East Suffolk and North Essex NHS Foundation Trust

Council of Governors

7th March 2019

Report Title:	Audit Indicator Selection Report, Quality Account
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Previously considered by:	NA

☑ **Approval** ☑ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

The quality report (also known as the quality account) incorporates all the requirements of the Quality Account Regulations as well as a number of additional reporting requirements set by NHS Improvement. The quality report specifically aims to improve public accountability for the quality of care and treatment.

The quality report forms part of the Trust's annual report.

Contained within the quality report are commitments to quality priorities within the domains of:

- Patient safety
- Clinical effectiveness
- Patient experience

Each NHS Trust is required to report on performance against the priorities and indicators set out in the previous year's report (the 'look back') and proposes priorities for the forthcoming year (the 'look forward'). Staff engagement is sought when devising quality priorities for consideration, as well as taking into account national quality workstreams and priorities.

Following the draft of the quality report, external consultation takes place with: North East Essex and East Suffolk Clinical Commissioning Groups; HealthWatch, and the report is scrutinised by our external auditors. Each will be invited to provide a statement on the content of the draft report that will be included in the published version.

The Council of Governors has a specific role in supporting the annual quality account that is described in the body of this report.

NHS foundation trusts also need to get assurance through substantive sample testing over one local indicator included in the quality report. Although the foundation trust's external auditors will be required to do the work, they will not have to provide a limited assurance report over this indicator in 2018/19 (this may be reviewed in future years). Depending on the specialist nature of the indicator selected, external auditors may wish to build on the expertise of others, including internal auditors' peer review, specialist review or a combination of these methods. The local indicator will be selected by the trust's governors.

The local indicator will continue to be determined by the governors of the NHS foundation trust. NHS foundation trusts' governors need to select the local indicator for assurance as in previous years. For 2018/19 we are recommending for acute providers that this indicator should be the Summary Hospital-level Mortality Indicator (SHMI).

Action required by the Council of Governors • The Council of Governors is **asked to agree** to select one indicator for detailed testing by the Trust's external auditors **by 7th March 2019**.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Improve quality and patient outcomes	☑
SO2	Provide better value for money	☑
SO3	Sustain and improve access to services that meet the needs of the population	☑
SO4	Deliver a sustainable, skilled workforce	☑

Risk Implications for the Trust *(including any clinical and financial consequences)*	If we do not have effective clinical governance and risk management arrangements, we are at risk of causing harm to a patient.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong

Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	National requirement to provide safer care and provide patients with the best possible experience
Financial Implications	Risk to reputation and subsequent financial loss
Equality and Diversity	There are no E&D implications

1. Introduction/Background

1.1 A quality report (or quality account) is a report about the quality of services by an NHS healthcare provider which NHS foundation trusts must publish each year as part of their annual report and accounts. These are regarded as an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

1.2 Annual guidance on the content of the quality report is provided by NHS Improvement; additional information to be included, which varies each year, is set out by NHS Improvement through a gateway letter, usually published in late January/early February.

1.3 Quality is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient experience focussed on the care provided.

1.4 The quality report incorporates all the requirements of the Quality Account Regulations as well as a number of additional reporting requirements set by NHS Improvement and NHS England.

2. Key requirements

2.1 The Department of Health requires providers to submit their final quality report to the Secretary of State by uploading it to the NHS Choices website by 30 June each year.

2.2 NHS Improvement Guidance for quality reports (2018/19) requires:

- **Part 1:** statement on quality from the Chief Executive of the NHS Foundation Trust.
- **Part 2:** priorities for improvement and statement of assurance from the Board. The description must include:
    - At least three **priorities for improvement** indicating the relationship, if any, between the identification of these priorities and the review of data relating to quality of care referred to in the assurance statement.
    - How progress to achieve next year's priorities will be monitored and measured, and
    - How progress to achieve these priorities will be reported.
- **Part 3:** other information, including an overview of the quality of care offered by the Trust based on performance in 2018/19 against indicators that were selected by the Board in consultation with stakeholders. The indicator set must include:
    - At least three indicators for patient safety;
    - At least three indicators for clinical effectiveness; and
    - At least three indicators for patient experience.

2.3 For those indicators selected by the NHS Foundation Trust, the report should refer to historical data and benchmarked data where available, so readers can understand progress over time and performance compared to other providers.

2.4 References should be given for the data sources for the indicators, including whether the data is governed by standard national definitions. Where these indicators

have changed from the indicators used in the 2018/19 report, the NHS foundation trust should outline the rationale for why these indicators have changed.

2.5 Where the quality indicators are the same as those used in the 2018/19 report and refer to historical data, the data reported should be checked to ensure consistency with the 2018/19 report. Where inconsistencies exist, NHS foundation trusts are required to include an explanatory note on any changes in the basis of calculation.

2.6 The purpose of the quality account is to enhance accountability to the public for the quality of NHS services. The content of the quality account is largely mandated by statute in terms of its content and structure, and includes:

- Statement on quality from the Chief Executive
- Statement of Directors' responsibilities in relation to the quality account
- Articulation of quality priorities for the year ahead
- Progress report on quality priorities identified for the previous year
- Review and publication of various other nationally benchmarked data relating to quality (eg incident reporting, standardised hospital mortality index (SHMI), venous thromboembolism (VTE) risk assessment, friends and family test (FFT)
- Review and publication of various other nationally benchmarked data relating to performance (eg referral to treatment (RTT) position and cancer access)
- Participation in national and local clinical audits
- Information on research participation
- Progress report in relation to performance against commissioning for quality and innovation (CQUIN) goals for the previous year
- Statement on compliance with Care Quality Commission (CQC) standards
- Statement on data quality
- Statements from external reviewers (commissioners, HealthWatch, , external auditors)

3. 2018/19 Quality Improvement Priorities

3.1 NHS Foundation trusts are required to obtain assurance through substantive sample testing over one local indicator included in the quality report, **as selected by the governors of the Trust.** The auditor will provide a response on its findings and recommendations for improvements on this indicator to the Board of Directors and the Council of Governors of the NHS Foundation Trust. To assist governors with this selection, the 2018/19 quality indicators will be provided to the governors prior to its full Council meeting on the xxxx 2018. The indicators set for 2018/19, with associated recommendations for audit, are outlined at **Appendix 1.**

Performance Indicators for 2018/19

Auditors will provide a limited assurance report on whether, based on the procedures performed and evidence obtained, anything has come to their attention that causes them to believe that the two mandated indicators have not been prepared, in all material respects, in accordance with the applicable criteria.
The NHS foundation trust's auditors will undertake substantive sample testing of the mandated indicators included in the quality report as follows:

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

1. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

2. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

3. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

4. Emergency readmissions within 28 days of discharge from hospital.

NHS foundation trusts providing community services

Community NHS foundation trusts should select two indicators that are relevant for the trust.
For NHS foundation trusts providing a mix of different types of services
NHS foundation trusts providing a mix of different services should follow the guidance above for the category of services from which they receive most of their income.

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

2. Emergency readmissions within 28 days of discharge from hospital

3. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

4. Other indicator(s) included within the quality report.

NHS foundation trusts providing acute services

NHS foundation trusts also need to get assurance through substantive sample testing over one local indicator included in the quality report. Although the foundation trust's external auditors will be required to do the work, they will not have to provide a limited assurance report over this indicator in 2018/19 (this may be reviewed in future years). Depending on the specialist nature of the indicator selected, external auditors may wish to build on the expertise of others, including internal auditors' peer review, specialist review or a combination of these methods. The local indicator will be selected by the trust's governors.
The local indicator will continue to be determined by the governors of the NHS foundation trust. NHS foundation trusts' governors need to select the local indicator for assurance as in previous years. For 2018/19 we are recommending for acute providers that this indicator should be the Summary Hospital-level Mortality Indicator (SHMI).

4. Recommendation

Action required by the Council of Governors:

- The Council of Governors is **asked to note** the attached outline of the Trust's quality improvement priorities for 2018/19.
- The Council of Governors is **asked to agree** to select one indicator for detailed testing by the Trust's external auditors **by xxxx 2019**.

Appendix 1

Priority 1: Safe

Measure	Target	Comment
Safety Thermometer - new harm only	>98%	Not recommended as a candidate for detailed audit testing. Source: data uploaded into national programme and point prevalence survey.
Number of avoidable hospital associated grade 4 pressure ulcers	0	Source: local data collection through QSiS and scrutiny through Harm Free Panel. Robust scrutiny in place already within the Trust and results are binary. Not recommended as a candidate for detailed audit testing:
A reduction in hospital acquired pressure ulcers	A reduction by 30% of hospital acquired pressure ulcers (total numbers) compared to 2017/18.	Source: Local data collection Robust scrutiny in place with confirmation of level of damage and external reporting and challenge
Number of vacancies for registered Nursing and Midwifery	Achieve ≤11% vacancy rate and sustain this throughout the year	Source: staff roster data capture. Not recommended as a candidate for detailed audit testing as it would not be considered by the Trust as adding value.
Number of vacancies for Healthcare Support Workers	Achieve ≤15% vacancy rate and sustain this throughout the year	
Number of cardiac arrests per 1000 admissions per month (excluding peri-arrests)	Reduce by 2% from previous year total	Not recommended as a candidate for detailed audit testing. Source: data uploaded into national programme and point prevalence survey.
% of deaths reviewed (using new national methodology)	>50%	Source: Structured Judgement Reviews undertaken by clinical staff. The process was commenced part-year during 2017/18 and not fully established at this point. Not recommended as a candidate for details audit testing this year, but a good candidate following full year implementation next year.

Average reported patient safety incident rate per 1000 bed days	Increase by 2% above 2016/17 average	Not recommended as a candidate for detailed audit testing. Source: data uploaded into national programme and point prevalence survey.

Priority 2: Effective/Responsive

Measure	Target	Comment
Number of avoidable deaths from sepsis established through mortality review	Year 1 baseline to be established	Source: Structured Judgement Reviews undertaken by clinical staff. The process was commenced part-year during 2017/18 and has been reviewed following merger therefore not fully established at this point. Not recommended as a candidate for details audit testing this year, but a good candidate following full year implementation next year.
Summary Hospital-level Mortality Indicator (SHMI)	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Recommended by NHSI for 2018/19
Cancelled operations on or after the day of admission as a percentage of total elective admissions	<=1%	Source: national target data. Already subject to external scrutiny. Not therefore recommended as a candidate for detailed audit testing.
Bed days lost to Delayed Transfer of Care (DTOC) as a percentage of total occupied beds	≤2.5%	Source: national target data. Already subject to external scrutiny. Not therefore recommended as a candidate for detailed audit testing.

Priority 3: Patient Experience/Caring

Measure	Target	Comment
Percentage of complaints responded to within 30 working days or within extension agreed with complainant	≥90%	Source: local data collection. Already subject to external scrutiny. Not therefore recommended as a candidate for detailed audit testing.
Pain assessment recorded with every set of observations	10% increase from baseline by Q4	Source: local data collection. Methodology for assessment changed and under regular scrutiny therefore not recommended as a candidate for detailed audit testing.
Percentage of patients aged 16 and over admitted as inpatients for more than 24 hours who have had a nutrition screening documented within 24 hours of admission.	10% increase from baseline by Q4	Source: local data collection. Already subject to external scrutiny. Not therefore recommended as a candidate for detailed audit testing.
Positive responses to catering service satisfaction survey	>=95%	Source: local data collection. Not recommended as a candidate for detailed audit testing as it is already subject to audit and would not add value.
Outpatient FFT	Response rate increased by 3% on previous year average	Source: national data collection. Not recommended as a candidate for detailed audit testing as it is already subject to scrutiny and established.

Priority 4: Staff Experience/Well-led

Measure	Target	Comment
Staff FFT - Likelihood to recommend as a place to work	2% improvement against previous year average	Not recommended as a candidate for detailed audit testing. The gathering of this data is via the survey of individual members of staff. As such, there is little to test in terms of controls that would add value.
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	2% improvement against previous year score	Not recommended as a candidate for detailed audit testing. The gathering of this data is via the survey of individual members of staff. As such, there is little to test in terms of controls that would add value.

I am confident that my organisation would address my concern (when I have raised concerns about unsafe practice)	2% improvement against previous year score	Not recommended as a candidate for detailed audit testing. The gathering of this data is via the survey of individual members of staff. As such, there is little to test in terms of controls that would add value. This is also a focussed priority for 2019/20 and therefore will have added value in the following year.