*Agenda Item No. 12*

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

## REPORT TO THE GOVERNORS' COUNCIL MEETING

| RESPONSIBLE DIRECTOR: | REPORT FOR: | | IMPACT ON BUSINESS: | | |
|---|---|---|---|---|---|
| Valerie Newton – Acting Chief Nurse | Decision | | High | Med | Low |
| | Consideration | ✓ | ✓ | | |
| | Information | | | | |
| **LEAD MANAGER:** | **REPORT TYPE:** | | **BAF REFERENCES & RAG:** | | |
| | Strategic | ✓ | | | |
| | Operational | ✓ | | | |
| | Governance | | | | |
| | **IMPLICATIONS:** | | **RELATED WORK: (PREVIOUS PAPERS TO BOARD/COMMITTEE)** | | |
| | Patient Care/Safety/ Experience | ✓ | | | |
| | Finance | | | | |
| | Workforce | | | | |
| | Policy | | | | |
| **PEER ASSIST (inc. clinical engagement):** | **PEER REVIEW:** | | | | |
| Suzanne Hinchliffe – Interim Chief Nurse Advisor | | | | | |
| **CQC Domain: (safe, caring, effective, responsive, well-led, use of resources)** | Safe, Caring, Effective, Responsive, Well led | | | | |

**Meeting Date:** **30 May 2019**
**Report Title:** **Strategic Quality Priorities**

**PURPOSE:**

This paper describes the Quality Priorities for the 2019/2020, approved at the meeting of the Quality and Performance Meeting in May 2019.

**SUMMARY:**

The quality priorities for 2019/ 20 represent key issues relating to patient experience and quality of care and are as follows:

- To improve the experience of patients and families at end of life.
- To ensure that discharge arrangements are clearly and timely communicated to the patient and his/her family.
- To reduce avoidable harm by improving the recognition and management of the deteriorating patient.
- To review and identify safe and sustainable ward staffing levels and skill mix together with plan of delivery.
- To reduce the number of inpatients experiencing a fall resulting in moderate / severe harm.
- To improve responsiveness to complaints within the Clinical Business Units (CBU).

| **Implications : Financial / Quality / Workforce / Policy:**<br><br>The proposed quality priorities are to improve quality standards within the Trust | | | | | | |
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| **Strategic / External** | **Operational** | **Financial** | **Clinical** | **Legal/ Regulatory** | **Reputational / Patient Experience** | **Workforce** |
| **√** | **√** | | **√** | **√** | **√** | |
| **RECOMMENDATION/S:** | | | | | | |
| To note the quality priorities for 2019 / 2020 | | | | | | |

# Revised Quality Objectives for 2019/20

The Quality Priorities for 2019/ 20 reflect key areas to improve the quality of care that the Trust provides to the patients we serve.

The choice of areas to address was informed by issues identified at audit, review of the Trust's Integrated Performance Report (IPR), patient stories, complaints and incidents that occurred.

They are summarised below:

| Objective | Actions | Outcome measure |
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| | **Patient Experience** | |
| To improve the experience of patients and families at end of life. | * To identify senior palliative care medical staff to lead improvements in palliative care in the Trust within the next 6 months;<br>* All patients recognised as approaching end of life to have an end of life care plan in place; IPOC<br>* Review staff education to include the following topics:<br>o Recognition of End of Life<br>o Nuts & Bolts<br>o Sage & Thyme<br>o Syringe Driver<br>* Review opportunities regarding the most appropriate place and environment for patients at End of Life | * 40% reduction in complaints and concerns related to end of life;<br>* Evidence of attendance at staff education sessions<br>* Retrospective audit in quarter 2 of 30 patients who have died in quarter 1 excluding sudden deaths –<br>- >90% care plans in place<br>- Medication administered within 30 mins of reported symptoms<br>- Support for families recorded. |
| To ensure that discharge arrangements are clearly and timely communicated to the patient and his/her family. | * To review and clearly identify discharge arrangements in patient health record that discharge, including arrangements, have been communicated to patient and/or family;<br>* To develop guidance for junior doctors to be given at induction on best practice in relation to facilitating discharge & ensuring a good experience for the patient and his/her family. | * 10% reduction in comments on Friends & Family feedback about problems with communication on discharge and<br>* 10% reduction in complaints in relation to communication of discharge arrangements |
| | **Patient Safety** | |
| To reduce avoidable harm by improving the recognition and management of the deteriorating patient. | * Incorporate NEWS 2 training for all new starters during induction and for existing staff within mandatory training; | * 50% reduction in incidents related to patient deterioration omissions during transfer between clinical areas; |

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| | * Introduce new trust-wide transfer/ handover SBAR tool by end of July 19;<br>* Implement guide for assessing requirement for a patient escort during transfer in all areas by end of May 19;<br>* Ensure safety huddles are implemented on all wards daily& patients of concern to be highlighted within huddles by end of July 2019;<br>* Audit compliance with NEWS2 & escalation process within *'Perfect ward'* by end of Sep 19;<br>* Post 2222 national audit review to be communicated to Divisional ACNs & AMDs from quarter 2;<br>* Implement trust wide the 'Stop the Clock' campaign prior to transfer. | * Trust-wide transfer /handover SBAR tool implemented in all clinical areas;<br>* Patient escort guide implemented;<br>* Compliance with the provision of ward safety huddles to be confirmed by matrons as part of their daily ward checks;<br>* Compliance audit of NEWS2 & escalation process incorporated into *'Perfect ward'*;<br>* Post 2222 national audit reviews communicated to Divisional ACNs & AMDs;<br>* Stop the Clock campaign implemented by end of July 19. |
| To review and identify safe and sustainable ward staffing levels and skill mix together with plan of delivery. | * Refresh the recommendations of the SAFER exercise undertaken during 2018/19;<br>* Align proposals with operational and financial opportunities;<br>* Engage with senior nursing staff with proposals ;<br>* Identify quality and patient experience benefits and outcomes expected as a result of delivery. | * Evidence of Board of Directors proposal communicated to CBU/Divisional and Executive colleagues;<br>* Evidence of engagement with UEA, trust partners and commissioners;<br>* Evidence of delivery plan alongside Divisional engagement;<br>* Evidence of patient experience and quality outcome delivery. |
| To reduce the number of inpatients experiencing a fall resulting in moderate / severe harm. | * All patients to have their risk of falling assessed on admission using a multi-factorial assessment;<br>* All patients considered at risk of falling to have an individualised falls care plan. To include requirement for cohorting, supervision, or use of assistive technology if appropriate;<br>* Consistently share information & agreed plan of care on all at risk patients during the ward safety huddles;<br>* Strengthen the 'falls | * 20% reduction in falls with harm over 2018/19;<br>* Falls Summit delivered in quarter 3;<br>* Post-fall protocol reviewed and implemented in quarter 2;<br>* Report on Peer review to be reviewed by Quality & Performance Committee in quarter 3;<br>* Root cause analyses on all falls with harm will demonstrate that in >90% of incidents the patient will have evidence of a multifactorial assessment, a care plan and evidence of |

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| | champion' roles in clinical areas with a bespoke training programme;<br>* Falls Summit to be held in autumn 2019;<br>* Peer review to be facilitated in quarter 2 to share learning and provide external assurance on current practice within the Trust;<br>* Take part in national NAIF audit programme to facilitate learning;<br>* Review Post-fall protocol. | implementation;<br>* Compliance with NAIF audit submission. |
| **Effectiveness** | | |
| To improve responsiveness to complaints within the Clinical Business Units (CBU). | * Review of complaints process to streamline clinical oversight and sign off at Divisional and Corporate level;<br>* Responding to complaints and ensuring learning/ changes to practice within the CBU as a result of complaints to be a key CBU performance indicator for 2019-2020;<br>* Progressive target improvements in response times throughout 2019/20. | * Revised complaints process and agreed sign off to be in place by end of June 2019;<br>* Response rates to improve progressively and to be consistently:<br>- > 50% by end of quarter 2<br>- >70% by end of December 2019<br>- >80% by end of March 2020<br>* Progress to be monitored monthly at Hospital Business Board. |

The committee is requested to consider and approve.

Valerie Newton
Acting Chief Nurse
8 May 2019