Frimley Health and Care

System Operating Plan 2019-20 Improving Quality

FINAL 11th April 2019

Improving Quality

Aim

We will develop a vision, framework and programme for system wide quality and a shared commitment to further developing a culture of quality improvement focusing on effective care, safety and ensuring people have a positive experience of care.

Description

In 2019-20 we will focus on making quality everybody's business and to support the delivery of consistently high quality care. We will develop an integrated and collaborative approach to quality governance and assurance across the Frimley Health and Care system that minimises duplication, reduces variation and delivers tangible improvements for local people and staff satisfaction. Our strategic approach to assurance and improvement includes the following:

- We will develop further our Frimley ICS Quality and Performance Committee to provide strategic leadership and oversight for quality across the ICS
- We will implement a shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and 3rd sector
- We will implement the quality governance and assurance mechanisms across the system that reduces duplication and focuses on improvement
- We will further develop quality resource and information flows across the system to reduce duplication and release capacity
- We will implement system approaches to quality through developing a single Frimley system quality account and agreed system priorities, developing an system-wide serious incident review and learning process where incidents cross organisations. There will specific actions and learning from the Gosport Independent panel and Government response that will be implemented across the ICS
- We will champion and integrate the concept of the 'persons time' as the most important currency in health and social care
- We will use existing /develop metrics to understand the impact of workforce on quality

There are ten key areas where there needs to be a system wide approach to make a difference in patient safety, effectiveness and experience. A system wide approach was established in 2018-19 and in 2019-20 there will be further developments. The following areas will be monitored through the agreed quality approach and process:

- Reducing Gram-Negative Blood stream Infections
- Sepsis
- Persons Time
- Work with care homes on quality initiatives in partnership with the care homes work stream
- Mortality Review
- Learning Disabilities Mortality Review Programme (LeDeR)
- People being cared for in the right place at the right time
- Falls
- Pressure Ulcers
- Safeguarding

Improving Quality

Description

Reducing Gram-Negative Blood stream Infections (BSIs)

The Secretary of State for Health has launched an important ambition to reduce Gram-negative Blood Stream Infections by 50% by 2021. Evidence shows that these infections may have contributed to approximately 5,500 NHS patient deaths in 2015. Escherichia coli (E. coli) BSIs, represent 55% of all Gram-negative BSIs. E. coli BSIs have increased by a fifth in the last five years and preventing BSIs should have a major impact on reducing the need to prescribe antimicrobials, which is a key way of reducing the rise in antibiotic resistance. The aim in 2019-20 is to further implement a system wide infection prevention and control action plan which will include a specific work stream on how to reduce the numbers of Gram-Negative BSIs. This action plan needs to deliver the reduction that is required to reduce the number of people contracting these infections. This needs ownership from all levels of the organisations in acute, community and primary care. Monitoring will be at an ICS level. Areas already for continuation in year is to reviews of all cases to identify any themes or trends, reduction of urinary tract infections (as this has been identified as the most common source) through a hydration campaign to the local population. We will implement the agreed catheter passport across the ICS and develop an ICS project on reducing the number of people who have catheters inserted. We will continue to learn from well performing organisations and participate in the National Collaborative.

Sepsis

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented. NICE published its first guidance on sepsis in July 2016. There needs to be a systematic approach towards the prompt identification and appropriate treatment of this life-threatening condition. Across the system there are opportunities to improve the identification of the deteriorating patient, in primary care, community care including care homes, urgent and emergency care and inpatients. The aim for 2019-20 is for the ICS Quality and Performance Committee to monitor the data, identify areas for improvement and monitor new approaches for their impact for example implementation and monitoring of NEWS 2 (National Early Warning Score) care homes and the Suspicion of Sepsis (SOS) Insights Dashboard.

Person's Time

Time is the most important currency in health and social care. It manifests itself in persons waiting, duplication, health and social care staff running around looking for things and needless harm being caused. Person time as a key metric of performance and quality and is best measured from the perspective of the person. The aim for 2019-20 from an ICS perspective is to implement the concept of persons time and to deliver services from a perspective of the person. Working with other work streams to support them to ensure the person is at the centre of planning and pathways valuing them and their time as being an important component of care , improving the patient experience whilst reducing waste for example medications are ready for when a patient is able to be discharged and using Skype for out patient appointments. Examples of good practice and benefits to be shared with ICS work streams and mechanisms for ensuring that this is embedded in the heart of service design such as incorporating into the QI assessments.

Care home Quality

As part of the Gosport action plan care homes in some cases are isolated organisations and the ICS will work with them on education and training for example Implementation of NEWS 2. To be provided with regular updates form the Care Homes Quality group on different quality initiative for example ensuring the quality of care provided to residents through primary and community care.

Improving Quality

Description

Mortality Reviews

Following the findings of the Care Quality Commission report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' (Dec 2016), the National Quality and Performance Committee (NQB) published the first edition of National Guidance on Learning from Deaths for Trusts (March 2017). The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process. Our aim for 2019-20 is to continue co-operation and co-ordination across all providers so that there can be shared learning from the reviews. There is also continuing oversight of improvement actions emanating from the mortality reviews. Both Frimley Health NHS Foundation Trust (FHFT) and Berkshire Healthcare NHS Foundation Trust (BHFT) have developed and implemented Learning from Death policies which align with the framework set out in the national guidance. These include defined processes for retrospective case record reviews, criteria for deeper reviews using Structured Judgement Review Model methodology, and identification of (and reporting on) cases where death was potentially avoidable. FHFT will be adopting the Medical Examiner Model. These reviews feed into Trust governance processes, with formally established review groups operating under committee and board oversight. This will continue in the forthcoming year. All organisations who hold mortality reviews also participate in a wider ICS Mortality Review Group, into which learning from provider mortality reviews is fed and cross-organisational improvement actions and learning are identified and promoted. These cross-organisational groups can facilitate multi-agency input into provider mortality reviews where required.

Learning Disabilities Mortality Review Programme (LeDeR)

These reviews focus specifically on reviewing the deaths of people with learning disabilities., through mortality case review. There is active participation in the LeDeR programme with organisations both in social and health care providing reviewers and representation on the LeDeR Reviewers and Steering Groups. Our aim for 2019-20 for LeDeR is to support health and social care professionals, to clarify causes of death and excess premature mortality for people with learning disabilities; identify variation and best practice; and identify and implement key areas for improvement. The aim of the programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population.

People being cared for in the right place at the right time

There are a number of work streams across the system that are working on the patient journey, particularly for those individuals who are frail. This could be through admission avoidance, or embedding and strengthening discharge processes across the whole system. For the ICS Quality and Performance Committee to understand any patient safety issues through monitoring complaints, concerns and incidents that are related to patient flow in and out of hospital. To escalate quality issues to the ICS A&E Board via the Quality dashboard. Develop a collective agreement of a zero tolerance approach to children and young people with mental health issues being cared for in an unsuitable and inappropriate therapeutic environment. To continue the joint working on Improving services for people with mental health needs who present to A&E (CQUIN 2017-19).

Falls

From January-December 2018 there were 3,345 falls reported as incidents across the ICS. In 2019-20 the ICS Quality and Performance Committee will develop a programme of work to share learning and monitor improvement following the NHSI falls improvement work in FHFT and BHFT Quality Improvement programme. The ICS will also identify the care homes with the highest numbers of falls and facilitate a falls intervention programme.

Improving Quality

Description

Pressure Ulcers

Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. In 2019-20 there will be an ICS approach in implementation of the Pressure ulcers: revised definition and measurement summary and recommendations. This will provide a consistent approach for staff. To work across the ICS on ways to reduce the number of pressure ulcers by learning from each other and to develop initiatives for celebrating successes e.g. services with no pressure ulcers identified for 100 days.

Safeguarding

In 2019-20 we will continue safeguarding being integral to all aspects of care delivery. We will support the continuous improvement of early detection of safeguarding risks to service users, system wide partnership working and appropriate onward referrals. We will develop an integrated and collaborative approach to safeguarding governance and assurance across the Frimley Health and Care system that minimises duplication, reduces variation and delivers system wide learning from serious case reviews, partnership reviews, domestic homicide reviews and mental health homicide reviews. We will develop our already established strategic group to include safeguarding leads from providers and CCGs across the ICS; this will provide leadership and strategic direction and also share and extend local projects to apply to whole ICS area. This may include for example, safe sleeping and carer initiatives.

We will also:

- Develop safeguarding resource and information flow across the ICS and reduce duplication across the Child and Adult agendas
- Provide safeguarding leadership during joint Ofsted/CQC safeguarding inspections and SEND inspections
- Develop the current Thames Valley ambulance forum to include all safeguarding leads within the ICS to avoid duplication and strive for continuous improvement
- Work with the local authorities and our Police partners to develop new safeguarding boards which synergise with the whole ICS partnership, ensuring the CCGs in each area hold equal responsibility for implementation in line with Working Together 2018
- We will work with the safeguarding adult boards to ensure integrated working across the ICS and standard practice when considering cases for safeguarding adult reviews
- Safeguarding teams will continue to link with the LeDeR and CDOP reviews to ensure a reduction of duplication and safeguarding oversight
- We will agree and implement new policies for the ICS outlining duties placed on health organisations under the new Liberty Protection Standards due to be implemented late 2019 and replacing the current Deprivation of Liberty (DOLs) system. Following the Gosport report and actions that the ICS has robust processes in place for Mental Capacity
- We will work to develop an ICS LAC designated professionals network work on priority work streams from the South East to feed into the national LAC framework
- To work across the system on youth violence initiatives

Improving Quality

Description

There is a significant amount of work being undertaken in the ICS Mental Health programme and the Quality Board will have a clear line of sight on both Out of Area Placements (OAPs) and Safety Planning:

Out of Area Placements (OAP)

A person with assessed acute mental health needs who requires acute adult mental health in patient care, is admitted to a unit that does not form part of their usual network of services is considered to be placed in an OAP. The negative impact for service users, their families and professionals involved in the care of the service user is significant. The impact includes: Being away from their families and friends (their support networks when they need them the most); increased length of stays; and poorer outcomes, including increased risk of suicide. The national aspiration is to eliminate OAPs by 2021 and this will improve care, experience and efficiency.

Zero Suicide Ambition – safety planning

Over the coming year the Zero Suicide Ambition will focus on safety planning and specifically on effective plans to reduce self-harm and suicide within mental health inpatient services and Crisis Response and Home Treatment Teams (CRHTT). Nationally, suicide levels on mental health wards has plateaued over the last 8 years and it is known from the confidential inquiry that the most vulnerable period for patients is in first few days post discharge. Improved safety planning will be personalised, of high quality and developed through robust and meaningful conversations with patients and their families to ensure that safety planning is seen as a therapeutic intervention that assists patients to keep themselves safe.

How will Quality look by the end March 2020?

Local Population

People will be cared for at the right time in the right place by a skilled workforce. Children, young people and their families will be able to receive care in the most appropriate setting in a more timely way. People will have received self care and prevention messages for example so that they do not suffer from blood stream Infections and if they do have an infection then they will be treated quickly for an improved recovery. People will be cared for in safe and good quality environments. As 'Persons Time' is beginning to be implemented people will experience services delivered in a way that values their time, which results in easier journeys through services in the identified areas for improvement. Reassure the local population on the actions and learning taken on serious incidents and the Gosport inquiry through organisation Boards. The ICS will ensure that equality and diversity impact assessments are undertaken on the work that it carries out with oversight through the ICS Quality and Performance Committee.

Staff

There will be a maturing Quality governance process in place across the ICS which will monitor quality indicators and patient experience using sources from the quality dashboard, learning from mortality reviews, LeDeR, safeguarding, complaints Gosport Independent panel and Government response and incidents. This will reduce bureaucracy and support staff in a culture of learning from incidents and complaints and a culture of improvement. The culture of improvement will be part of the Improvement Network (IN) which will offer guidance and mentoring in Quality Improvement (QI), cascade the development of system leadership and QI skills, tools, mind sets and behaviour across the ICS, connect people working on improvement across the system and establish and grow a library/knowledge bank of quality improvement best practice (see Section 7 under System and Leadership Development).

Improving Quality

Outcomes and Benefits

Quality will be better understood and managed at a system level, with a maturing quality dashboard that provides analysis at a system level and this will facilitate improvements through the following:

- To promote self care messages to the public to reduce the number of Gram negative blood stream infections. Reduction in the number of blood stream Infections and thereby reducing the need for antibiotics, reducing the opportunity for infections to develop a resistance to them
- Sepsis – Earlier identification will lead to quicker appropriate treatment for the deteriorating person and improve their outcome for recovery. An increase in the earlier detection of sepsis and NEWS2 implemented in Care Homes
- Mortality reviews, LeDeR Serious incidents and safeguarding – These processes can assure the public and staff that actions and learning are being undertaken. Organisations will share in a system-wide commitment to ensure that local and national recommendations are enacted into service delivery from LeDeR
- Improved quality in care homes will reduce unplanned admissions, and an educated workforce
- Persons Time – to deliver services in a way that values the individual users time in the identified areas for improvement
- To reduce the harm suffered by people while in health and social care settings from falls and pressure ulcers
- Children and Young People will be treated and begin their recovery sooner and this will be measured through the number of CTR carried out for children in crisis in the wrong environment. Reduction in number of A&E attendances

Key Risks and Mitigation

- No agreed strategic approach on the future processes to monitor and assure on quality areas
- A lack of joint working on the ten key areas. These risks will be mitigated via the ICS Board which will hold the Quality and Performance Committee to account for delivery of quality across the ICS in the key areas
- No reduction in the Blood stream infections. This risk will be mitigated through the Infection prevention and control action plan and will be monitored by NHS England
- No reduction in the number of falls or pressure ulcers. This will be mitigated by quarterly monitoring and improvement plan if no reduction
- No identified leads for the programmes of work. Quality and Performance Committee will identify leads in April 2019
- Not implementing key actions from the Gosport independent panel and Government response. This will be monitored by NHSE and NHSI

Improving Quality

Milestones

Q1	Q2	Q3	Q4
• Quality Operational Group established and identified leads • Implementation completed of the quality governance assurance and data flow mechanisms • Scope of human factors training to support system wide improvement in learning from incidents completed • ICS action plan agreed for the Gosport review	• Review and refinement of the quality dashboard completed • Review completed of the Quality and Equality and Diversity Impact Assessments • System-wide serious incident review process implemented • Quality impact assessment on workforce challenges completed • Work with the other workstreams on the concept of 'person's time' mapped and embedded within the service redesign processes	• Shared definition, vision and understanding of quality to establish a single view of quality across health and social care, including the voluntary and 3rd sector developed • A single Frimley system quality account developed • Human factors training across ICS implemented	• Benefits of the quality dashboard evaluated • Shared definition, vision and understanding of quality agreed • Single Frimley system quality account signed off • System-wide serious incident review process embedded • ICS action plan for the Gosport review implemented • Implementation of actions from the Quality impact assessment. • Audit of learning from person time activity completed
• Sepsis data reviewed and areas for improvement identified. Sepsis dashboard scoped for implementation	• Catheter project developed to reduce the number of long term catheter insertion by 20% by 2020. Audit catheter numbers for baseline	• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions	• KPI data trajectory reviewed for reduction of Gram negative BSIs. • Reduction in the number of catheters • Suspicion of Sepsis Insights dashboard implemented

Improving Quality

Milestones

Q1	Q2	Q3	Q4
• Plan of care home quality work presented to ICS Quality and Performance Committee. Annual review for 2018-19 completed • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. • Learning and improvements on falls from the work undertaken by FH and BHFT shared and ICS actions to reduce the number of falls identified	• Quarterly review of progress against the plan completed • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.	• Improvement data shows improve outcomes for patients Monitor the impact of the implementation of the NEWS 2 in care homes with a reduction in the unplanned admissions. • Quarterly review of progress against the plan completed and for ICS Quality and performance committee. Any quality issues identified particularly around support from Primary Care • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee.	• Quarterly review of progress against the plan completed (and taken where?). Any quality issues identified particularly around support from Primary Care • Quarterly report and learning from the mortality reviews and LeDeR presented to the ICS Quality and Performance Committee. • Number of falls across the system reduced by 10%
• Baseline data reviewed from 2018-19 CQUIN on improving services for people with mental health needs by identifying a new cohort of patients. Milestones as per the CQUIN • Baseline data reviewed on the number of children and young people being cared for in an unsuitable environment • Baseline data reviewed for all organisations on the number of days where there has been no pressure ulcers developed. Public messaging for prevention developed and circulated	• Quarterly report presented to Quality and Performance Committee on progress and improvement • Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee	• Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement • Quarterly numbers of pressure ulcers identified across the ICS reported to the Committee	• Quarterly report to Quality and Performance Committee through the Quality report on progress and improvement • Reduction achieved in number of incidents reported from the baseline in Q1 • Celebration event for those services who have improved or had no pressure ulcers over the year. Public messaging evaluated • Reduction achieved from the baseline on number of pressure ulcers across the ICS

Improving Quality

Milestones

Q1	Q2	Q3	Q4
• Consistent approach for definition measurement and reporting Baseline data established. % reduction agreed across the ICS			
• To develop a plan on how to work across the system on youth violence initiatives	• Ambulance forums established • Standard practice across the ICS when considering safeguarding adult reviews aligned • Audit completed on the robustness of systems for determining mental capacity	• Safeguarding resource and information flow across the ICS developed • LAC designated professionals network extended to Hampshire and Surrey professionals Priority workstreams from South East feed into the national LAC framework	• Annual report on activity completed • Audit completed on the practice across the ICS • Evaluation report completed on plan Monitor the implementation of the plan and evaluate whether this has been successful • Audit completed on the robustness of systems for determining mental capacity