East Suffolk and North Essex NHS Foundation Trust

Council of Governors

7th March 2019

Report Title:	Quality Improvement Priorities 2019/20
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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.

This report informs the Council of Governors of the Key priorities for the Trust for 2019/20 chosen to continue to support improvements in Patient Safety, Clinical Effectiveness and Patient Experience.

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 2019/20.

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 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)

2018/19 Quality Improvement Priorities

ESNEFT priorities for improvement in 2018/19

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views of users have helped inform the Trust's priorities for 2018/19.

Patient safety priority 1:

To improve compliance with the Sepsis 6 care bundle

Why is this a priority? The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It was developed in 2006 by a group of physicians and nurses working on an educational programme to raise awareness and improve the treatment of patients with sepsis.

The management of sepsis from presentation in ED after admission to hospital usually involves three treatments and three tests, known as the 'Sepsis Six'. These should be initiated by the medical/ nursing team within an hour of red flag marker identification unless a non-sepsis rationale is documented by a clinician for diagnosis.

Lead Directors: Medical Director and Chief Nurse

What is our target?

• Timely identification of sepsis in the Emergency Department and acute inpatient settings as per the National Guidelines of the 'Sepsis 6' defined above

• Timely treatment of sepsis within 60 minutes

• Compliance with Sepsis 6 in ED >90% at end of 12 months

What will we do to improve our performance?

- Implement clinical sepsis tool to guide screening and treatment
- Implement mandatory training (e-learning programme) for all clinical staff
- Enable the prescribing of intravenous fluids by nursing staff to manage the early treatment of sepsis
- Increase awareness of the signs and symptoms of sepsis for healthcare professionals and the public through education
- Implement Sentinel, electronic observation and escalation trigger software to increase awareness and response time to sepsis and the deteriorating patient.

How will we measure and monitor our performance?

- Audit timely identification and treatment of sepsis
- Monitor compliance with staff training for doctors and nurses
- Compliance with Commissioning for Quality and Innovation (CQUIN) national goals for identification and treatment of suspected sepsis

How and where will progress be reported?

Regular reports and updates to:

Time Matters, Patient Safety, Quality and Patient Safety Committee and Deteriorating Patient Group

Patient safety priority 2:

To reduce the numbers of inpatient falls

Why is this a priority?

Ensuring that our patients receive 'Harm Free' care during their admission is a key priority for any healthcare provider. The impact on patients following a fall in hospital can be wide ranging and complex.

The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2019/20.

Lead Director: Chief Nurse

What is our target?

A reduction of inpatient falls per 1000 bed days to below 5 within the two acute hospitals. The Community Falls per 1000 bed days improvement trajectory will be reduced based on the national best practice and benchmarking completed in quarter 1.

What will we do to improve our performance?

- A review of the current best practice, benchmarking and current number and type of falls within the community to establish a trajectory for improvement in community falls
- A Trust-wide improvement plan for Falls will be developed
- An aggregated action plan will be implemented for falls incidents resulting in harm
- The Falls Prevention inpatient service will be developed within Corporate Nursing and Quality Divisions, with leadership provided by the Site Director of Nursing on behalf of the Chief Nurse

How will we measure and monitor our performance?

- Incident reporting of all inpatient falls are monitored through Patient Safety & Quality Team and reported upon via the Ward Safety Dashboard to Matrons Group, chaired by the Chief Nurse.
- All falls resulting in serious harm are investigated at the earliest opportunity and case were reviewed through the weekly Harm Free Forum chaired by the Site Director of Nursing. This identified immediate learning will inform quality improvement plans.
- Monthly review of falls activity and trends will form part of the Patient Safety Report.
- Inpatient falls incidents will be triangulated with PALS, Complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust.

How and where will progress be reported?

Regular reports and updates will be provided to: Matrons Meeting, Patient Safety Group, Harm Free Group and Quality & Patient Safety Committee.

Clinical Effectiveness Priority

Getting it right first time (GIRFT) programme improvements

Why is this a priority?

GIRFT is a National programme working with frontline clinicians to identify and reduce unwarranted variations in service delivery and clinical practice. Clinical Specialty visits have taken place in some areas and others are currently underway or are planned.

Lead Director: Medical Director

What is our target?

Clinical Specialties will identify the top 3 areas for improvement during quarter 1 and develop the action plans required to achieve the improvements.

What will we do to improve our performance?

- Specialties to produce action plans and deliver against GIRFT Report recommendations, focussing on the top 3 areas requiring improvement.
- The GIRFT Board will receive the specialty updates, agree milestones for improvement and support with identification and mitigation against risks identified.

How will we measure and monitor our performance?

- Agree key milestones and monitor performance against the milestones at GIRFT Board
- Ensure the improvements are included within the Quality Improvement Faculty within ESNEFT to support clinicians to develop and sustain improvements.
- Identify a key person from the Transformation Team to support the clinical teams with planning and improvements

How and where will progress be reported?

Regular reports and updates to:

Time Matters Board, Clinical Effectiveness Group and Quality & Patient Safety Committee

Patient Experience priority:

Patient experience priority:

To continue to improve our care to those at the end of their life and support patients who have limited treatment options.

Why is this a priority?

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high quality care enables us to make a loved one's final

weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning treatment and care wanted, and an individual plan of care tailored to the needs, wishes and preferences of the dying person; agreed, coordinated and delivered with compassion.

Lead Directors: Chief Nurse & Medical Director

What is our target?

- To deliver high quality, compassionate and dignified end of life care for all patients.
- Patients will receive the right care in the right place
- To increase the number of patients dying in the place of their choice.

What will we do to improve our performance?

- Recognise timely identification of patients in the last year of life by increasing use of end of life support tools
- Discuss with patients and their families their wishes and document on My Care Choices Register (MCCR) and develop this across ESNEFT.
- Access patient's MCCR on every emergency admission
- Work with system partners to improve end of life care at home provision.
- Use national and locally recognised tools, i.e. the regional DNACPR form, the yellow folder , treatment options form and the Individual Care Record for the last days of life, SPICT and MCCR
- Promote co-ordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice.
- Facilitate palliative and end of life care training and education for staff using innovative and creative approaches to learning.
- Continued access to specialist palliative care assessments, seven days a week.

How will we measure and monitor our performance?

- Monitored themes from complaints relating to end of life care and share these complaints with clinical staff.
- Monitored results from DNACPR and national end of life audits to highlight themes for improvement.
- Audited use of individualised care Individual Care Record for the Last Days of Life plans to ensure best possible practice.
- Expanded post bereavement follow up service with families

How and where will progress be reported?

Regular reports and updates to: Time Matters Board, Patient Experience Group, Quality & Patient Safety Committee

Clinical effectiveness, Patient Experience and Staff Experience priority:

NHS
East Suffolk and North Essex
NHS Foundation Trust

To improve clinical outcomes for patients with mental health conditions, improve mental health well-being for staff and transform Mental Health provision across ESNEFT.

Why is this a priority?

This is a national priority to ensure people receive prompt access to ensure parity of both mental health and physical health care. NHSE advises that one in four adults and one in ten children experience mental illness and many more know and care for people who do.

There is evidence that 25-33% of people admitted to acute hospitals also have a mental health condition, with mental health disorders accounting for 5% of all Emergency Department (ED) admissions.

By providing effective mental health support to patients, and expertise to staff where required, we can minimise the time a patient needs to stay in an acute hospital environment and build effective mental health services for children and young people.

ESNEFT staff require support, education and tools to enable them to improve their own well-being and recognise and support patients and carers who require further support.

Lead Directors: Director of Human Resources, Medical Director, Chief Nurse

What is our target?

- Complete a baseline audit to identify the current support in place and variances between sites.
- Recruit and appoint to vacancies to roll out psychiatric liaison services across acute inpatient services.
- Gain understanding of current referral processes into mental health and community services. Map 'to be' processes and commence work with system partners to streamline processes

What will we do to improve our performance?

- Organisational education programme for: workforce across Nursing and AHP & enhanced by the development of ward link educators at band 6 & undergraduate Programme
- Develop process for performing emotional wellbeing assessments across all inpatients and targeted outpatients – (including detail of responses to positive assessment)
- Communications programme for what support is available for our own staff, what, where, how?

How will we measure and monitor our performance?

- Monitor the ED breaches for patients requiring mental health support.
- Monitor the length of stay for patients who have a mental health co-morbidity
- Monitor provision of staff support and training

How and where will progress be reported?

Regular reports and updates to: Time Matters Board, Clinical Effectiveness Group, Patient Experience Group, POD