East and North Hertfordshire NHS Trust

Agenda Item: 9b

TRUST BOARD – JULY 2013
IMPROVING PATIENT OUTCOMES STRATEGY 2013/14

PURPOSE	To propose priorities for the focus of Improving Patient Outcomes performance within the Trust for 2013/14
PREVIOUSLY CONSIDERED BY	RAQC on 17 July 2013
Objective(s) to which issue relates *	☑ 1. To continuously improve the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services ☐ 2. To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction ☑ 3. To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services ☑ 4. To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable ☑ 5. To support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services ☐ 6. To improve our staff engagement and organisational culture to be amongst the best nationally
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Failure to continually improve patient outcomes is likely to result in the Trust becoming an outlier for clinical performance with unnecessary suffering for patients and reputational harm for the organisation.
Healthcare/ National Policy (includes CQC/Monitor)	The Operating Framework for the NHS in England 2012/13 The NHS Outcomes Framework 2013/14 Quality in the new health system – Maintaining and improving quality from April 2013; National Quality Board
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☑	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	Medical Director
PRESENTED BY:	Medical Director
AUTHOR:	Medical Director and Clinical Improvement Lead
DATE:	10th July 2013

Trust Board – July 2013

IMPROVING PATIENT OUTCOMES STRATEGY 2013/14

1. EXECUTIVE SUMMARY

East and North Hertfordshire NHS Trust strives for excellence and continual improvement in its vision to be "amongst the best NHS performing Trusts within the country". Our foremost value of "putting our patients first " has led to the production of this *Improving Patients Outcomes* (IPO) strategy with a focus on measurable clinical outcomes, ever improving patient safety and the provision of contemporary care pathways particularly for those with chronic or complex problems.

The IPO strategy will facilitate achievement, not only of the Trust's strategic objectives, but also quality improvements required by the NHS Outcomes framework and the Trust Development Authority. The document also references existing Trust strategies that collectively with IPO enable the provision of high-quality clinical care.

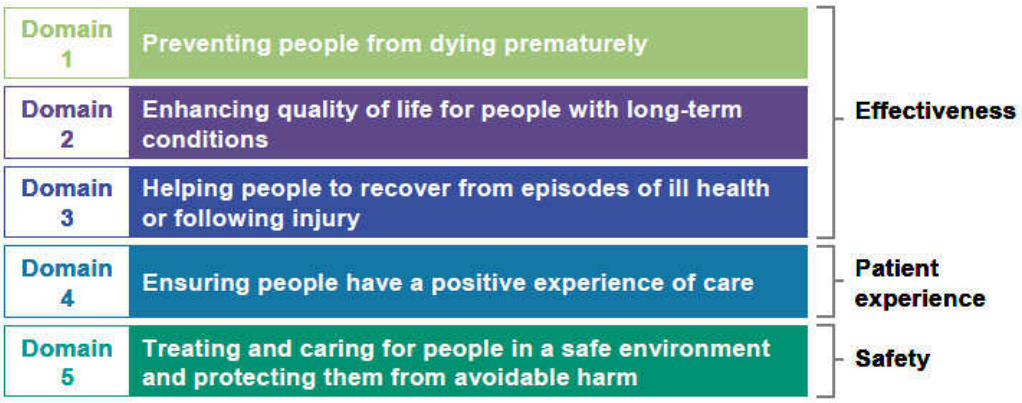
2. BACKGROUND

2.1 Department of Health Strategic Drivers

The Operating Framework for the NHS in England 2012/13 DH; Nov 2011. This document describes the national priorities, system levers and enablers needed for NHS organisations to maintain and improve the quality of services provided, while delivering transformational change and maintaining financial stability.

The NHS Outcomes Framework 2013/4 DH; Nov 2012 contains ways to help the NHS focus on measuring outcomes (Figure 1). The indicators used are grouped around five domains, which set out the high-level national outcomes that organisations should be aiming to improve.

Figure 1



Equity & Excellence – Liberating the NHS; DH; July 2010. The establishment of Clinical Commissioning Groups (CCG's) in April 2013 means that CCG involvement will be expected in the redesign of patient pathways and local services. This should

ensure that developments are clinically-led and based on more effective dialogue and partnership with hospital specialists and other agencies.

2.2 Improving Quality in the NHS

Public confidence in the NHS has been shaken this year in the wake of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013.* The report contained an extensive list of recommendations for the whole health economy and beyond. Those relevant to service providers have been considered in the preparation of this strategy specifically including, but not limited to:

- Ensure openness, transparency and candour about matters of concern
- Enhance education, training and support for the provision of healthcare
- Develop and share means of measuring and understanding the performance of individual professionals, teams, units and provider organisations

In the lead up to this report a series of documents were released, including commissioning guidance, emphasising a focus on clinical quality:

Quality in the new health system – Maintaining and improving quality from April 2013; National Quality Board;Jan 2013. This document sets out how quality should be maintained and improved and concentrates on how we should prevent, identify and respond to serious failures in quality.

Toward High Quality Sustainable Services, Planning Guidance for NHS Trust Boards for 2013/14; Trust Development Authority; Dec 2012. This sets out the responsibilities to create an environment and the aspirations and ambitions to be shared so that Trusts can deliver high quality, sustainable services for patients and local communities.

Commissioning for quality and innovation (CQUIN): 2013/14 guidance; NHS Commissioning Board; Feb 2013. The key aim of this framework is to secure improvements in the quality of services and better outcomes for patients in partnership with the CCG, whilst also maintaining strong financial management.

Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS; DH, Dec 2011 proposed the establishment of Academic Health Science Networks (AHSN). These are intended as a vehicle by which the NHS and universities will work with industry specifically to improve patient and population health outcomes by translating research and innovation rapidly into practice and developing and implementing integrated health systems. ENHT is the Lead Trust in the Beds & Herts Node of the Eastern AHSN.

2.4 Emerging Trends

The demographic implications of the rising number of elderly people, including those with long-term conditions (LTC) is a challenge for the NHS as outlined in the *Annual Report of the Chief Medical Officer 2012, DH.* Strategies to address this challenge will undoubtedly include greater use of telemedicine enabling those patients with LTC to monitor their conditions remotely thus reducing the need for hospital attendance.

There is increasing societal expectation for 7 day working and effective ways to deliver clinical services outside the standard working hours are described in *NHS Equality for all – Delivering safe care – seven days a week;* NHS Improvement; 2012.

3 PURPOSE

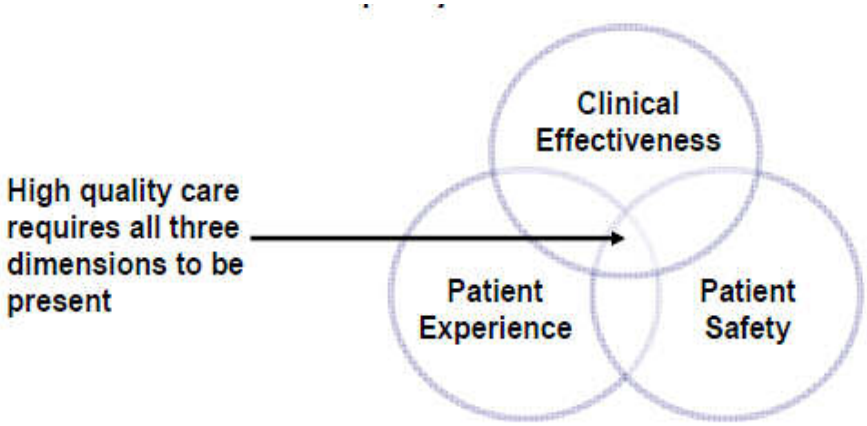
The Trust's vision aspires to be "amongst the best NHS performing Trusts within the country".

The National Quality Board are clear that "*"the most effective mechanism for preventing quality failure was for organisations and individuals providing care to be continuously striving for improvement; for the system to support and expect professional pride and ambition to deliver the very best quality of care for patients across all services".* It is therefore appropriate that the Trust underpins its vision through the delivery of five values shown in Figure 2, which summarise the way the Trust wishes to work.

Figure 2

3.1 What is High Quality Care?

The Venn diagram in Figure 3 below illustrates its composite dimensions



Continual improvement of clinical quality requires attention to all three dimensions. This strategy will concentrate on Clinical Effectiveness (see 2.1 Domains 1-3) and builds upon the Patient Safety strategy (Domain 5). These are described in more detail in Figure 4. There is a well developed Patient Experience strategy in place and new schemes relating primarily to patient experience are not discussed in this paper.

Figure 4

What is Clinical Effectiveness ?	**What is Patient Safety ?**
Uniform implementation of key-evidence based interventions	Minimise avoidable harm
Indicators of quality outcome and success	Information sharing and learning
Clinical data to frontline staff	Reduce inappropriate variation

In *Quality in the new Health system – Maintaining and improving quality from April 2013, t*he National Quality Board say "An organisation that is truly putting patients first will be one that embraces and nurtures a culture of openness and learning". They also say "Clinical teams understand the quality of service they are providing to patients through routinely measuring and benchmarking their performance with peers across the three dimensions of quality – safety, effectiveness and patient experience.

This is achieved, in part, by ensuring that clinical pathways, where available, are in line with key clinical guidance. Examples of relevant key clinical guidance underpinning this strategy are attached in Appendix 1. It also requires the consideration of clinical audit and outcome data by clinical teams.

Of course Clinical Quality cannot be regarded in isolation. The lessons emanating from the Keogh mortality reviews have shown that adequate staffing levels with appropriate skill mix, operational efficiency with smooth patient flows, effective leadership and good financial controls are inextricably linked with clinical quality. These important issues are addressed through other strategies and ongong work streams *eg* Skill mix review. However, where appointment to specific, mostly medical, posts is integral to quality improvement initiatves this has been incorporated.

4 HOW DOES THIS FIT?

The Trust's strategic aims collectively strive for improvement. The relevant aims are:

- To continuously improve the quality of our services in order to provide the best care and **optimise health outcomes** for each and every individual accessing the Trust's services
- To excel at customer service, achieving outstanding levels of **communication** and patient, carer and GP satisfaction
- To provide and support the best standards of **integrated care** for the elderly and those with long term conditions by developing key partnerships and services
- To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, **innovative** and integrated services which are sustainable

The Trust's objectives and Annual Plan align with this IPO strategy which is also supported by the Patient Safety Strategy and the Patients and Carers Experience Strategy. The interrelationships are shown in matrix form in Figure 5.

The aims described within the IPO strategy for the forthcoming year are the same as those described with the ENHT Quality Account although because of the prescriptive format constraints are presented in a different way.

The Trust's Quality Account priorities for 2013/14 are:

Priority 1 – Improving safety
Priority 2 – Improving clinical outcomes
Priority 3 – Staff/development / engagement
Priority 4 – Improving patient experiences

5 STRATEGIES FOR IMPROVEMENT

The Trust's quality improvements are agreed with the TDA in light of current quality performance levels, align with the five domains defined in *The NHS Outcomes Framework 2013/14*; DH; Nov 2012 and are considered the primary reference points for the remainder of the document. The Trust has provided evidence to the TDA to confirm compliance with all 27 requirements in the Integrated Quality Checklist.

5.1 Quality improvement objectives

These are shown below along with the various interrelations. The remainder of the paper will focus on the contents of the green boxes.

Figure 5

Domains (See 2.1)	Quality Improvement Objectives	Existing Strategies	Quality Account Priorities	Trust Objectives (See p 1)
1	*To reduce mortality*		*Improving clinical outcomes*	1
2	*To enhance quality of life by reducing emergency admissions for acute conditions*			3, 5
	Improving inpatient care of diabetes			
3	*Improving post-operative outcomes for high-risk patients (deteriorating patient, frail elderly, those with comorbidities)*			1, 4
4	*Improving the experience of patients using our services*	*Patient Experience*	*Improving patient experiences*	*2*
5		*Patient Safety*	*Improving safety*	4

5.2 Strategic Aims

The strategic aims and objectives are detailed in the series of Tables below. Aspects of quality care that represent “Business as usual” are not listed but rather the focus is on new or developing initiatives. Patient Safety includes the 2013/4 iteration of the Patient Safety strategy as well as Trust-wide initiatives, usually the remit of the Clinical Governance Steering committee (CGSC), designed to generically improve standards of care. The development focus for the CGSC in 13/4 will be on

- Improved access to information support for decision making
- Appropriate staff balance: Throughout the week and between Lister and QEII
- Safer inpatient processes

The CGSC committee will also actively contribute to the emerging I,M&T strategy to facilitate delivery of these areas of focus.

Domain 1 – To reduce mortality				
Scheme	CQUINS	Key risk	Measuring Performance	Key Milestones
Implement Improving Patient Outcomes Strategy	No	Failure to secure funding or recruit	Through constituent schemes in year	IPO Review 06/14
Implementation of 5 revised clinical pathways from 2012/3 (See Appendix 2)	Local	Financial due to SHMI lag time or for staff recruitment	Crude mortality & HSMR fortnightly to Exec Committee Medical Director report to RAQC CCG mortality reviews	Phased audits Q4 data for outcomes
Development of 4 new clinical pathways for 2013/4 (See Appendix 2)	Local	Temporary staff Inability to recruit		Audit Q2 Develop Q3 Implement Q4
Directorate focus on mortality for specialty pathways to drive systematic evaluation of outlying performance	No	Clinical understanding	Monthly CG Rolling Half Day Divisional Performance Reviews	M6 training session with MD and Dr Foster
Further improve coding performance through revised structure, systems and ward clerk programme	No	Support for Project management Financial	Coding Review group Reports to Executive Committee	Q2 Develop plan Q3 Implement
Stroke: meet all Trust aims regarding stroke care	No	Inability to recruit Consultant Stroke Physicians Inability to control emergency demand	Monthly "Floodlight" to RAQC (exception reporting to Board) Bi-monthly performance review within Medical Division Acute Medicine Rolling Half Day	TIA access targets Admit <4 hours in ED Scan within 60 mins 90% stay stroke unit
Primary Percutaneous Coronary Intervention- 24/7 service	No	Lack of CCG or SCG approval Failure to recruit skilled staff	Divisional Board Cardiology RHD Dashboard Consultant-level outcome data	Q1 Advertise Q2 Recruit / Train Q3 Refurbish Lab 2 Q4 Launch service
98h Consultant cover on labour ward &1:27 midwife ratio	No	Failure to secure funding or recruit	Bi-monthly performance review within Women & Children's	Q1 Locum Consultant Q3 Substantive appt Q4 Additional nurses
Achieve NICE standards for Neonatal service	No	Failure to recruit	Audit to demonstrate compliance	Q2 Recruit Q4 Additional nurses
Optimise total parenteral nutrition use in pre-term babies	SCB	Baseline unrepresentative	Bi-monthly Clinical Quality Review Divisional Board	Q1 Agree baseline
Enhance out of hours Medical cover	No	Calibre of staff 2 site complexity	Bi-monthly performance review within Medicine	Q2 Increase cover + Assess further need

Domain 2a - To Enhance Quality Of Life By Reducing Emergency Admissions For Acute Conditions				
Scheme	CQUINS	Key risk	Measuring Performance	Key Milestones
Unscheduled Care – reduce hospital medical emergency admissions by 10% across local health system • Develop alternative clinically appropriate pathways • Consultant telephone triage for GPs • Extended hours AAU Consultant cover	Local	Inability to recruit	Monthly "Floodlight" to RAQC Twice monthly review by TIMP Bi-monthly Clinical Quality Review Quarterly CQUINS monitoring	Q1 Plan & milestones Q2 3% reduction Q3 6% reduction Q4 10% reduction
Unscheduled Care – increase proportion of patients discharged at weekends by 20% with local health system	Local	Community provision	Monthly "Floodlight" to RAQC Twice monthly review by TIMP Bi-monthly Clinical Quality Review Quarterly CQUINS monitoring	Q1 Plan & milestones Q4 20% increase
Dementia – Identify, assess and refer on those identified as potentially having dementia. - Ensure named lead clinician and RAID training for staff - Ensure dementia patient carers feel supported.	National	RAID training just on single site	Monthly CQUINS group Bi-monthly Clinical Quality Review Quarterly "Floodlight" to RAQC (exception reporting to Board)	Monthly audit >90% for any consecutive 3 months
Ensure patients admitted with acute exacerbation of COPD are discharged with a completed care bundle.	Local	Failure to secure funding or recruit	Monthly CQUINS group Bi-monthly Clinical Quality Review Quarterly "Floodlight" to RAQC (exception reporting to Board)	Q1 Pilot audit tool Q2 50% to Q4 75%
Appoint interface Geriatrician	No	Failure to secure funding or recruit	Divisional Performance Reviews	Q2 Secure funding Q4 Commence service
Development of Ambulatory pathways in Gynaecology	No	Failure to secure funding	Divisional Performance Reviews	Q3 Secure funding Q4 Implement
Acute Oncology advice line	No	Failure to secure funding or recruit	Divisional Performance Reviews	Q3 Launch service
AMBER care bundle (for uncertain recovery patients) Key aim- Discharge to preferred place of care	No	Availability of places	Sisters forum	Q2 Audit & rollout QEII Q4 rollout Lister
Additional Consultant staff and Senior Nursing support for the Emergency Department	No	Unable to recruit Consultant staff Nurse funding	Divisional Board TIMP	Reduction in episodes of harm
Bid to EAHSN for funding for relevant Long Term Condition projects	No	Bid unsuccessful	Eastern AHSN Beds & Herts Node meeting	Q1 Submit bids

Domain 2b – To Improve The Inpatient Care Of Diabetes				
Scheme	CQUINS	Key risk	Measuring Performance	Key Milestones
Ensure patients admitted with a diagnosis of diabetes should be discharged with a completed care bundle which includes - Access to the inpatient DM Team within 24h within working hours or 48h our of hours for patients on insulin - Patients who smoke to be referred to cessation service	Local	Unable to recruit key staff	Monthly CQUINS group Bi-monthly Clinical Quality Review Quarterly "Floodlight" to RAQC (exception reporting to Board)	Q1 Pilot audit tool Q2 30% Q3 45% Q4 60% M5 New consultants and nurses start
Implement next working day Paediatric diabetic review	No	Unexpected leave	Divisional Board	Q2 Substantive Consultant starts
Improve training through roll-out insulin safety e-learning	No	Lack of awareness	ESR download	TBC
Increase number of patients with insulin pump access for Type 1 diabetes	No	Minimal – staff secured	National Pump Audit at Diabetes RHD	Q3 Double clinic provision
Support 7 day working for inpatient diabetes and endocrinology services	No	Minimal – staff secured	NaDIA audit at Diabetes RHD	Q3 New staff in post
Bid to EAHSN for funding for EASIPOD (pre-pregnancy care programme to reduce severe adverse pregnancy outcomes)	No	Bid unsuccessful	EAHSN Beds & Herts Node committee	Q1 Submit bid

Domain 3 - Improving post-operative outcomes for high-risk patients				
Scheme	CQUINS	Key risk	Measuring Performance	Key Milestones
Centralise the Elective General Surgery service to the Lister	No	1 surgeon in dispute. Safety for QEII site	HSMR for QEII site in fortnightly report to Executive Committee	Q2 centralise
Enhanced Emergency Theatre management through increased utilisation of elective capacity and more senior support	No	Unwillingness of theatres to manage Elective overruns	Divisional board Divisional Performance	Q1 Specialty data Q2 Identify issues Q3 Improve access
Geriatric support to pre-operative preparation and post – operative recovery	No	Unable to identify funding		TBC
Double capacity in high-risk Consultant Anaesthetist led pre-admission clinics from 2-4 per week	No	Minimal – staff secured	Anaesthetic Directorate	Q1 Service increase
Increase use of oesophageal Doppler monitoring	No	Training	Anaesthetic Rolling Half Day Divisional board	Initial target 60. Re-evaluate mid-year.

Rollout the enhanced recovery programme schedule to Urology	No	Education Culture and resource	Twice monthly review by TIMP Surgery performance review	Q4 Implementation
Publication of consultant-level activity and outcome data in 6 specialties performed within the Trust	No	Reputational Public Understanding of statistics	Medical Director report to RAQC	Q2 Publication

Domain 5 – Patient Safety				
Scheme	CQUINS	Key risk	Measuring Performance	Key Milestones
VTE Risk assessment - % of adult inpatients assessed using national tool	National	Lack of training Temporary staff	Monthly CQUINS group Bi-monthly Clinical Quality Review Monthly "Floodlight" to RAQC (exception reporting to Board)	Q1-4 Achieve 98%
VTE Root cause analysis – number of patients who have RCA for DVT/PE within 90 days of hospital admission	National	Baseline unrepresentative		Q1 Establish baseline and agree trajectory
NHS Safety Thermometer (HAPU, Falls, UTI)	National	Random distribution of patients (single snapshot)	Monthly CQUINS group Bi-monthly Clinical Quality Review Monthly "Floodlight" to RAQC (exception reporting to Board) Divisional Performance Reviews	Q2 20% reduction HAPU & maintain falls with harm <0.2 Q4 Maintain target
Establish risk-based patient safety walkabout programme	No	Successful other bids	Patient Safety committee (escalation to CGSC)	Q2 Commence
Consent improvement plan • Knowledge centre (KC) area on consent • Focus on training both face to face and e-learning • Increase procedure specific consent forms • Adapt consent form to enable data capture	No	Locum staff Lack of clinical engagement	Action Plan monitored by Clinical Governence Strategy Committee	Q1 Improve KC Q2 RHD presentations
Roll-out Datix web for real time logging of incidents	No	Manual data entry	PLICS report to RAQC	Q2 Full rollout
Implement National Early Warning system	No	Bank/Agency staff	Patient Safetfy Committee. Nursing Indicators. Divisional & Trust Nurse fora	Q2 Implementation Weekly sample audits
Drug Errors – schemes focus on anticoagulation and delays with critical medicines.	No	Bank/Agency staff Staff on unfamiliar wards	Monthly "Floodlight" to RAQC (exception reporting to Board) Relevant Performance Reviews Medication forum	Q4 Serious dispensing 3-6 Q4 Administering 145-161
Participate in EAHSN patient safety workstream	No	Workload	EAHSN Beds & Herts Node committee	TBC

Medical Director and Director of Nursing approve quality impact assessments for all CIPs	No	Minimal	CCG scrutiny	
Diminish risk by effective Appraisal and Revalidation of non-training grade doctors	No	Temporary appointments	Bi-annual Responsible Officer report to RAQC	95% of plan by M12 (excluding on-hold)
Further improve Clinical Audit and Clinical Effectiveness Performance to reduce variation and promote learning	No	Inability to handle remit with fewer personnel	Bi-annual Clinical Audit and Cliinical Effectiveness reports to RAQC Status reports to RHDs 3 per year Divisional Performance Reviews	Revised KPIs for 12/13
Improve rates of Mandatory Training to reduce clinical risk	No	ESR	Monthly "Floodlight" to RAQC	90% by Q2 14/15
Access to Information to support decision making – • Electronic document library development • Use of Trust "compatible" apps	No	Delay to appointment due to banding issues	Clinical Governance Steering Committee	Knowledge Centre Survey Q1 established Apps approval mechanism
Access to Information to support decision making – • Health records project – centralisation & tracking	No	Funding. Project support & staffing inadequate.	Clinical Governance Steering Committee	M5 Action plan to CGSC for approval
Access to Information to support decision making – Further development of clinical dashboards for RHDs to include benchmarking of key pathways	No	Clinical understanding	Clinical Governance Steering Committee	Q4 Embedded
Maintaining safety at Lister and QEII during pre-consolidation year	No	Inappropriate staff deployment Loss of staff from QEII site	Crude mortality & HSMR monthly to Exec Committee Medical Director report to RAQC	Q3 Report to RAQC from MD, D of N and D of Ops
Maintaining safety at weekends including additional radiology support (ultrasound and interventional)	No	Inappropriate staff balance between sites	Crude mortality & HSMR monthly to Exec Committee Medical Director report to RAQC	Q2 Define job plans Q4 Recruit
Increase use of Image-guided radiation therapy thus reducing normal tissue toxicity	SCB	Funding if leasing arrangements are not possible	Bi-monthly Clinical Quality Review	Q1 Agree target minimum 20% increase

7. RECOMMENDATION

The Medical Director welcomes comments from the committee on this document and recommends to RAQC that it approves the IPO strategy for 2013/4

Appendix 1 - Clinical Guidance utilised

Cardiovascular Disease Outcomes Strategy D of H 2013

National Heart failure Audit 2011/2

NICE Clinical Guideline CG108 Chronic Heart Failure

Coronary Heart Disease National Service Framework

NCEPOD – Acute kidney Injury 2009

Renal Association guidelines on AKI 2011

CEM Severe Sepsis & Septic shock Audit 2011/12

Acute Stroke report 2011/2 RCP

Adult Community Acquired Pneumonia Audit 2011 BTS

National Diabetes inpatient Audit 2011/2

Hyperglycaemia in acute coronary syndrome

European Association of Urology, guidelines on urological infections 2011

SIGN 88 – management of suspected bacterial urinary tract infections 2012

Cancer patients in crisis: Responding to urgent needs RCP and RCR 2012

High quality acute care 2011

Clinical Ward rounds in medicine – Principles for best practice RCP and RCN 2012

Acute medical care for frail older people RCP 2012

Delivering a 12 hr, 7-day consultant presence on the Acute Medical Unit.

The higher risk general surgical patient RCS and D of H 2011,

Knowing the risk- A review of the peri-operative care of surgical patients NCEPOD 2012

Appendix 2 – Mortality CQUINS schemes

CQUIN Pathways	TARGET Q3	2012/13	SHMI Oct '11 – Sep '12	HSMR Oct '11 – Sep '12
Acute Renal Failure	SHMI within normal limits	89.3	177.7	99
Congestive Heart Failure	SHMI within normal limits	96.7	117.3	102.6
Respiratory Infections (RI)	SHMI within normal limits	101.7	117.7	95.2
Septicaemia	HSMR ≤ 100	89	144.4	138.6
Urinary Tract Infection	HSMR ≤ 100	81.8	130.4	108.6
Pneumonia (replacing RI)	Replacement	96.1	122.8	100.1
Acute Myocardial Infarction	New schemes Audit Q2 Redesign pathway Q3 Implement pathway Q4	126.4	135.6	118.9
Stroke		96.2	118.6	98.1
Fractured of Neck of Femur		82.8	124.98	89.3
Unexpected ITU admission in hospital inpatients		*Indicators to be agreed*		