'aspirational' experience stories. Building on the successes to date all clinical services/teams will have achieved this by 310317	310318
		To design quality improvement goals in respect of hearing the best experience story from everyone who uses the service by 310319	310319
	• Support service teams have reflected the part they play in achieving the experience vision on Team Information Boards and everyone in the team can describe this.	To continue to challenge support services teams to be curious about and reflect their impact on achieving the 'aspirational' experience story for people who use our services. This will be reflected in the ways in which support services team articulate their impacts on people who use our services during quarterly reviews.	310318
People who use our services are at the heart of everything we do	• We will have co-designed Always events. These will be embraced by all and a fundamental part of everyday practices.	To continue the roll out of the completed always event pilot across learning disability teams	310317
		To incrementally develop a further 10 'always events' across the organisation and with networks and support services in line with the improvement plan.	310318
		Feedback from people who use services and staff will demonstrate the impact of 'always events' '	310319

	• People will give 95% positive feedback about their experiences of the complaints process. • We will respond well the first time with no re-opened complaints. • 100% of complaint responses reviewed will be person centred and personalised.	To continue to strengthen the person centred approach to complaints management built around people's individual needs and preferences.	310318
		To further develop the investigation modular training package which keeps the people who use services and those close to them at the heart. To ensure that everyone who leads investigations into feedback received in the form of complaints has access this programme.	310318
		Continue to measure and demonstrate the impact of the training programme	310319
		Demonstrate year on year improvements in the quality of responses to feedback received in the form of complaints	310319
	• The 'sharing experiences' forum will consistently be hearing positive stories	The 'sharing experiences' forum has evolved into the Hearing Feedback Steering Group to strengthen the focus on all feedback which informs improvements. The impact of poor experiences and the delivery of resulting improvements will be the focus of Dare to Share/Time to Shine sessions in 2017/18.	310318
		An annual profile of the stories shared and the associated outcomes will demonstrate learning and the sharing of learning across the organisation and beyond.	310318
	• The voice of people who use our services will be heard in a variety of ways as an introduction to all key meetings from team to board.	To collate feedback and stories that can be used to inform quality improvement at team level and articulate people's experiences of our services.	310316 to 310319
		To work with the Board to further develop the ways in which Board members engage with the stories shared at Board meetings. To share an improvement proposal with the Board	310318

		Chair for implementation in the coming year.	
People who use our services are at the heart of everything we do	• Carers see a collaborative team approach to care and are recognised as important partners in care as evidenced by their feedback and experience stories.	Continue to work with Lancashire County Council as the lead for the Lancashire wide carer's strategy. To embed the best practice principles relating to carers and their involvement in care	310318 310318
		To continue to evaluate the feedback from carers as part of the real time feedback portfolio.	310318
		To support the people who are carers truly being partners in care we will engage in the Triangle of Care national programme.	310319
		An annual profile of the feedback from carers by the Networks will demonstrate progress towards carers being recognised as partners in care	310317 to310319
	• We listen to and learn from the experiences of people who use our services with co-design and the 'you said, we did' model evidenced. .	Continue to develop the Friends and Family Test and portfolio of 'real time' reports within the Optimum system. . Strengthen 'you said/ we did' reporting and learning across all teams.	310318
		To build on our communication with people who use our services through the Voice news newsletter	310316 to 310319
		Ensure that feedback from people who use services is driving the quality improvement agenda through the Quality Improvement Framework programme.	310317 to 310319
	• We have an open and transparent culture where we routinely share	To continue to strengthen the quality surveillance function to inform quality improvements	310318

	learning from good practice, near missies and incidents.	Continue to strengthen the 'Dare to Share, Time to Shine' model of sharing and learning from incidents, near misses and complaints. The QI team will lead the programme with a minimum of 6 Dare to Share events annually.	310318
		The outcome of the Dare to Share and impact on the quality of care received by people using services will be reported as part of the quarterly Hearing Feedback Report to the Quality and Safety Committee and provide assurance regarding lessons learnt	310316 to 310319
People who use our services are at the heart of everything we do	• We will deliver outstanding safe care confirmed by internal and external assessments. The Quality Improvement Framework methodology is informing the development of the responses to the recommendations following the CQC inspection in September 2016. The priority areas of focus are: pressure ulcer prevention, violence reduction, falls, inpatient physical health. Examples include: Introducing Safety Huddles .	Pressure Ulcer prevention: Zero avoidable pressure ulcers in our care by 2017 Prevalence rate maintained below 5% for 5 months	
		To Achieve a physical health harm free rate of +95%	
		To achieve a Mental Health Harm Free Care programme target of 90% progressing to 95% across mental health inpatient wards	
		To implement the Community Mental Health Harm free Care quality improvement programme	
		Falls prevention: To reduce falls as reported on Datix by 5% encompassing people using inpatient services, intermediate care beds and learning disabilities supported living services.	
		To reduce incidents involving violence and aggression by 10%	
		Implement a suicide prevention strategy to achieve zero inpatient suicides	
		Develop and test daily safety huddles in inpatient settings Co-designing best principles and systems to support seclusion	
		Develop and test a new therapeutic model to the use of seclusion in inpatient mental health settings co-designing best principles and systems to support rehabilitation	
		Develop and test a new therapy and nursing model on the community hospital ward	
		Implement the End of Life Care approach using the QI methodology to test and improve	310318

	100% Compliance with health and safety legislation	Develop and launch a programme of risk based health and safety audits	300916
		Implement an action plan to ensure compliance with the Safer Sharps Regulations	
		Develop and launch a programme of contractor health and safety assessments	
	Implement the 'sit and see' programme to support us to see care through the eyes of people who sue our services giving a measure of care and compassion.	To introduce the 'sit and see' programme in the organisation across a number of 'test' sites to inform the feedback approaches and reporting formats.	310317
		Develop a programme of 'sit and see' observations across the organisation for the licenced practitioners to lead together with co-observers	310318
People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	**Strategy and Business Planning** The team will support initiatives to engage and support	Supporting People Plan roadshows to demonstrate the link from the Trust vision through the strategy to frontline staff PDRs Team development sessions:– ensuring alignment of individual's PDRs to team objectives Facilitation of Finance Directorate development session using appreciative leadership model	
	Property Services RRCS Property Services will support the team to have the opportunity to develop to be the best they can be and the behaviours of every person and team reflect the 8 quality commitments	Everyone in the teams across Property Services can describe the part they play in achieving the aspirational best experience story Property Services will support the team to understand the part they play and their team plays in achieving high quality, compassionate, continually improving care	310318 310318

	Pharmacy and Medicines Management		
	• To roll out and implement EPMA	To prepare a business case for EPMA in the community teams (subject to successful funding) Progress to roll out depending on outcome.	310318
		To continue to embed EPMA across all in patients wards	310318
	• To build on the Foundation laid re education and training in medicines management to ensure that we have a workforce that is equipped to deliver effective medicines optimisation	To continue to scope out and develop educational resources re medicines management in particular for new business	310318
	Medical Directorate:		
	Development for medical staff and support to build a career within LCFT.	Evaluation of consultant development programme by first cohort and plan for second cohort. Appointment of tutor for non-training grade doctors. Recruitment and Retention plan for medical staff.	310318
	All medical Clinical/Educational Supervisors accredited by the GMC.	Design annual educational appraisal process to integrate with medical appraisal. Annual Educators Conference	310318
	Staff motivated to be involved in clinical audit.	Support and motivation from the Clinical Audit team for staff to evaluate and improve their practice through clinical audit methodology.	310319

People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	Junior doctors supported and valued by the Trust	Implement required actions following HENW visit.	310319
	Human Resources • We listen to and learn from experiences of people who deliver and support the delivery of services and are able to share how this has made a difference to the quality of care.	Continue to build on the staff friends and family test with additional questions and 'snap' surveys	310317
	• Everyone understands the part they play and their team plays in achieving high quality, compassionate, continually improving care.	Further refine and develop the PDR process	310317
		All PDR's to clearly articulate everyone's role in achieving the Vision for Quality	310317 to 310319
	• Customer service and service improvements are a focus of HR work to ensure delivery of a high quality service	HR career pathways – developing talent Maximising the apprenticeship levy Re-design of the HR service	310316 to 310319
	Health Informatics A clear framework for clinically led IT enabled change.		310316 to 310319
		The organisation has appointed a CCIO who will lead on a clinical advisory group which will steer clinical involvement with EPR	

	Partnership working – building on this through the Lancashire Provider Collaborative and work such a EPACCS & Better Care Together	LCFT are working in partnership with the Lancashire Health Economy to deliver new HI ways of working which support improved patient care and information flows.	
	HI Survey & Feedback - HI keep gathering and learning from feedback from our service users	A series of service improvement plans are currently in development and will be rolled out. Including: – a welcome email for new starters which will outline the core business units of Health Informatics, – a profile management plan and a desktop link which will direct users straight to the Helpdesk SharePoint page – IT Support - IT Champions to feedback user needs. – IT Training – Easier and better use of skype. – IT Training – Better basic IT training.	
People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	**Performance and Information** Automated and systematic information provision that further enable transparency of reporting and of the quality of care provided. A team that supports the trust in providing insight on service provision rather than simply data.	Automated and systematic information provision that further enables transparency of reporting and of the quality of care provided. A team that supports the trust in providing insight on service provision rather than simply data.	310318

	Finance: **The finance team will continue to** engage with, listen to and guide and network and support services colleagues in best financial management	The Annual finance away day is an opportunity for the whole team to come together, take time out of the office to engage with each other and reflect on another year. It addresses the need for a "state of the nation" update from the Finance Directors about the Trust performance, but it also serves as an opportunity to look outside the Finance team at the wider Trust. At every away day, guests are invited from Trust networks and services to speak to the Finance team about the services they deliver, the service users and how these important services are both valued externally, but equally how Finance is contributing to their delivery and performance.	310316 to 310319
		Procurement has mirrored the approach by Financial Accounts, aligning support directly to Networks and service – this alignment helps to build relationships, increases knowledge and understanding and improves the responsiveness of Finance to Network needs. Procurement is able to attend Network management meetings and is encouraged to work more remotely at Network bases to be on site and on hand. This type of working has led to improvements in the areas of Supplies and Stores at the Harbour and Training of staff on Procurement systems across the Trust	
	Transformation Advisory Service People who deliver and support the delivery of services are involved in all transformations and tenders their feedback and ideas will inform and shape the narrative.	Continuing team development sessions: ensuring alignment of individual staff PDRs to team and trust objectives Continued support to Network Coleagues in relation to transforming services Continued support of the Trust key priorities and identified	310318

		business development opportunities.	
People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	**Networks with Nursing and Quality** • A new model of volunteering will be developed in line with national guidance and recommendations.	To continue to embed the best practice principles for volunteering and involvement	310318
		Develop and implement volunteer mentor training and support 310317	310317
		To continue to develop a version of the Friends and Family test style experience feedback template for volunteers and implement by 310318. Volunteer feedback will be 95% positive	310318
		To increase the number of volunteers by 10% annually	310316 to 310319
		We will have 700 volunteers playing an important role in improving people's experiences of care, building stronger relationships between services and communities and in supporting integrated care.	310316 to 310319
	• Distributed and shared leadership, cross boundary cooperation and common approaches to leadership from team to board is a reality. This is supported by a visible and enabling board and senior leadership team.	The "People Plan" will continue to be delivered. Progress the people plan development programme and implement the delivery phase across the organisation	310319
		Embed a Health and Wellbeing whole organisational culture, one that see's the role modelling of appreciative behaviour, consistent and clear communication, and better consideration of the impact of change on our people	310319

		Review organisational culture annually through a number of tools including Staff FFT, Staff survey findings etc.	310317 to 310319
		Implementing the recommendations of the Freedom to Speak Up Review and Learning not Blaming Report	310317 to 310319
		Further develop a 'work-with' model where senior leaders work alongside staff to better understand day to day challenges and opportunities implement this across 2017/18.	310316 to 310319
People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	• Board members and senior managers are visible and known to teams across the organisation	Further improve ways in which communication flows from frontline people to board members: 12 Good practice visits to take place annually.	310316 to 310319
	• Implement the Frontier Framework programme in collaboration with NHSE and Coventry University	An economics based model the Production Possibility Frontier Framework approach to measuring and presenting the impact of staff experiences and those of people who use our services on productivity metrics will be in place across 6 service lines.	
	• Staffing for safety and quality will be achieved across inpatient and community services.	**Inpatient services:** Continue to support teams of understand the impact of and links between staffing and quality and safety using data and information to support this.	310318
		Continue to strengthen the roll out of eRostering across all teams together with the embedding of the Red Flag alerting process and the provision of team level staffing information correlated with quality and safety indicators.	310318
		Care Hours per patient day (CHPPD) using the Hurst toll is being piloted	

	Community services: We will pilot and implement the Hurst community tool alongside more robust caseload management to reflect activity and CHPPD in community services.	310318
• Everyone has the opportunity to develop to be the best they can be and the behaviours of every person and team reflect the 8 quality commitments supported by the Quality Academy	Co-designing innovative approaches to clinical supervision and personal development reviews. Developing and testing a new supervision and personal development review model.	310318
	Reflective practice is embedded through: Effective supervision being in place evidenced by improving staff survey and staff FFT feedback	310319
	Developing new approaches to Core Skills training. To test a range of accessible ways for people to achieve competencies in Core Skills to ensure the provision of safe, effective services.	310318
	To continuously develop a quality focused trust induction programme	310318
• 100% compliance with preceptorship requirements as set out in the Learning Development	To deliver effective leadership on multi-professional Preceptorship that supports all newly qualified healthcare professionals assimilating into the organisation.	310316
• 85% compliance of completions within agreed national timeframes. • Safe well trained staff who are fit for purpose	To provide effective leadership on the Care Certificate that supports all newly appointment healthcare assistants/support workers new to healthcare	310316
• 100% utilisation of MPET and SLA funding for 2016/17 and improve organisational ranking into the Top 5 (across the North West).	To deliver effective training opportunities in relation to Continuous Professional Development in line with Trust strategic priorities.	310316

	• 100% compliance with NMC revalidation requirements	To deliver effective leadership on NMC revalidation that supports all NMC registrants to meet revalidation requirements.	310316
	• We have a Professional leadership structure reflective of all professions	Professional leadership is embedded with effectives reported via an evolving assurance framework	310316 to 310319
		A clinical senate will be developed to strengthen clinical involvement across all professions.	310317
People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide	• We are recognised as being committed to the Health and Wellbeing of our workforce and have achieved the Workplace Wellbeing Charter Networks demonstrate their engagement in staff health and wellbeing.	Progress the health and wellbeing plan: Achieve the health and well-being CQUIN 310316 Achieve the health and well-being CQUIN 2017-18	310318
		Embed Schwartz rounds across the organisation by 2019	310318
		Embed Schwartz Rounds across adult community and mental health and children's services by 2018 and Secure Services by 2019 Schwartz Rounds will take place x 10 across each year	310319
		Work towards achievement status of the Workplace Well-being Charter across the required 2 year period to commence in 2017	310316 to 310319
		Ensure consistent Network reporting/assurance on Staff Health and Wellbeing	310318
		Psychological Wellbeing – work collaboratively to design a tiered pathway that clearly defines our support offer, signposts to services and provides resources	310318
People who deliver and support the delivery of services are motivated, engaged and proud of		Champions to be identified in all Networks and incrementally increased from 60 to 150 in the next 12 months.	310318
	• The Trust will be able to	Develop system to support compliance new legislation and	310317

the service they provide	demonstrate quality, safe and effective safeguarding processes and practice	guidance. (see below) New Guidance e.g. ; Care Act, Intercollegiate Document NICE Domestic Abuse Clinical Guideline, Revised CLA & Intercollegiate document.	
		To ensure implementation of the MCA and deprivation of Liberty safeguards (DoLS) process.	310317
		Monitor and implement LCFT Domestic Abuse Action Plan	310916
		Develop and strengthen systems to ensure compliance with statutory and legal responsibilities and requirements for PREVENT	310317
		Review & implement the revised guidance for promoting the health of CLA in collaboration with CCG's & CSC	310916
		CLA receive high quality statutory health assessments The Trust engages with multi agency partners as required in providing services for vulnerable your people and their families including CLA.	310317
A quality focused culture is embedded across the organisation – we will all be working together to always be the best we can be	**Corporate Governance and Compliance** • We will make it easier for people to do the right thing, creating effectiveness and efficiency within the organisation	Develop an Assurance Toolkit that combines all the learning together in one place that will increase understanding of assurance and how evidence provides confidence in compliance reporting across the organisation.	310316 to 310319
		Launch a Knowledge and Legal Advice Centre to provide a place where we share internal knowledge and legal advice across teams and networks to support people to access the information that they need at the touch of a button.	

		Review the Board Assurance Framework reporting process to ensure that it continues to meet the requirements of the organisation and adds value from a risk assurance perspective.	
	Property Services RRCS Property Services will ensure that cost improvements and transformation programmes involve a comprehensive assessment of the benefits and any risks to quality	Property Services will ensure that cost improvements and transformation programmes involve a comprehensive assessment of the benefits and any risks to quality	310318
	• RRCS Property Services will develop a property plan that is dynamic and is used to direct investment to ensure that the Trust delivers services in premises that meet the quality agenda, are in the most suitable locations and contribute to the Trust's operational efficiency.	Revised Property Plan	310318
	Pharmacy and Medicines Management To build on the firm foundation re medicines management	Pharmacy in Mental Health and Community Trusts (extension of Operational productivity and performance in English Acute Hospitals unwarranted variation) in line with the project plan To scope and develop outcome measures for effective medicines optimisation in order to support the Five Year Forward View for mental health	310716
		To ensure that all services have good medicines governance systems	310316 to 310319

A quality focused culture is embedded across the organisation – we will all be working together to always be the best we can be	**Medical Directorate:**		
	Continuing review and development of medical appraisal to enhance this process for medics across the Networks.	Further development of appraisal and revalidation system.	310319
		Submission of all revalidation recommendations to the GMC on time.	
	Improved performance in national clinical audits, benchmarking and accreditation programmes	Development or governance and project plans with Network involvement.	310318
		Identify barriers to engagement.	
		Rollout of dashboard and job planning system across all Networks	
	Consultant job plans to include quantitative data derived from consultant dashboard		
	Increased engagement with research development and delivery activities	Promotion of commercial research opportunities, research grant opportunities and research internships.	310319
		Stronger partnership links with local research partners, including Higher Education Institutions.	310318
	Human Resources		
	Continuously review improvements programmes on processes	Robust workforce planning process	310317
		Organisational reset	
		Attendance Management project	

A quality focused culture is embedded across the organisation – we will all be working together to always be the best we can be	**Health Informatics** Partnership working – building on this through the Lancashire Provider Collaborative and work such a EPACCS & Better Care Together	• Develop plan with LPRES team for work relating to LCFT systems. • Develop plans with Health Economy partners relating to the ACS/ACO footprints. • Deliver outcomes as per agreed LCFT activities with ACS/ACO partners. • Deliver LPRES work within LCFT systems as per agreed plan.	
	Performance and Information • Standard Quality Assurance and validation processes in place. • -Corporate wide Information Management Strategy, including data quality. • -Integrated Quality and Performance Trust at a Corporate, Network and Service Level • -SLAs that support quality of service provision to internal customers and commissioners • -Improved quality of data across more areas and better transparency.	Integrated Quality and Performance Trust at a Corporate, Network and Service Level Improved quality of data across more areas and better transparency. Services migrated will be reported from the new PAS Ability to evidence contractual achievement	310318
	Finance: **Ensuring the organisation achieves financial targets and control totals**	Procurement will be undertaking assessment to Level 1 of NHS Procurement Standards in 17/18 The Trust has been selected as part of Carter "v2" – review of Mental Health and Community Trusts Northwest Mental Health Collaborative Procurement Board	310318
	Transformation Advisory Service The TAS will work to ensure that	Clear and comprehensive understanding of the team offer and the process within the Trust	311218

	everything they do support the organisation to be the best we can be.	Launch TAS sharepoint hub to provide a place where we share our business development plans and suite of transformation tools	
A quality focused culture is embedded across the organisation – we will all be working together to always be the best we can be	**Networks with Nursing and Quality** • Quality governance is embedded and evidencing positive outcomes	The Quality and Safety Sub-Committee will receive assurances from Network Quality Reports and Chair's Reports from Trust Quality and Safety groups	310318
		The Quality Surveillance Report (Tile) will continue to be strengthened to provide an effective overview of quality and safety priorities and performance	310318
	• All cost improvement and transformation programmes are involve a comprehensive assessment of the benefits and any risks to quality	The Quality Impact Assessment 'star chamber' model will be further developed to provide assurance that assessment of the impacts on quality are made at project initiation and are a continuous part of a programmes roll out and implementation..	310318
	• We are recognised as delivering high quality, compassionate continually improving care through national recognition through awards and innovative practice	Increase submission for and achievement of national awards/recognition as evidenced in the Quality Account	310318
		National reputation as a QI organisation	310318
	• The annual Quality Account is recognised as an exemplar of best practice	Continue to progressively develop quarterly Quality Accounts	310318
		To develop an annual portfolio of quality improvement stories in conjunction with an annual QI conference.	
	• Achieving the national and local quality improvement challenges through the CQUIN programmes	Achievement of 2016/17 CQUIN programmes	310317
		Achieve the National 2017/18 CQUIN programmes	310318
	• We will be a national leader in Quality Improvement (QI) – "always being the best that we can be". Teams will be empowered and	Continue to work in partnership with AQUA to deliver the Quality Improvement building blocks programme.	310718
		To develop a Quality Improvement plan on a page together with a detailed QI plan and learning programme with timelines and	310317

		trajectories	
	supported to be curious about how they are doing, using data and listening to feedback from people who use our services, their families, carers and people working at Lancashire Care to inform continuous quality improvement.	All clinical teams/support services teams will engage with the QI learning programme in line with the dosing formula as part of an annual roll out plan	310318
	• The QIF methodology and menu of tools will be spread across every area of work in both our clinical and support services and this will be underpinned by learning programmes. Quality improvement priorities will be informed by feedback from people who use services and underpinned by evidence based best practice standards.	All teams will evidence quality improvement initiatives	310319
		The annual quality improvement conference will enable teams to showcase their evidence based improvements through presentations, posters, work-shop sessions.	310118
A quality focused culture is embedded across the organisation – we will all be working together to always be the best we can be	• Clinical care pathways will be informed by NICE guidelines; NICE Quality standards and evidence based best practice standards. Pathways	Clinical care pathways will encompass clinical outcomes, patient reported outcomes	310318
		Co-produce the new electronic patient record to ensure that outcomes can be readily reflected and reported in line with the intelligence framework model.	310318
	• Safe and effective processes are in place to safeguard all vulnerable people who access our services	Safeguarding activity is recognised as part of everyday practice and there is evidence to support this	310316 to 310319
		To refresh and revise LCFT Safeguarding Vision	310316

		To apply the Safeguarding requirements of the Care Act and develop Safeguarding practice to support compassionate , safer & better care	310316
		Care act Implementation strengthened and understood via planning and work streams of a Task and Finish Group	310316
	• Real time feedback reporting and an experience dashboard is established from team to board enabling information to be shared in a timely way informing continuous quality improvements.	To continue to embed and further develop the experience dashboard.	310316
		To continue to work to co-produced solutions with IM&T to progress access to team level data for everyone with an annual roll out plan	310317 to 310319
	Serious incident investigations will be the best they can be	Continue to embed the Investigations and Learning team to improve investigations and the recommendations shared.	310318
		Continue to strengthen our mortality review process in response to learning from the CQC review of deaths.	310318
	• We are recognised as an organisation that provides outstanding experiences and achieves excellence in safe and effective care. o No Care Quality Commission (CQC) enforcement action o An improved rating of Good at the CQC Follow-up Inspection o A reduction in serious incidents by 10% o Zero outstanding actions from CQC inspection and monitoring visits o Zero mental health law	Internal Quality Assurance Visits will be driven by intelligence from quality surveillance	310316 to 310319
		Launch and embed a revised Quality SEEL tool for Networks and Corporate services	310318
		Launch a Quality module for sub-contracted services.	310318
		Undertake a review of the system of Blue Light safety alerts.	310317
		Implement a robust framework for Network level clinical procedures.	300917
		Undertake a review of mental health law training and implement an improvement plan	310318

		breaches. o Zero SI's relating to inappropriate management of physical ill health within a mental health inpatient environment.	Develop a framework for Network Mental Health Law Groups to learn from mental health law incidents/CQC and MHA inspections.	310317
			Develop a plan to enhance the clinical usage of the ECR/NHA Module.	310317
			To develop and implement a physical health training and support programme for mental health inpatient qualified staff	310916
			All CQC inspection plans will be completed and actions delivered on time	310316 to 310319
			All CQC Mental Health Act Monitoring Visit action plans MHA will be completed and delivered	310316 to 310319