

REPORT TO THE TRUST BOARD: PUBLIC
30 January 2020

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 focuses on primary care, exploring the needs and assets that exist with regard to understanding and assuring quality in primary care, and how our approach to quality assurance will need to extend or adapt in support of this.

The Quality Improvement section outlines some initial thinking for the Board to discuss around expanding the focus of quality improvement work to extend beyond quality improvement projects and move towards also encompassing the application of improvement skills, tools and methods in everyday work and interaction with services. In addition, the Board's will want to pay attention to how, for the first time, we are starting to test out application of the Triple Aim' framework for a Trust wide population. Notably, supporting the 'Community Mental Health Transformation Programme', a two-year funded programme to redesign community mental health across East London for people with severe mental illness.

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

Improved patient experience	<input checked="" type="checkbox"/>	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	<input checked="" type="checkbox"/>	
Improved staff experience	<input checked="" type="checkbox"/>	
Improved value for money	<input checked="" type="checkbox"/>	

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. There is nothing presented in this report which has a detrimental bearing on equalities.
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.
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Glossary

Abbreviation	In full
ELFT	East London NHS Foundation Trust
IHI	Institute for Healthcare Improvement
QI	Quality Improvement
QA	Quality Assurance
ILP	Improvement Leaders Programme
ICP	Improvement Coaches Programme

1.0 Quality Assurance

1.1 In this report we consider some of the challenges and opportunities brought about by the increasing role of the Trust in supporting and providing primary care. Specifically, we will explore the mechanisms for quality assurance, how we recognise and understand quality in general practice, and support improvement and excellence. In preparing this paper we have tapped into existing knowledge of the field of general practice, and would like to acknowledge and thank the following for their thoughts and insights:

Dr Mohit Ventakaram, Executive Director of Commercial Development

Dr Kate Corlett, Medical Director for Primary Care

Dr Liz Dawson, Clinical Director Beds Community Health Services

Dr Deri Trigg, Clinical Director Tower Hamlets Community Health Services

Sri Putti, Practice Manager - The Greenhouse Practice

Jenny Cooke, Project Director (and recently commissioner for primary care in Tower Hamlets)

1.2 Since the launch of the Trust Strategy in 2018, the Trust has been working towards improving the quality of life for all we serve. In September 2019, Dr Navina Evans, Chief Executive, highlighting that “having a greater presence within primary care would benefit patients, carers, staff, services and the wider Trust, and would support our strategic objective to lead on the delivery of integrated care.”

1.3 This greater presence would build upon the primary care we have already been providing in three GP practices in East London that support homeless people with complex issues.

Practice	Location	CQC Rating
Newham Transitional Practice	Newham	Good
Health E1	Tower Hamlets	Good
The Greenhouse	City and Hackney	Outstanding*

*Inspection conducted in June 2017 before the service was provided by ELFT. Rating currently being reviewed as part of standard regulatory process.

1.4 Clinical regulation of primary care is undertaken by the Care Quality Commission. Whilst regulatory processes are similar to those used for the inspection and rating of Mental Health (MH) and Community Health providers, there are some differences in methodology. If a GP

practice is rated as 'good' or 'outstanding', the CQC will inspect at least **every 5 years**. Much like the MH/community regulatory process, every year the CQC will also carry out a formal review of the information held about the practice.

- 1.5 The formal annual regulatory review helps to prioritise inspections where the information suggests that the quality of care at the practice has changed since the last inspection. This can be either a deterioration or improvement and will enable the CQC to carry out a more focused inspection that concentrates on areas with the most change and risk. Changes are identified by reviewing:
- the data held on the CQC Insight
 - information from stakeholders, for example Healthwatch, or a Clinical Commissioning Group (CCG)
 - Information the Trust provides, including through a structured telephone call each year (as part of the provider information collection).

If no action required by the CQC, they will inform the practice that they have carried out the review and that no further action is needed at this stage and publish a note about the practice, on the CQC practice profile page. If the data indicates that the quality of care may have improved or deteriorated since the last rating the CQC may decide to inspect, or ask the practice to clarify any information. If the CQC decide to inspect, they will write to the practice to inform them that they will carry out an inspection in the next six months then, send a two-weeks notice of inspection. An annual regulatory review forms part of the ongoing monitoring but it cannot change the rating, only an inspection can do this.

2.0 Analysis in this report

- 2.1 The text below explores how we measure and understand quality in primary care, and considers how this compares to existing approaches. We will go on to consider what more we may need to do in order to ensure that primary care services provided by ELFT have a profound understanding of the quality of service they wish to provide, are compliant with national and regulatory standards and ready for inspection, are able to identify strengths and priorities for improvement, and are supported and enabled to deliver change and improvement where needed.

3.0 What we understand about quality in primary care

- 3.1 Existing frameworks to measure and support quality

- Clinical Regulation – Care Quality Commission

As already described, general practices are subject to regulation by the CQC. The regulations and key lines of enquiry are the same as those for all healthcare providers, and fall under the now familiar 5 domains of safe, effective, caring, responsive and well-led. There is a wealth of guidance as to best practice in relation to these domains provided on the CQC website by Prof Nigel Sparrow OBE, CQC's Senior National GP Advisor.

- Quality Outcomes Framework (QOF) – NHS Digital

Measures are agreed as part of the GP contract negotiations every year. These indicators have points attached that are given to GP practices based on how they are doing against

these measures. The indicators change every year but in general they cover management of some of the most common chronic conditions, for example asthma and diabetes, management of major public health concerns, for example smoking and obesity, providing preventative services such as screening or blood pressure checks.

- National Institute for Health and Care Excellence (NICE) guidelines

NICE has published a huge range of guidelines, pathway descriptions and quality standards relevant to and setting out best practice for general practice. As a helpful resource the NICE website provides Clinical Knowledge Summaries of the most common and significant presentations in primary care, with clear, practical knowledge to help put UK guideline recommendations into practice and the best evidence, national guidance, policies and practice.

3.2 Quality assurance activity

A review of quality assurance activity typically undertaken in primary care suggests that there are familiar methods employed to supplement the reporting of QOF data. It also reveals the limitation of time to dedicate to quality assurance activity, generally ascribed to the busy nature of the clinical work, often undertaken alone, and in the absence of specialist/skilled resource to support and enable such work.

- Clinical Audit

Our existing services conduct clinical audit locally, they are part of the central programme, and audit locally against NICE guidelines. Research indicates that audit is widely used in general practice as a means of understanding reliability and quality. In addition general practitioners are required to undertake clinical audit as part of their revalidation process. There are a number of national audits relating to general practice that take place each year, and there is an expectation that services take part in relevant audits. In addition, commissioning bodies may commission clinical audit activity in response to particular quality concerns or to further understanding of a particular aspect of quality.

- Service user feedback

Our existing services struggle with the continuous collection of patient reported experience measures (PREM), including the friends and family test. The quality assurance team are working closely with services to support them with this, however the transient and often chaotic circumstances of the users of the services are likely to play a significant role.

Nationally, the GP Patient Survey is an independent survey is run by Ipsos MORI twice a year on behalf of NHS England. The survey asks about experiences of local GP practice and other local NHS services. The survey includes questions about a range of issues, such as how easy or difficult it is to make an appointment at a practice, satisfaction with opening hours, the quality of care received GPs and practice nurses, along with other measures. In common with similar undertakings in mental health services, the survey provides a valuable insight for services, deepening understanding of quality and identifying areas for improvement, but its power is tempered by the response rate, which for the last survey ran at 33% nationally, but 18% locally (Tower Hamlets CCG).

- CQC readiness

Our existing services have regularly participated in the ELFT internal readiness programme, involving, as a minimum, an annual self-assessment against core standards, and offering the opportunity for peer to peer review of services. Research suggests that such processes for measuring compliance and building inspection readiness are not widely used in general practice.

- Accreditation

There are currently no external, nationally recognised, accreditation schemes for general practice in the UK; in contrast to the range of schemes and learning networks for mental health services driven by the Royal College of Psychiatrists. Such schemes do exist outside of the UK (in Australia for example), but the UK literature around the subject suggests that there is still a relatively limited evidence base demonstrating the effectiveness, cost effectiveness, and appropriateness of accreditation in general practice.

3.3 Structures and support

Several organisations exist that provide support to primary care services in understanding and improving quality. Most notably

- Royal College of General Practice
 - Supporting the development of Primary Care Networks that focus on bringing services together to develop
 - Leadership development support
 - Organisational development and change management
 - Person-centred care and community development
 - Population health
 - Collaborative working
 - Providing learning and development, accredited training etc.
- GP confederations/care groups

Such groups typically exist within a borough/commissioning area, and serve to bring together services across that area to improve the quality of primary care, to provide a collective voice to influence the development and redesign of local services, and develop primary care in the local health and social care system.
- Practice Patient Participation Groups (PPG)

These groups are a requirement of GP contracts. They are a representative sample of the practice population with the role of being a critical friend to the practice; advising the practice on the patient perspective and providing insight into the responsiveness and quality of services; encouraging patients to take greater responsibility for their own and their family's health; carrying out research into the views of those who use the practice; organising health promotion events and improving health literacy; regular communication with the patient population.

3.4 What do outstanding services look like, and how do we know?

It is apparent from speaking to those with experience and expertise in delivering and leading primary care services, that many of the markers of excellence are the same across care settings:

- Fundamentally safe
- Has a clear vision and strong leadership
- Person centred and influenced services
- Happy, motivated and caring staff
- Easy and appropriate access
- Providing holistic care and meeting individual needs (providing continuity where needed)
- Mapping capacity to demand and delivering value

Increasingly those features of outstanding primary care that may once have seemed specific to that field, are now shared in light of the move towards integrated models of care, and the aim to improve population health and well-being, such as focus on prevention and health promotion, greater integration with social care, making more services available in one place, and taking key services out into the community.

This view is reinforced by the CQC in their inspection report for the ‘outstanding’ rated Greenhouse Practice in Hackney. The report highlights strong leadership, safe systems and a safety culture, accessibility, responsiveness to individual need, implementing evidence based care, co-location of other services, ease of access as strengths, and commitment to accessibility and the availability of commonly required specialist practitioners to input on care as points of difference.

With this consistency, the metrics to recognise excellence are largely aligned with those already monitored within ELFT, or collected as part of a standard data set:

- Staffing metrics – vacancies, retention, sickness, equalities, engagement
- Patient feedback, satisfaction and experience measures
- Incident reporting
- Access and waiting times
- Non-attendance at appointments
- QOF targets/clinical outcomes

There is scope to develop specific metrics to monitor quality of primary care service, which may serve as either quality assurance and/or quality control measures. The views of those with expertise in the field suggest that certain conditions or outcomes may offer proxies for measuring clinical care, and the functioning of the wider system, for example management of hypertension, and A&E attendance with low acuity. Similarly unmet, and hidden, demand are potentially high value data items.

3.5 Where ELFT may add value for primary care services

Feedback suggests a range of ways in which the Trust could potentially support primary care services to deliver outstanding services, and positively impact on quality in the broadest sense. As already noted, the focus of this report is specifically quality assurance.

It is very apparent that quality assurance activity already takes place in our existing primary care services. It is equally apparent that the nature of general practice presents particular challenges to monitoring and improving quality. Quality assurance in primary care, arguably even more so than is already the case for ELFT services, needs to be realistic, pragmatic and meaningful. For primary care services in ELFT there is the potential to deliver this through:

- Accessing existing robust and proven quality assurance processes, such as service user feedback systems, ongoing CQC readiness, and Service User Led Accreditation
- Using accreditation, service user feedback and people participation structures not only to enhance understanding of quality, but as a springboard to more profound levels of people participation, in quality assurance and beyond, and the routine involvement of service users at care, service and system level.
- Using informatics resource to automate the audit and monitoring of reliability of systems and processes, and achievement of key outcomes
- Ready access to data over time that can serve as both data for assurance, and data for improvement, and support to maximise the understanding and utility of data
- Collaboration with the Quality Assurance team and other primary care services to co-design bespoke systems for quality assurance, and access the potential for peer review, spot-checking, learning networks, and perhaps implementation of standardised bundles of care/intervention as assurance mechanisms
- Collaboration on the development of measures of quality at a local systems level

4.0 Next steps

4.1 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.

4.2 For existing services there is a need to further support these Transitional Primary Care services to engage with core quality assurance processes – developing meaningful local audit, supporting the real-time collection and use of service user feedback, developing learning networks, supporting service user involvement in the quality assurance of primary care services

4.3 In preparing us for greater reach into primary care provision, we should also consider:

- Interoperability of IT systems and accessibility of data
- Identify or develop core clinical quality metrics linked to the Trust's strategic objectives not already known or measured

5.0 Quality Improvement

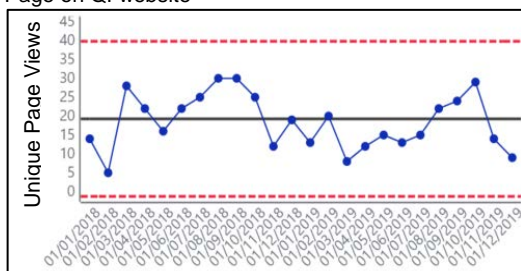
5.1 This report will give an update on the current objectives of the Quality Improvement department for 2019/2020 and the organisation's current three large-scale improvement efforts. A notable observation in this report are the early signs of convergence across the around a central concept of 'daily improvement'. This is a move from purely project based QI to the use of the method and tools more broadly outside of quality improvement projects. This will not replace the role of formal QI projects and the existing support structures for trying to solve complex problems. However, people will have the added option of using QI tools and methods to understand and tackle less complex, ad hoc problems that do not require a rigorous process and support structure.

5.2 Department Objectives:

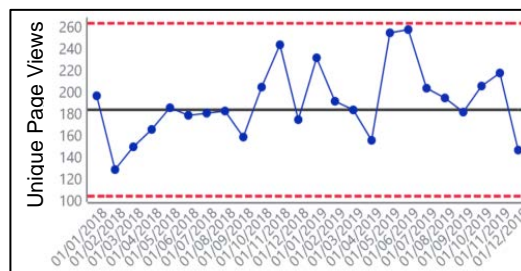
- Objective 1: Encourage the use of improvement in everyday thinking, skills/practice and active sharing of these stories

Storytelling is fast becoming 'business as usual' to support the work of the QI department, but more importantly is gaining momentum across QI projects as an effective way to draw out the compelling narratives behind improvement work. This message was emphasised in new 'storytelling' sessions within our main training programmes, the Improvement Leaders Programme (ILP) and the Improvement Coaching Programme (ICP). The upcoming 2020 ELFT Quality Conference on 19 May will focus on storytelling, specifically how ELFT is making a difference to people's quality of life, as told by ELFT staff, service users and carers.

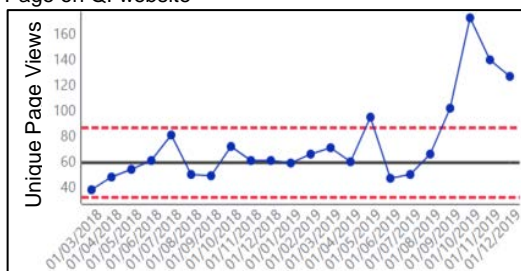
Measure 1: Engagement with QI Newsletter Main Page on QI website



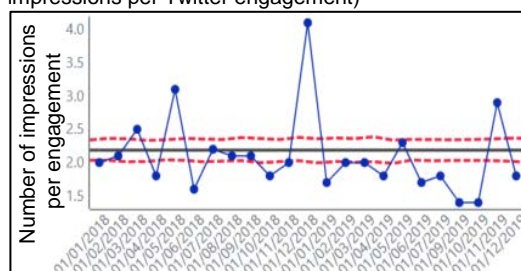
Measure 3: Engagement with QI Tools on the website



Measure 2: Engagement with QI Stories Main Page on QI website



Measure 4: Twitter Engagement Rate (Number of impressions per Twitter engagement)

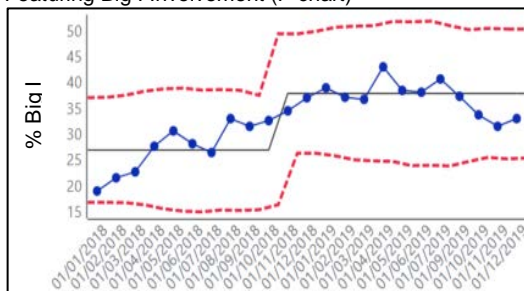


- Objective 2: Improving impact of people participation in QI for individuals and teams

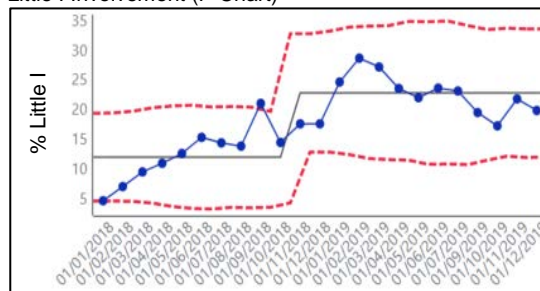
Previous gains have been sustained to improve the involvement in QI of the people we serve. We have primarily been looking at improving 'Big I' involvement, which is having service users as core project team members alongside staff through the life of a QI project. The other component has been improving 'little I' involvement, which entails engaging service users and carers at some point during the life of a QI project. When overall progress against the two quantitative measures is considered, the percentage of 'Big I' involvement has plateaued at around 38%. When this is combined with percentage of 'little i' Involvement which is around 22%, we are seeing 60% of active QI projects having some form of service user involvement. In addition to the level of people participation, we have also been measuring the experience of service users involved in QI projects

Over the coming months we will be thinking about how to further strengthen service user and carer involvement in improvement work, particularly how 'daily improvement' could give more permission for improvement work to take place more organically closer to the point of care without always needing formal QI projects.

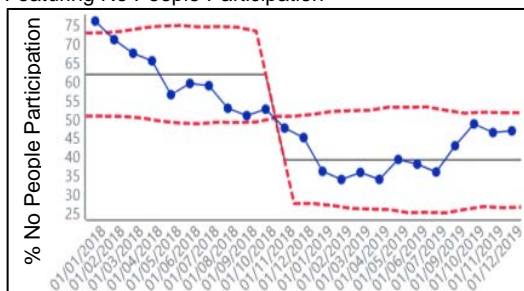
Measure 1: Percentage of Active QI Projects Featuring Big I Involvement (P chart)



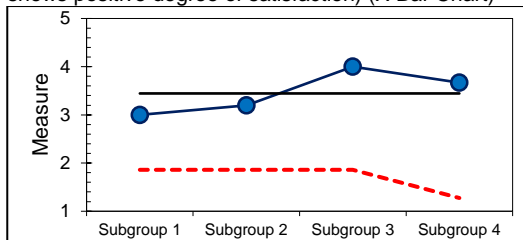
Measure 2: Percentage of Active QI Projects Featuring Little I Involvement (P Chart)



Measure 3: Percentage of Active QI Projects Featuring No People Participation (P chart)



Measure 4: Service user rated experience of being part of QI project team (Each data point is the average score given by 5 service users. A score of above 3 shows positive degree of satisfaction) (X-Bar Chart)



- Objective 3: Improving impact of QI sponsors at ELFT around activating, supporting and evolving QI work/continuous improvement

Current change ideas being tested to strengthen to sponsor support for QI work include incorporating initial sponsor and project lead meetings to set expectations and facilitate progress in the early days of project work. This also aims to build key relationships between sponsors and project work.

A series of focus groups with sponsors across the trust helped clarify the key attributes and responsibility of sponsorship. This has led to a re-working of the definition of sponsorship, pro-active involvement of the sponsor, development of new sponsor specification and an 'early days' meeting to clarify expectations.

- Objective 4: Improving the quantity and quality of coaching support to QI projects

The number of trained QI coaches currently supporting QI projects at ELFT currently stands at 65%. This is the number of coaches allocated to active projects, out of the total number of trained & in-training coaches working in the organisation.

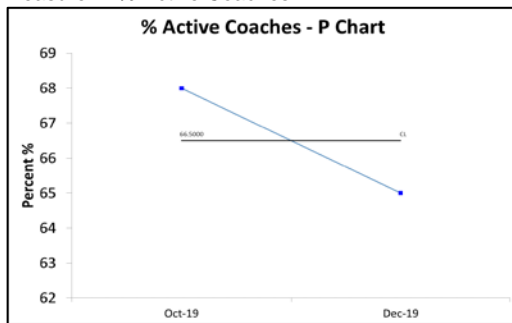
Two service users completed their training as QI Coaches in 2019. This has given them the opportunity to learn more advanced quality improvement skills and enabled them to build their experience and confidence coaching QI projects. Another benefit has been the opportunity for us as an organisation to learn how to best support and create a great experience for our service user QI coaches.

The corporate QI coaches have been testing offering consultation slots to people involved in corporate QI projects and to corporate staff in general. The coaches learnt that they could add value by helping people 'understand the problem' using QI tools and methods which could help better form ideas for QI projects. In addition, they also noticed that some problems did not need formal QI projects but would benefit from using some of the tools and methods. They have already started testing this change ideas and adapting it by offering the consultations where people work to see if it has the intended impact.

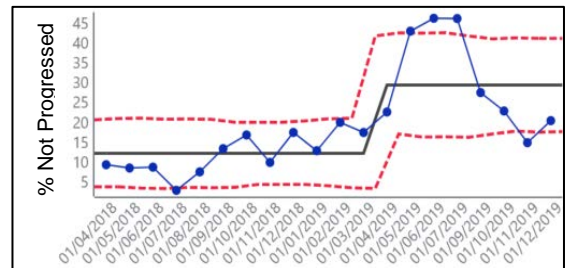
Coaches are also testing out bite-size QI training that can be delivered in a short space of time to help equip people with the method and some tools so they can start to apply these in daily improvement. This is going to be tested out in team away days, coaching sessions and any situations where people need this training to kick start their daily improvement work.

As with the other objectives, we are starting to see a shift away from this objective supporting the QI programme as it has been historically, project based, but moving more towards 'daily improvement' where people are given permission and support to do improvement in their everyday interaction and delivery of services in addition to formal QI projects. Over the next 2 years, the role of coaches will transform to support this additional approach to quality improvement.

Measure 1: % Active Coaches



Measure 2: Percentage of active projects on LifeQI with a score of ≤ 2.5 and that have not progressed in the last 3 months

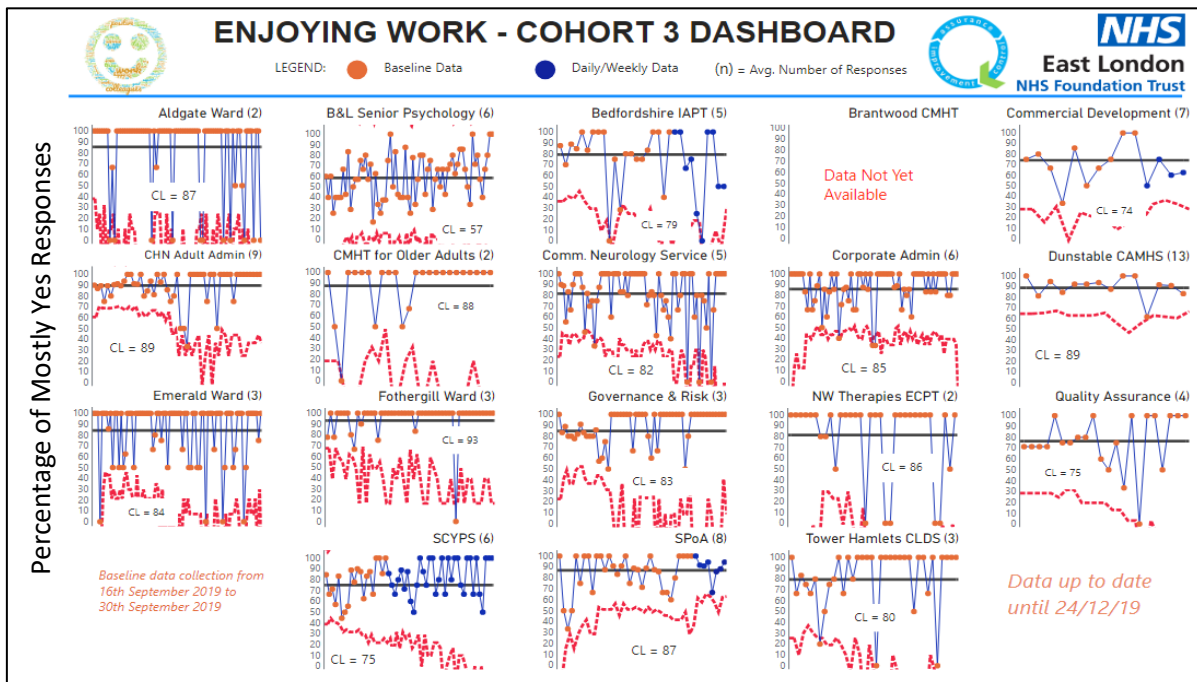


5.3 Large-scale improvement efforts:

- **Enjoying Work**

The 'Enjoying work' programmes relates to improving staff experience at work. A total of 18 teams continue to take part in cohort 3 of the 'Enjoying Work' collaborative learning system, which is running in parallel with wave 9 of the Improvement Leaders' Programme. One team has withdrawn from this learning system since the last board report due to challenges around workload - this has been supported by the team's local sponsor and we are ensuring they have support as required to undertake work on this in the future. We have had one additional corporate team join the learning system since the last board report.

Teams continue to use a mixture of subjective and objective outcome measures, to help them measure the impact of their work. An important thread running through the learning system is the importance of storytelling with teams developing this narrative both inside and outside of the learning sets.



- Triple Aim

This is our framework for applying quality improvement to populations (groups of people with similar needs) and aiming to simultaneously improving population health outcomes, quality of care and value for money.

Of the 13 projects focused on the Triple Aim, eleven now have measurement systems in place and all are actively testing change ideas. Developing measures for the teams has been challenging. Understanding the barriers has enabled discussions around potential solutions to ensure progress. These include deploying coaches to support teams to develop measurement system with regular flow of data to assist them to assess whether changes have resulted in improvement.

The Triple Aim framework is now being applied at greater scale, as part of our broader Trustwide planning approach for 2020-21. One example of this is the current support to the 'Community Mental Health Transformation Programme', a two-year funded programme to redesign community mental health across East London for people with severe mental illness. Local primary care networks (PCN's) are engaged across three boroughs, with four pioneer PCNs identified to lead first wave of testing.

- Value

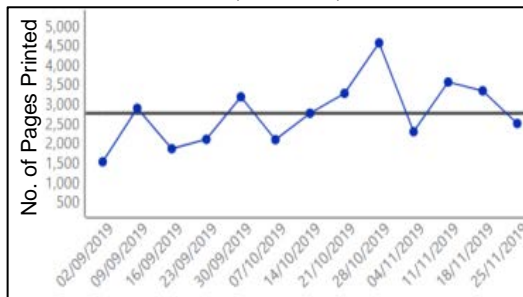
The aim of the Value workstream is to apply quality improvement to reduce waste and ensure value for money across the Trust.

The 'corporate print reduction' QI project is progressing and have been collating their baseline data weekly. The chart below (Measure 1) demonstrates printing on the 4th floor of Trust HQ. The team have developed their aim to reduce overall corporate printing by 20% and reduce colour printing by 50% by 31 March 2020. The project team is represented by a range of corporate departments and together they have finalised a driver diagram and conducted a survey to develop change ideas. The team have tested their first change idea, to create awareness by using eye catching statistics on walls near all printers in Trust HQ.

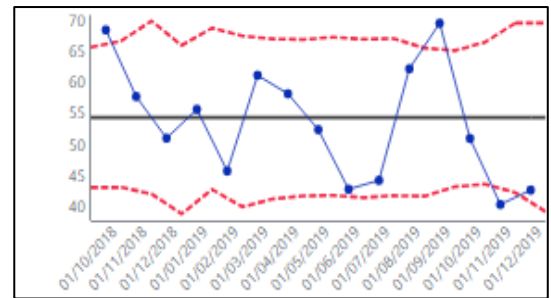
The 'salary overpayment' QI project aims to reduce salary overpayments by 30% by June 2020. Conducting a root cause analysis of the system, the team found that a large number

of leaver forms were being submitted late contributing to approximately one third of overpayments. The team have tested a change idea which enables the staff member to submit their own leaver form instead of the manager. Baseline data in the chart below (Measure 2) showed 55% of leavers forms were submitted late over the past year. The corresponding median cost of overpayments was £13,778 per month. The team commenced testing this change idea in October 2019, and the chart below shows special cause in November and December on the percent of leaver forms submitted late (representing a sign that the change idea may have disrupted system performance in a positive way).

Measure 1: Number of pages printed weekly on the 4th floor of Trust HQ (Run Chart)



Measure 2: % of leaver forms submitted late (P Chart)



6.0 Action being requested

6.1 The Trust Board are requested to RECEIVE and DISCUSS this report