NHS
East London
NHS Foundation Trust

# REPORT TO THE TRUST BOARD - PUBLIC
## March 2021

| **Title** | Quality Report |
|---|---|
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| **Accountable Executive Director** | Dr Amar Shah, Chief Quality Officer |

**Purpose of the Report:**

The Quality Report provides the board with an overview of quality across the Trust, incorporating the two domains of assurance and improvement. Quality control is now contained within the integrated performance report, which contains quality measures at organisational level.

**Summary of Key Issues:**

The quality assurance section provides an update on the development of quality assurance systems within primary care. There are now governance structures in place, and some quality assurance processes have begun – namely CQC readiness, NICE guidance implementation, executive walkrounds, collection of patient-reported experience measures and the first clinical audit. Further work is required to adapt and introduce other quality assurance processes, such as audits and service user-led accreditation.

The quality improvement section describes progress against the current 90-day plan. The report provides a summary of a number of the active QI projects across the organisation, which provides an indication of the breadth and variety of work underway – from tackling inequalities, improving flow, enhancing safety, enjoying work and improving value – all linked directly to our ELFT strategy. The annual visit from our partners, the Institute for Heatlhcare Improvement, is underway, which provides a point of reflection, learning and planning for the year ahead. The last two months has also seen the introduction of a mixed-method evaluation into our quality improvement work, to help us routinely understand and respond to people's experience of accessing and utilising quality improvement in their daily work.

**Strategic priorities this paper supports (Please check box including brief statement)**

| | | |
|---|---|---|
| Improved patient experience | ☒ | The information provided in the Quality Report supports the four strategic objectives of improving patient experience, improving population health outcomes, improving staff experience and improving value for money. Information is presented to describe how we are understanding, assuring against and improving aspects related to these four objectives across the Trust. |
| Improved health of the communities we serve | ☒ | |
| Improved staff experience | ☒ | |
| Improved value for money | ☒ | |

**Committees/Meetings where this item has been considered:**

| Date | Committee/Meeting |
|---|---|
| | N/A |

**Implications:**

| | |
|---|---|
| Equality Analysis | Many of the areas that are tackled through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity. |
| Risk and Assurance | There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards. |
| Service User / Carer / Staff | The Quality Report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers and staff throughout the Trust. |
| Financial | Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance. However, there is nothing presented in this report which directly affects our finances. |
| Quality | The information and data presented in this report help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care. |

## 1.0 Quality Assurance

### 1.1 Background

The primary care directorate was initially formed in May 2020 with the appointment of the Medical Director for Primary Care. Leadership was augmented with the appointment of a Service Director for the directorate in September 2020. The directorate currently encompasses six primary care services:

- The Greenhouse Practice in Hackney
- Health E1 in Tower Hamlets
- Newham Transitional Practice in Newham
- Leighton Road Surgery
- Cauldwell Medical Centre
- The Homeless and Vulnerable Persons Outreach Service

The directorate now has well established Quality and Governance structures, based around a directorate-wide DMT and Quality Assurance Group. Each service has a lead GP and a practice/service manager, and has its own governance group that has sight of the local quality and safety issues, and feeds into the directorate structure.

In January 2020 the Trust Board received a report that anticipated the addition of new primary care services; and considered some of the challenges and opportunities brought about by the increasing role of the Trust in providing primary care, exploring the mechanisms for quality assurance, and how we recognise and understand quality in general practice.

The report concluded *“ELFT is well placed to support existing, and future, primary care services to understand the quality of their services, and support and enable improvement where needed. It is evident that there is alignment with regards to the fundamentals of quality, and that a number of quality assurance metrics and processes are transferable.*

*Equally it is apparent that there is some adaptation required to optimise our quality assurance capability."*

This report will set out progress to date in building and implementing an effective and bespoke quality assurance system across the directorate.

## 1.2 Quality Assurance workstreams

Quality Assurance is the range of methods by which the organisation ensures that it is doing what it should be doing, and to the required standards. In practice, effective quality assurance processes support regulatory compliance and are crucial to inspection readiness and sustaining an outstanding rating, as well as supporting and promoting learning and improvement.

Our core quality assurance (QA) processes are:

- Supporting CQC Compliance and Inspection Readiness
- Clinical Audit
- Service User Led Accreditation
- Patient Reported Feedback Measures
- Administration of NICE Guidance
- Administration of Executive Walkrounds

### *1.2.1 Supporting CQC Compliance and Inspection Readiness*

This workstream involves all clinical services undertaking an annual self-assessment against core regulatory standards. Directorate management teams review the findings and with the range of other intelligence they have, choose a selection of their services to take part in a peer-to-peer review of the service, which looks at evidence to support the self-assessment, provides objective judgement of compliance, identifies areas of strength and opportunities for improvement, and facilitates sharing of learning and good practice across services.

Whilst regulatory processes are similar to those used for the inspection and rating of mental health and community health providers, there are some differences in methodology, and the key lines of enquiry an inspection team will follow.

During Q3 2020/21 the QA team and the primary care directorate worked together to adapt the self-assessment questions to fit the primary care-specific key lines of enquiry, and ensure a meaningful process.

During December and January, the services undertook their self-assessments, and the results were forwarded to the service and directorate leadership. The consensus at this time was that there would be limited value in follow-up peer-to-peer reviews, given the relative immaturity of the directorate, recent actual CQC activity, and ongoing actions to improve. At this point, therefore, findings were fed into existing CQC action plans.

In September 2020 Leighton Road Surgery had a full CQC inspection and their rating was changed from 'inadequate' to 'requires improvement'. In November 2020 Cauldwell Medical Centre had a routine CQC 'monitoring call'. The call went well and as a new provider for this service we have been advised to expect a full inspection in 2021. Learning from these inspection experiences and the implementation of the trusts internal readiness process will be brought together at a directorate CQC workshop in early April 2021. In addition peer to peer reviews are currently being arranged to take place during April 2021.

Current ratings (for those services subject to ratings) are set out below:

| **Practice** | **Location** | **CQC Rating** |
| --- | --- | --- |
| Newham Transitional Practice | Newham | Good |
| Health E1 | Tower Hamlets | Good |
| The Greenhouse | City and Hackney | Outstanding* |
| Cauldwell Medical Centre | Bedfordshire | Good |
| Leighton Road Surgery | Bedfordshire | Requires Improvement |

### *1.2.2 Clinical Audit*

The Quality Assurance team manages the process by which clinical services undertake quarterly audits against both mandatory Trustwide standards and locally determined standards. The team also co-ordinates participation in national audit.

Having reviewed existing mandatory audits, the directorate concluded that only one (infection control) was applicable to primary care. This was completed by all primary care services for the first time in Q3 of 2020-21, with excellent results and all standards being met.

Directorate-specific audits have not commenced as yet. The intention is for the services to work with the QA team to develop audit standards specifically for primary care. This is intended to include a suite of clinical and non-clinical audits that will monitor some of our priority areas:

- Antibiotic use
- Cervical screening
- GP avoidable appointments
- Call waiting times

### *1.2.3 Service User Led Accreditation*

This consists of a self-assessment against service user-defined standards for excellence followed by a visit by service user assessors to test the self-assessment and judge compliance with the standards. The service user led accreditation scheme has not yet been implemented within the primary care directorate, due both to the competing priorities within the newly formed directorate (particularly CQC readiness) and acknowledgement that the process and standards would need to be reviewed to assess suitability for the setting, and may well require some work to develop and refine. Allied to this, the directorate management team feel that the development of mature patient participation groups is the immediate priority, and the foundation upon which this development work and future implementation could take place.

#### *1.2.4 Patient Reported Experience Measures (PREM)*

All of our practices receive feedback from the national GP Patient Survey each year. The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over two million people across the UK. The results show how people feel about their GP practice. The results of this survey are available nationally and reviewed by the CQC prior to inspections, with the results potentially influencing the judgement and rating of a service.

The directorate has worked with the QA team to develop a patient-reported experience measures for primary care that are informed by the national survey, and will enable services to continuously monitor the things that are most important to their patients, whilst remaining aligned with trust priorities. Below are the survey items designed:

1. *I usually get to see or speak to my preferred GP when I would like to*
2. *It is easy to get through to this GP practice by phone*
3. *I was offered a choice of appointment when I last tried to make a general practice appointment*
4. *How would you describe your experience of making an appointment?*
5. *When you saw or spoke to the healthcare professional at your last general practice appointment, did you feel listened to?*
6. *Were you involved as much as you wanted to be in decisions about your care and treatment during your last general practice appointment?*
7. *I have had enough support from local services or organisations in the last 12 months to help manage my long-term condition(s)?*
8. *Overall, how was your experience of this GP practice?*
9. *Please can you tell us why you gave your answer?*
10. *What could we do better?*

Surveys were designed and built at the end of 2020, and have now been implemented across all practices. Practices are able to adapt collection methods to suit their

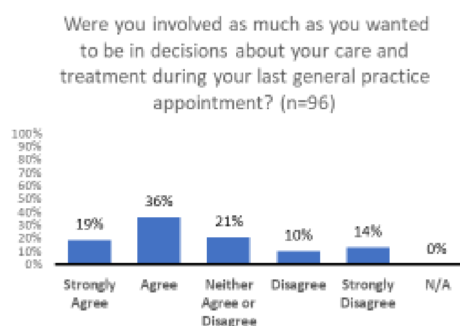
population, and have used a range of methods such as business cards and posters with QR codes, text messaging, phone calls, and including links on correspondence.

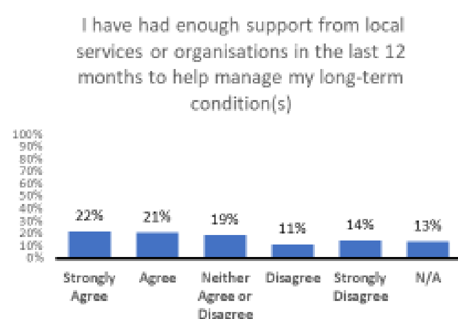
Initial results are extremely encouraging, with over 700 responses collected during January. Each service was provided with a detailed report of the feedback collected during January, with an extract from the report shown below for illustration.

Staff from each of the services has received training to enable them to access their own data as and when they require it. Access to continuous feedback, both quantitative and qualitative, means that services are better able to make decisions about service improvements and where to direct resources, and can track improvements in real time. The most significant themes coming out of the survey responses relate to waiting times for calls and appointments, and the practices are working hard to reduce call volume, time taken to answer calls and availability of appointments.

The practices have increased available appointments to over 10,000 per month, are promoting online contact, and have begun an exercise to source and procure improved telephony systems.

**Cauldwell Medical Centre** n= 97



### *1.2.5 NICE Guidance*

The QA team manages the process by which new and updated guidance is received into the Trust, its relevance assessed, the guidance disseminated to relevant services for review, and where necessary gap analysis and actions to address are undertaken.

The primary care directorate has a GP as an identified lead for NICE guidance, Dr Farah Paruk. The directorate is implementing the process in line with the rest of the Trust. Dr Paruk will triage latest guidance, identify relevant guidance for onward circulation, and also identify guidance which requires a more detailed ‘gap analysis’ to provide assurance around implementation, or identify risks. This process is overseen by the Quality Assurance Group at directorate level, and the Quality Committee at a trustwide level.

#### *1.2.6 Executive Walkrounds*

Executive Walkrounds, though currently held virtually, continue apace with approximately 200 taking place each year. Our Executive Directors visit a team each week to hear directly from staff, using a standard set of questions that capture both what the team is proud of, and what is getting in the way. The notes are shared in real-time with local management teams, who are expected to respond to any issues raised. Each of the primary care services has received a formal walkround since the inception of the directorate last year, along with other informal visits. The feedback from walkrounds has been shared, and has shone a light on some of the challenges for services new to the trust around IT systems and payroll for example, as well as highlighting achievements and positive progress.

### 1.3 Next steps

Over the next six months the primary care directorate and QA team will build on this progress in setting up structures and processes to:

- Develop and implement directorate clinical audit standards
- Develop a primary care specific Service User Led Accreditation programme
- Develop and implement service user surveys for the Homeless and Vulnerable Persons Outreach Service
- Support the embedding of continuous service user feedback and action across the directorate

## 2 Quality Improvement (QI)

### 2.1 Improvement work

In the last quarter, there has been a reduction in total active QI projects (figure 1). This is expected as directorates and improvement advisors have been ensuring that the LifeQI online platform accurately represents active improvement projects.

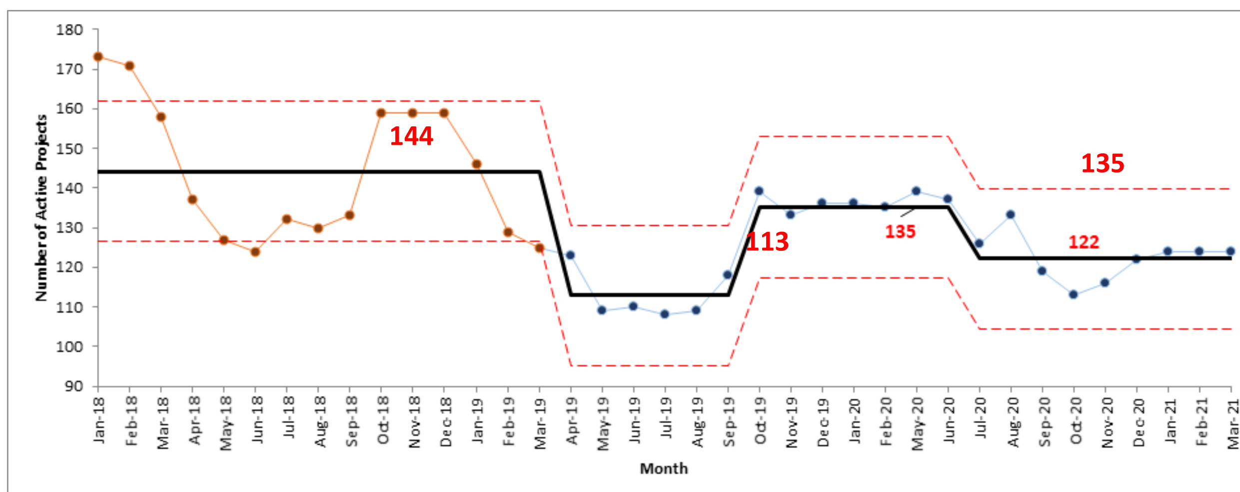


Figure 1. Total active QI projects across ELFT

Below are a few of the current quality improvement projects from across the organisation:

**Newham Mental Health Liaison Team – Improving Referrals**

The Mental Health Liaison team based at Newham University Hospital identified that the percentage of referrals that were successfully completed to the community was lower than expected. This resulted in compromised continuity of care on discharge for service users. A multidisciplinary project team was formed to include consultants, trainee doctors, nurses, and administrative staff. The project aim was *"to improve the percentage of referrals that were appropriately completed by 30%".* The team created a driver diagram to help articulate their theory of change.

Starting in November 2019 the team tested ten different change ideas using 'Plan Do Study Act' (PDSA) cycles over a period of a year. Changes tested included developing an electronic referrals board, developing standard criteria of what to include in referrals, providing team education and developing their process for ensuring referrals are completed. As a result of the changes there was an improvement in the percentage of referrals completed correctly from the baseline of 35% to the current 84%. The team are now implementing the successful changes to sustain the gains they have achieved.

**Newham Community Health – Sally Sherman ward – Improving oral health**

Staff at 'Sally Sherman' ward (East Ham Care Centre) provide care for people with dementia. A common issue was poor oral health, with families expressing concern. The team used QI to help them think through the problem and in October 2019 started a QI project with the aim of *"improving the oral health of 50% of dementia patients by November 2020".*

The project team demonstrated good practice by ensuring there was diversity in the team membership. The team captured baseline information about the current state of oral health. The first test of change they tried was to collaborate with a dental service practitioner who committed to an initial oral examination for each patient, and future examinations for signs of improvement in oral health. The team discussed inviting a family member or carer to the project but this was plan was disrupted by Covid. Although this project paused due to time pressures during the pandemic, the team are planning to test their change ideas again in the next month, and will again be inviting family members or carers to join the work.

**Bedfordshire and Luton mental health - Watching the Pennies: saving time, money and reducing waste project at Oakley Court**

The team of administrators at Oakley Court detected a quality issue as regular overspending on items in their stockroom. A QI project team was developed, and they first set out to understand the problem by using root cause analysis. They used the 'five whys' and cause-and-effect diagram. This exercise identified causes that led to overspending, which included over-ordering of stock leading to stockpiling, poor storage system in storeroom, items expiring and items going to the wrong ward which were then not reused. The team set an aim, developed their driver diagram and identified three change ideas for testing:

1. The systematic tracking of orders
2. Improving the process and embedding as business as usual
3. Developing a culture of accountability

The team have been monitoring their outcome measure using a statistical process chart and have now achieved a 50% reduction in non-pay ward costs (figure 2).

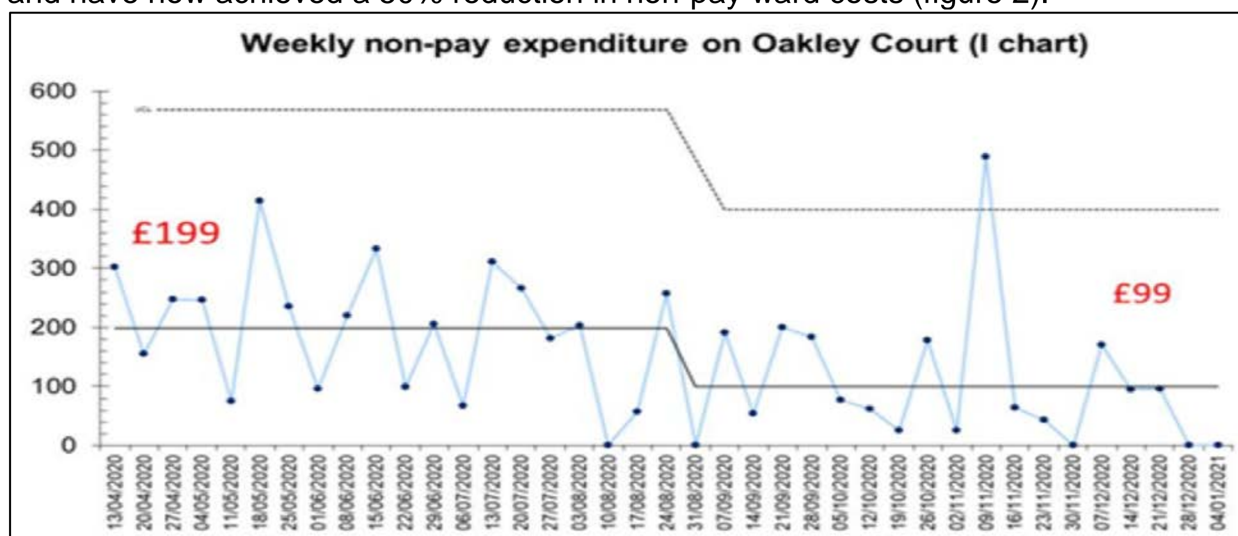



Figure 2. Weekly non-pay costs on Oakley Court

**City and Hackney – Covid-secure project**

A QI project team in City and Hackney directorate led by Becks Lingard (Borough Lead Nurse), Lucy Goody (Gardner Ward Manager), and Claire Ritchie (Modern Matron) initiated this work in response to how secure staff felt in terms of Covid-19 risk on the wards. The focus was to reduce potential spread of Covid-19 infection. Initially the team met daily to progress the work rapidly and tested changes such as daily Covid-secure huddles daily, and a Covid-secure checklist to focus attention on key infection control activities. The team have been running PDSA cycles on a daily basis, regrouping at the end of the day to capture learning. The team have seen a shift upward in the number of daily huddles (0.75 to 1.91) and a reduction in the number of Covid infection issues raised in the checklist (2.27 to 0.88). Staff are marking an increasing number of 'green' Covid-secure days. Becks Lingard states, "*the biggest learning is that staff felt more unsafe when they weren't able to properly support the patients to isolate on admission, that in itself has helped them develop further ideas around letters and community meeting discussions.*"

## Forensics – Sexual Safety

ELFT are part of the national Sexual Safety Collaborative which has the aim to ensure that everyone who uses and works on mental health inpatient wards is sexually safe. The John Howard Centre is represented on the national collaborative by three wards - Ludgate, Broadgate and Clerkenwell.

The Clerkenwell ward project has the aim to reduce sexual safety incidents by 30% by June 2021. Sexual safety and sexual needs are discussed regularly with patients in various forums such as community meetings, ward rounds and with their primary nurse. Change ideas have included adapting the Patient Porn Plan from Ludgate Ward to an easy-read version; having discussions around ethical porn with patients and encouraging patients to use ethical porn as part of their Patient Porn Plan; and having a Love, Sex and Intimacy Group with patients. Patient involvement in this project has been essential in raising awareness and testing changes. As shown in figure 3, sexual safety incidents have reduced by 53%. The next steps for the project are to work with a Psychosexual Therapist to further understand patients' sexual needs.

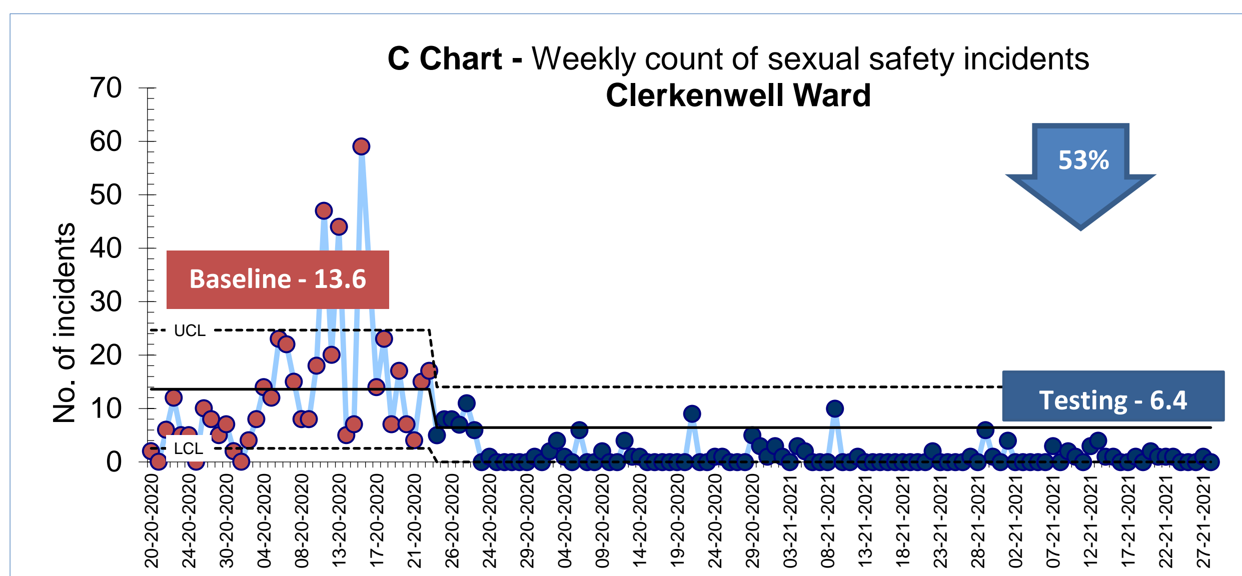



Figure 3. sexual safety incidents reduction of 53%

## Dunstable CAMHS - Family Inclusive Practice

Families are at an increased risk of marginalisation, social isolation, and poverty when a parent has experience of mental distress. Additionally, children of parents with lived experience of mental distress are at risk of developing their own mental health, emotional and behavioural difficulties. In a survey within CAMHS, it was reported that 72% of parents identified as having experienced mental distress.

The project team was formed in May 2020 and was initially taking other approaches to solve the problem, including an audit of parental mental health and research methods for a team member's dissertation involving qualitative research exploring the problem. The team are now using the Model for Improvement as part of a QI project. They are currently working to define an aim, create a family of measures and begin testing. They are also looking at how to involve parents in the project team. They have agreed to start capturing weekly data in their team meetings around whether family or other services were discussed and whether a positive, neutral, or negative tone was used.

**SCYPS (Specialist Children and Young People's Service) – Enjoying Work**
SCYPS started working on staff wellbeing and satisfaction in 2019 with a project as part of the Enjoying Work learning system. This ended as the Covid-19 pandemic started in March 2020. Since then, wellbeing initiatives have made great progress. However, the SCYPS working environment has changed vastly and has led to different stresses and pressures. SCYPS know anecdotally that staff wellbeing and resilience is low, which has an impact on engagement at work and patient outcomes.

The team started a new project in January 2021 and have joined cohort 4 of the Enjoying Work learning system. They are currently in the 'Understanding the Problem' phase of the sequence for improvement. They have carried out an appreciative inquiry to help them surface what matters to them as a team and what to focus on for the project.

**IAPT – Triple Aim**

Shaping our Future workshops were held across the IAPT services during summer 2020 to learn from the impact of the first wave of the Covid-19 pandemic. Bedfordshire Wellbeing Service (BWS) reflected on inequalities presenting in the local population. The staff and service users agreed that a triple aim approach to these problems would be beneficial. A project team was formed and determined that the scope should exclude digital inequalities and race discrimination, as these are being explored in other workstreams. In November 2020 the project team was formed and has big I involvement from two service users. The sixteen people in the group meet fortnightly using Microsoft Teams and have a dedicated channel for project files and communications.

From their three-part data review, they have chosen the population segment of Asian men over the age of 40 who are living in Bedford. The partner interviews are now underway and interviews to gain insights from members of the population will also be scheduled.

**Primary Care – Vaccination**

Leighton Road Surgery has been serving the Leighton Buzzard population for over 40 years. The practice joined the Trust in 2020 and, although they have had vaccination campaigns every year since 2014, this was the first time they have utilised QI tools to organise their campaign.

Last year the practice achieved 63.5% vaccination of their target population. The team reports that "*utilising QI techniques like nominal group technique to build a driver diagram, as well as forming a QI team have made a huge impact, bringing everyone together to decide what ideas to put in practice… the enthusiasm around QI has made a great difference*". The involvement of service users in the campaign has also been a substantial part of the success. One of their main change ideas (the Drive-Thru Clinics) had wide participation of service users. The project has seen improvement in vaccination across the different age groups. Figure 4 shows a sample of that improvement within the over 65 years' age group.

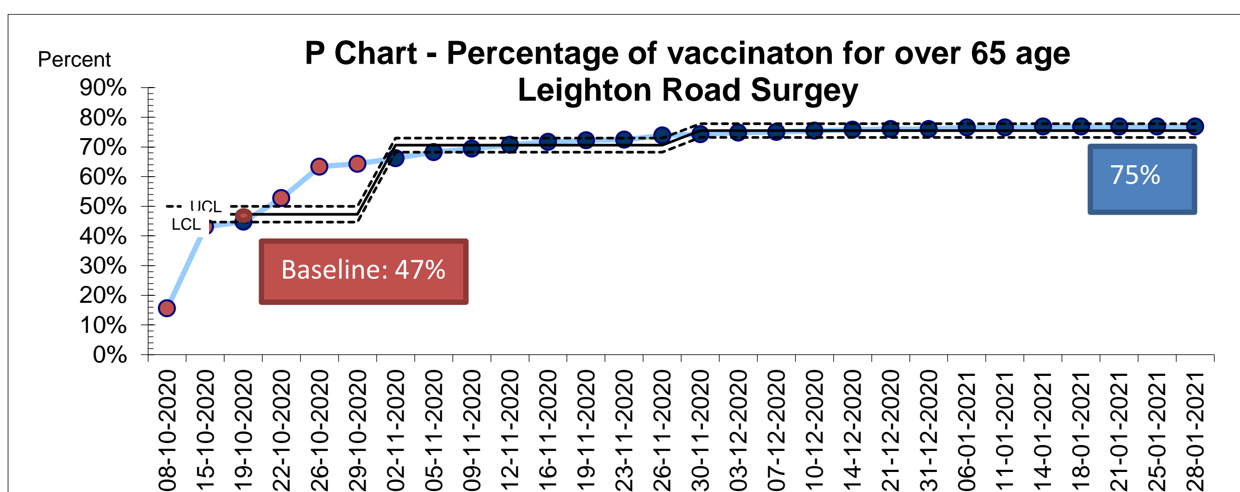


Figure 4: improvement in vaccination percentage for over 65's at Leighton road surgery

**Bedfordshire Mental Health Crisis - Authentic Service User/Carer and Staff Coproduction in QI Projects**

The aim of this project is to improve the average rating of the authenticity of co-production in QI projects in the Crisis mental health directorate by 20%. The original project lead initiated this project from the poor experience she had from being involved in a QI project as a service user. There were numerous other accounts from other service users across the Trust who had a poor experience when involved in QI projects.

A team was formed consisting of a mix of ELFT staff, service users, quality improvement team representatives and People Participation Leads. The team began to understand the problem by first asking participants the question 'what gets in the way of great involvement?' The team began to develop their driver diagram, creating primary drivers from the team answering the question "what does great involvement look like", which also led into the team developing their family of measures. The team have now started testing their first change idea.

2.2 Staff and service user experience

**Enjoying Work**

The collaborative learning system has continued since summer 2020. So far 12 teams have joined the learning system, 8 of them remain involved, 3 withdrew due to competing priorities and 1 team has completed their project. Some of the themes teams are testing include improving the experience of working from home, reducing variability of the new starters' joining process, and improving awareness and understanding about the impact of racism.

**Support for Coaches with Lived Experience**

Previous experience of recruitment, working conditions and remuneration of QI coaches with lived experience has lacked a robust process which has resulted in varied experience for QI coaches with lived experience. The QI department, in collaboration with the current six QI service user coaches and people participation leads are working toward a more standardised and inclusive process so that service user involvement is more meaningful and rewarding for both service users and staff.

2.3 Capability Building

**Improvement Coaches programme**
Cohort six of the improvement coaching programme concluded at the end of February, with over 90% attendance at every session despite the challenges that the pandemic presented. Of the 82 participants who started, 75 graduated with 52 new coaches within ELFT supporting QI projects. The remaining graduates are from partner organisations in North East London. The ELFT QI coaches will join a community of over 100 improvement coaches across all directorates, supporting active QI work.

**Pocket QI**
Pocket QI continues to be well attended despite the pandemic. Analysis demonstrates that switching to virtual has had little effect on demand or completion. With effect from January 2021, new starters at ELFT are being asked to complete Pocket QI within their first three months.

**Improvement Leaders Programme (ILP)**

To date, ELFT has trained over 1000 staff, service users and carers in the improvement leaders programme, where participants learn and apply the QI method to a real-life complex issue in their service. Wave 10 will commence in May 2021 in a new virtual format. Recruitment for the course is underway with 129 sign up so far across all directorates, with places offered to our partner organisations in each of our two integrated care systems.

**Annual Visit from the Institute for Healthcare Improvement (IHI)**

The annual visit from ELFT's strategic partner, the Institute for Healthcare Improvement (IHI) is underway. This is an opportunity for directorates to reflect on progress with quality improvement and benefit from the experience of our IHI partners. After seven annual visits, our IHI faculty are now well known to staff and service users across the Trust. Sessions have commenced in February 2021 and will conclude by May 2021.

**Programme Evaluation**

The QI department recently commenced a mixed-method evaluation to understand how quality improvement is perceived and approached throughout the trust. The purpose of the evaluation is to help capture insights that can inform change ideas, in order to better engage and support staff and service users across the Trust to utilise QI. A sample of fourteen team leaders from across the trust were interviewed, accompanied by a survey administered to twenty teams. The data will inform the development of a small number of change ideas, which will be tested from April 2021. The intention is to repeat this process on a 4-6 monthly basis.

3.0 **Recommendations and Action Being Requested**

3.1 The Board is asked to **RECEIVE** and **DISCUSS** the report.