

<p>Yorkshire and the Humber Strategic Health Authority</p> <p><b>BOARD MEETING</b></p>	
<p><b>Date: 5 October 2010</b></p>	<p><b>Report Author:</b> Professor Chris Welsh - Director of Care, Quality and Productivity</p>
<p><b>Title of paper: NHS Yorkshire and the Humber Regional Quality Improvement Plan October 2010 – March 2012</b></p>	
<p><b>Actions Requested:</b></p> <ul style="list-style-type: none"> <li>• To note and approve the content of this Plan</li> <li>• To note the establishment of a Quality Improvement Team to oversee and support delivery.</li> <li>• To agree to receive progress reports on a six monthly basis.</li> </ul>	
<p><b>Governance Requirements</b></p>	
<p><b>SHA Objectives supported by this paper:</b> This paper supports the SHA corporate strategy objectives of delivering the year on year quality improvement and delivering a health service ‘of the highest quality and value regardless of who you are or where you are from.’</p>	
<p><b>Risk Management:</b> This report supports the mitigation of the following potential risk identified in the Assurance Framework: ‘SHA does not identify and manage poor patient safety and clinical quality systems in Trusts or PCTs’.</p>	
<p><b>Board Assurances:</b> Through the implementation of this plan the Board will receive a range of sources of assurance about the quality of services.</p>	
<p><b>Risk Assessment:</b> There are potentially significant risks to clinical quality associated with current financial pressures and major organisational change. This plan aims to mitigate these risks in drawing together our key regional quality goals and outlining how these can be delivered.</p>	
<p><b>Communication (including public and patient involvement):</b> There has been extensive consultation in developing this plan, including with clinicians, partner organisations, our Patient Safety Champions and staff who work in the field of public and patient engagement.</p>	
<p><b>Resource Implications – including productivity and value for money:</b> The actions to deliver this plan are subject to robust productivity and value for money assessment, notably use of the Regional Innovation Fund and patient safety funding from the Department of Health.</p>	

<b>Legal Implications:</b> None.
<b>Equality and Diversity:</b> This plan aims to improve the quality of care for all, in particular for those who are most vulnerable and in greatest need.
<b>NHS Constitution:</b> This paper aims to improve the quality of health services across Yorkshire and the Humber.

# **NHS Yorkshire and the Humber Regional Quality Improvement Plan October 2010 – March 2012**

We work towards:

*‘Yorkshire and the Humber being a healthy place to live, with a health service that is a match for anywhere in Europe, providing you with a service of the highest quality and value regardless of who you are or where you are from.’*

SHA Corporate Strategy, 2010

## **1 INTRODUCTION TO THIS PLAN**

This plan outlines in a set of tables our key priorities for transformational, systematic and sustainable quality improvement in NHS services in Yorkshire and the Humber over the next 18 months, within the context of major organisational change in the NHS and unprecedented pressure on public spending.

Under the headings of the SHA’s business model, the plan goes on to outline the assurance mechanisms, performance management levers and sources of support (the ‘enablers’) that will be offered at regional level by the SHA on the quality agenda. Quality is central to the SHA’s Single Accountability and Assurance Process (SAAP).

We recognise that individual organisations and teams within them will have their own quality priorities and initiatives to reflect the diverse needs of the people that they serve. This plan does not attempt to cover all these, but is designed to complement and support local work at a strategic level.

In developing the plan, the SHA has consulted widely with clinicians and other leaders in our region, plus partners, notably the Department of Health (DH), the NHS Institute for Innovation and Improvement, the National Patient Safety Agency (NPSA) and our Patient Safety Champions. Delivery of our goals will require on-going collaboration and leadership.

The recent White Paper ‘Equity and Excellence: Liberating the NHS’ outlines plans for radical change, including the development of GP commissioning consortia and the potential establishment of an NHS Commissioning Board from April 2012. This plan sets out what can be achieved in the NHS in Yorkshire and the Humber up to that time. We must build on the progress we have made to date and prepare the evolving system to commission and deliver the best quality services in the future.

## **2 CONTEXT**

The imperative to improve quality (ie patient safety, patient experience and clinical outcomes) sits alongside the pressing need to reduce costs and improve productivity. This is referred to as the ‘quality and productivity challenge’ or ‘QIPP’, the latter term indicating the contribution of innovation and prevention to meeting the challenge).

This plan builds on findings from our analysis of reported incidents, the priorities identified by patients and their carers as part of the National PPE (Patient and Public Engagement) Outcomes Framework and what frontline clinical staff have told us is important to them. The goals have been selected on the basis of their potential to address both quality and productivity imperatives at pace and at scale. Another factor in their selection is their measurability. The quality and productivity challenge requires us to be much more rigorous about the measurement and delivery of quality services, and to be far less tolerant of unreasonable variation in standards.

We need to significantly improve both the quantitative and qualitative assessment of safety and other aspects of quality in order to understand what affects it and how to improve it. In particular, in the coming months and years, it will be important to risk assess the potential impact on service quality of any changes to staffing levels and conversely to quantify the benefits of improving quality in financial terms eg through reductions in length of stay and numbers of hospital beds. There is a growing body of evidence to support the notion that better quality care can cost less.

Our priorities are aligned with national priorities (notably the 8 High Impact Actions for Care, the developing High Impact Actions for Patient Experience and the national QIPP workstreams). They are also designed to complement and add value to existing regional programmes of work, notably those of the 11 Healthy Ambitions Pathway Leadership Boards in their pursuit of better health outcomes across the region. Through the Quality Improvement Team, we will engage with these Boards and with commissioners and service providers to deliver our goals.

This plan has evolved from the SHA's Patient Safety Strategy 2007-2010 and the work of the Patient Safety Action Team and others in improving quality. In the last three years, our focus on quality and support for this agenda has strengthened significantly. We have learned lessons from serious incidents and inquiries in our own region. We have also examined the lessons from events elsewhere (notably the inquiry into Mid Staffordshire NHS Foundation Trust). We have made strides to embed quality in commissioning, for example through development of a regional CQUINS (Commissioning for Quality and Innovation) scheme, World Class Commissioning (WCC) competency development and the transfer of Serious Untoward Incident (SUI) performance management to PCTs. We have had a positive impact on services, for example reducing healthcare associated infections (HCAI) and improving patient survey scores, and in facilitating better collaboration across the system for a common goal (for example the work of the Healthy Ambitions Pathway Leadership Boards and the Clinical Leaders Network).

We have established a Quality Observatory, which has already delivered a number of successful outputs, notably the QIPP metrics packs, providing evidence to support high quality and cost effective clinical practice. The impact of these is currently being evaluated. We are actively discharging our statutory duty to promote innovation, including managing a Regional Innovation Fund (RIF). Another important development is the establishment of the regional HIEC (Health Innovation and Education Cluster), which has three key priorities:- patient safety, long term conditions, plus maternal and child health. Its over-arching aim is to make 'good practice, common practice'. Part of the 2010/11 RIF will go towards HIEC projects to support this over-arching aim and key goals within this plan.

### 3 HIGH IMPACT ACTIONS

Regional goal and measure (by end of March 2012)	Rationale for inclusion	How – key SHA, commissioner and provider actions	Lead
Reduce Grade III and IV pressure ulcers by 80% in acute care settings and 30% in community care settings	High Impact Action; National Safe Care QIPP workstream priority	<p>SHA</p> <ul style="list-style-type: none"> <li>• Secure engagement with Directors of Nursing to scope current work in relation to pressure ulcers, and implement nurse sensitive indicators and High Impact Action.</li> <li>• SHA to agree with Quality Observatory re reporting of HIA data</li> <li>• Scope current work in providers and share best practice</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Support providers and monitor their progress towards achieving the goals</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• Develop robust system to measure, report, and learn from grade III &amp; IV pressure ulcers</li> </ul>	Karen Warner, Patient Safety Manager
Reduce serious injury and death from falls by 50% Measured by NRLS data (from NHS organisations) and from ambulance service data (falls in the community)	High Impact Action; National Safe Care QIPP workstream priority	<p>SHA</p> <ul style="list-style-type: none"> <li>• Secure engagement with Directors of Nursing to scope current work in relation to falls, and implement nurse sensitive indicators and High Impact Action.</li> <li>• Agree with Quality Observatory re reporting of HIA data</li> <li>• Scope current work in providers and share best practice through variety of mechanisms</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Support providers and monitor their progress towards achieving the goal</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• Develop robust system to measure, report, and learn from falls which result in serious harm or death</li> </ul>	Karen Warner, Patient Safety Manager

<p>Reduce urinary catheter acquired infection by 50% as measured by QIPP Safe Care methodology (currently being developed)</p>	<p>High Impact Action; National Safe Care QIPP workstream</p>	<ul style="list-style-type: none"> <li>• Reduce catheterisation rates, reduce the length of time catheters are in situ</li> <li>• Ensure staff are appropriately trained in catheter care</li> <li>• 100% compliance with the High Impact Action for catheter care</li> </ul>	<p>David Thompson, Associate Director of Clinical Engagement</p>
<p>Ensuring patients die in their place of choice – the number of people dying at home as a proportion of all deaths to show an increase (proxy measure) in Y&amp;H</p>	<p>High Impact Action</p>	<ul style="list-style-type: none"> <li>• Hold a regional event to promote national QIPP priorities, to be organised for autumn/winter 2010</li> <li>• Engage with social care partners through the EoLC Pathway Leadership Board Care Home Project to improve the delivery of end of life care including preferred place of death</li> <li>• Continue to share good practice with health and social care colleagues through events supported by the EoLC Pathway Leadership Board</li> <li>• Deliver two commissioners workshops for improved delivery of end of life care in July and December 2010</li> <li>• Promote the use of advanced care planning in the delivery of EoLC</li> <li>• Work with the Quality Observatory to collate data on place of death (proxy measure) as detailed within the EoLC Pathway Leadership Board metrics</li> <li>• Develop a strategy for the promotion of the nationally developed EoLC e-learning modules</li> </ul>	<p>Cath Wardle, Integrated Governance Programme Manager/EoLC Pathway Manager</p>
<p>Ensure patients are optimally nourished and hydrated (current measurement as per regional CQUIN; to be developed to incorporate other care settings)</p>	<p>High Impact Action</p>	<ul style="list-style-type: none"> <li>• SHA to work with commissioners and providers to implement the standard of all patients in NHS-funded care settings to be screened for nutritional status using an approved screening methodology; for those identified to be at risk, a full nutritional assessment to be provided, and based on the outcome of assessment, a care plan devised and implemented as per 'Essence of Care'</li> </ul>	<p>David Thompson, Associate Director of Clinical Engagement</p>

Promoting midwife led care to (1) demonstrate year on year decreases in the caesarean section rate in line with the locally agreed trajectory set for CQUIN	High Impact Action; Healthy Ambitions; HIEC priority	<ul style="list-style-type: none"> <li>• Healthy Ambitions and HIEC work programmes in place.</li> </ul>	Jean Hawkins, Strategic Lead for Children & Families
Reducing delayed discharge by promoting nurse led discharge (percentage reduction to be determined following scoping work)	High Impact Action	<ul style="list-style-type: none"> <li>• Scoping work in providers to explore feasibility and potential numbers – to be conducted by 31.10.10.</li> <li>• Training of nurses to lead discharge</li> <li>• Patients to be given expected date of discharge on admission or as soon as possible thereafter</li> </ul>	David Thompson, Associate Director of Clinical Engagement
Fit and well to care - reduce sickness absence in the nursing and midwifery workforce to no more than 3%	High Impact Action	<ul style="list-style-type: none"> <li>• Health and Wellbeing Champion (Libby Sedgley) appointed</li> <li>• Engagement of HR and Occupational Health practitioners</li> <li>• Self-assessment underway</li> </ul>	Rebecca Smith, Associate Director, HR

## SPECIFIC LEADERSHIP, TRAINING AND DEVELOPMENT GOALS

Delivery of Board development resources to enhance leadership and assurance of quality	Regional priority – response to identified development need	<ul style="list-style-type: none"> <li>• Enhance induction materials and resources for NEDs – October 2010</li> <li>• Event(s) for Boards – complete by March 2011</li> </ul>	Rachel Gregson, Associate Director of Integrated Governance, Karen Warner, Patient Safety Manager and Geraldine Sands, Safeguarding Lead
Developing GP consortia competencies in relation to commissioning for quality	National and regional priority	<ul style="list-style-type: none"> <li>• Action plan to be determined – autumn 2010</li> </ul>	Ailsa Clare, Director of Commissioner Development
<p>Medical leadership</p> <p>a. Completion of AQMAR (Assuring the Quality of Medical Appraisal for Revalidation) self-assessment by all Trusts / PCTs in region</p>	National and regional priority	<p>(THESE APPLY TO a, b and c)</p> <ul style="list-style-type: none"> <li>• Deliver MOU / SLA with National Revalidation Support Team for 2010/11</li> <li>• Continue regular Medical Director Network meetings</li> <li>• Provide 1 to 1 support to Trusts and PCTs</li> <li>• Continued participation in Y&amp;H Collaborative Pathfinder Pilot Steering Group</li> <li>• Run Y&amp;H Stakeholder Event by end of 2010</li> </ul>	Professor Chris Welsh, Director of Care, Quality and Productivity and Dr Colin Pollock, Deputy Regional Director of Public Health

<p>100% by March 2011</p> <p>b. Successful completion of phase 1 of Y&amp;H Collaborative Pathfinder Pilot - March 2011</p> <p>c. Successful completion of phase 2 of GMC Affiliates pilot - March 2011</p>			
<p>Standardised, multi-professional patient safety induction tool</p>	<p>Regional priority</p>	<p>Proposed HIEC project</p>	<p>Dr John Wright, Dr Rebecca Lawton – Co-Directors, HIEC patient safety workstream</p>

### **ADDITIONAL CROSS-CUTTING QUALITY GOALS**

<p>Analysis of and feedback on Quality Accounts to support spread of good practice and address top issues requiring improvement</p>	<p>National priority</p>	<p>Quality Observatory and Integrated Governance Team action plan (complementary to national work) – to include a learning and sharing event – winter 2010/11</p>	<p>Jake Abbass, Deputy Director,, Quality Observatory and Karen Warner, Patient Safety Managert</p>
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CQUINs development for 2011/12 and use of CQUINs data for benchmarking and sharing improvement methodology	National, local and regional priorities	PCT-led Quality Forum action plan	Sue Hillyard, Associate Director, Performance
Support Trusts aspiring to be FTs to achieve the necessary quality governance thresholds	National, regional and local priority	SHA to establish a diagnostic process to work with FT applicants using the Monitor governance framework <ul style="list-style-type: none"> <li>- providing developmental support as required to Trusts &amp; their PCTs</li> <li>- providing evidence to underpin SHA assurance responsibilities</li> </ul> Timescale: autumn 2010 On-going implementation	Neil Ferguson, Provider Development Manager
Annual assessment of workforce risks	National, regional and local priority	As part of the workforce planning cycle set out in 'Workforce Ambitions', the SHA requires PCTs to undertake an annual assessment of workforce risks (including staffing levels, recruitment, retention, skill mix, education and training) – next one due at the end of October 2010; SHA to collate and undertake regional analysis to be completed by the end of November – to guide future SHA action including supporting regional and local interventions and feedback nationally to the Department of Health and Centre for Workforce Intelligence.	Helen Smith, Associate Director of Workforce Strategy
Continued production of QIPP metrics packs,, Better for Less briefings and other resources to support quality improvement	Regional initiative	Production schedule in place, focusing on key priorities.  Evaluation of impact – autumn 2010	Ian Holmes, Associate Director , Economics and System Management and Professor Brian Ferguson, Director, Quality Observatory

## 4 PATIENT SAFETY

### Our aims

- Zero tolerance of avoidable harm to patients
- Maximum reliability safety systems, practices and processes

Regional goal and measure (by end of March 2012)	Rationale for inclusion	How – key SHA, commissioner and provider actions	Lead
Continue to improve the reporting and analysis of incidents – and action in response	Regional priority	<ul style="list-style-type: none"> <li>• Integrated Governance Team to work with Quality Observatory to improve feedback on incidents reported - SUIs (serious untoward incidents) and other incidents reported (NRLS data)</li> <li>• To ensure action is taken on a prioritised basis in relation to key issues identified – this may include under-reporting (as identified in primary care) as well as action in relation to individual SUIs or ‘clusters’ of SUIs or other incidents</li> </ul>	Rachel Gregson, Associate Director, Integrated Governance and Cath Wardle, Integrated Governance Programme Manager Dr John Wright and Dr Rebecca Lawton, Co-Directors, HIEC Patient Safety Theme
Improve medication safety as measured by a goal of 20% reduction in reported medication SUIs i.e. those resulting in serious harm/death	National QIPP worksteam - ‘Medicines & Procurement’  Regional priority – as shown by SUI data	<ul style="list-style-type: none"> <li>• SHA to ensure commissioners have baseline data that allow them to understand the number and type of medication SUIs and SHA, Pharmacy and other clinical networks to share information on SUIs related to medicines and examine and share strategies to reduce these, including compliance with NPSA medicines safety alerts</li> <li>• The Deanery to continue working closely with the three Medical Schools to underpin and influence the undergraduate curriculum in prescribing. A working group has been established to develop standardised delivery both at undergraduate level and at Junior Doctors induction</li> </ul>	Michele Cossey, SHA Pharmacy & Prescribing Lead  Professor Sarah Thomas, Postgraduate Dean

<p>Improve safeguarding of children in the NHS services as measured by 50% reduction in safeguarding SUIs where the perpetrator was known to adult mental health or services</p>	<p>Priority risk issue within Ofsted's annual report on serious case reviews</p>	<ul style="list-style-type: none"> <li>• PCT/ SHA assurance process re adult MH health already taken place following NPSA Rapid Response Report.</li> <li>• Integrated Governance team to record number and proportion of safeguarding SUI involving mentally ill adult on a quarterly basis</li> <li>• Workshop for safeguarding leads in adult mental health services to be organised for autumn 2010 by HYIP and sustainable network group to be established by practitioners</li> <li>• Best practice re risk assessments and safety thresholds to be shared so that they become common practice</li> <li>• Support of mental health and children's healthy ambitions pathways has been sought</li> </ul>	<p>Geraldine Sands, Strategic Lead for Safeguarding &amp; Partnerships</p>
<p>Improve partnership working and external scrutiny of NHS safeguarding arrangements for adults by demonstrable increases in referrals to Local Safeguarding Adults Boards (LSABs) from NHS organisations in Y&amp;H</p>	<p>National priority - within draft guidance 'No secrets' to be published 2010</p>	<ul style="list-style-type: none"> <li>• Baseline data to be established with each LSAB</li> <li>• Workshop to develop model of safeguarding and interface with patient safety and SUI system planned for Sept 2010. Model to differentiate between safety and safeguarding</li> <li>• YHIP working with trusts and PCTs to promote partnership working on adult safeguarding in 2010/11</li> <li>• Each PCT has been asked to establish safeguarding leadership roles</li> <li>• Referral rates to LSCBs to be measured from Feb 2012</li> </ul>	
<p>All organisations to be 100% compliant with safety alerts notified on the central alert system by the due date</p>	<p>National and regional priority</p>	<p>SHA</p> <ul style="list-style-type: none"> <li>• Act as advocate for commissioners and providers with NPSA as central alert system is enhanced at national level</li> <li>• Undertake, report and provide feedback on a point prevalence survey to assess alert compliance quarterly commencing Sept 2010</li> <li>• Incorporate compliance with safety alerts into contracts from April 2011</li> </ul>	<p>Marie Chappell, Integrated Governance Manager</p>

		<ul style="list-style-type: none"> <li>• Safety alert compliance will be a standard agenda item on PCT performance visits</li> <li>• Input from HIEC to speed up and spread best practice in relation to implementation of safety alerts</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Work with providers to improve compliance</li> <li>• Develop assurance system for compliance</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• Respond to all CAS alerts within set deadlines</li> <li>• Develop and implement action plans and share with commissioners</li> </ul>	Dr John Wright and Dr Rebecca Lawton, Co-Directors, HIEC Patient Safety Theme
Reduce VTE by 50% in all care settings – as per QIPP safe care measurement system (plus use of national CQUIN – measure - % of all adult patients who have had a VTE risk assessment on admission to hospital)	National Safe Care QIPP workstream priority	<p>SHA</p> <ul style="list-style-type: none"> <li>• Secure engagement with Medical Directors to scope current work in relation to VTE</li> <li>• Agree with Quality Observatory re reporting of VTE data</li> <li>• Scope current work in providers and share best practice</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Monitor providers progress towards achieving the percentage reduction</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• Develop robust system to measure, report and learn from the incidence of VTE</li> </ul>	David Thompson, Associate Director of Clinical Engagement / Karen Warner, Patient Safety Manager
Compliance with the forthcoming NPSA Rapid Response Report on actions to address common issues arising from mental health homicide investigations	National and regional priority	Plan to follow when RRR published (autumn 2010)	Heather Raistrick, Adult Services Lead; input from Wendy Ambler, Integrated Governance Manager

No 'never events' (as measured by incident (NRLS and SUI) data)	National and regional priority (ref: Operating Framework; White Paper)	<p>SHA</p> <ul style="list-style-type: none"> <li>Ensure all PCTs and providers are aware of definitions of never events and relevant preventative action (eg WHO surgical safety checklist) and that incident reporting and management systems are robust</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>Report to the SHA on providers' compliance with safety alerts/other preventative action in relation to never events</li> <li>Ensure any never events which may occur are subject to priority SUI investigations and learning is implemented and shared rapidly</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>Take action to comply with safety alerts and other preventative action in relation to never events</li> <li>Should a never event occur, report, investigate and take action as a priority</li> </ul>	Karen Warner, Patient Safety Manager
Reduce mortality ie aim for all providers' HSMRs being within or better than the 'acceptable' range (as defined by Dr Foster or any alternative national measure recommended by the DH review)	National and regional priority	<p>SHA – Protocol to be documented (complementary to CQC process)</p> <ul style="list-style-type: none"> <li>Review data and identify outliers from expected range</li> <li>Bring to attention of PCT commissioner any issues of concern and ask them to identify causal factors with provider; support PCT in identifying best practice eg facilitate peer review if appropriate</li> <li>Where action identified, provide support and performance manage PCT commissioner to ensure satisfactory resolution</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>Ensure provider investigates outlying mortality and takes action as appropriate</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>Investigate and take action as appropriate</li> </ul>	Professor Chris Welsh, Director of Care, Quality and Productivity
Robust implementation of the Memorandum of Understanding with the Police and HSE to ensure that	Priority arising from two major inquiries in Y & H (Norris – LTHT and	<p>SHA</p> <ul style="list-style-type: none"> <li>Awareness raising of existing MoU guidance to police forces</li> <li>Implement revised Dept of Health revised guidance once this is published</li> <li>Review of providers arrangements via commissioners</li> </ul> <p>Commissioners</p>	Cath Wardle, Integrated Governance Programme Manager /EoLC Pathway Manager /

<p>patient safety is the foremost concern following serious incidents which require Police/HSE investigation – as measured by satisfactory review results (design of review to be determined)</p>	<p>Airedale inquiries)</p>	<ul style="list-style-type: none"> <li>• Awareness raising with providers re; creating effective working relationships with police Providers</li> <li>• To implement the guidance and contribute to effective working relationships with police, HSE and SHA</li> </ul>	<p>Justine Paul, Governance Programmes Manager</p>
<p>All providers confirm action in response to the NPSA's 'Being Open' initiative – to support a culture of openness with patients, carers and the public on safety issues</p>	<p>National (NPSA) and regional priority</p>	<p>SHA to set up system for commissioners to seek assurances from providers regarding the implementation and monitoring of this guidance</p>	<p>Angela Deacon, Integrated Governance Support Manager</p>

## 5 PATIENT EXPERIENCE

### Our aims

Ensure people have a positive experience of care

- *Compassion, empathy and responsiveness*
- *Coordination and integration*
- *Information, communication and education*
- *Physical comfort*
- *Emotional support, relieving fear and anxiety*
- *Involvement of family and friends*

*(Institute of Medicine, 2001)*

Regional goal and measure	Rationale for inclusion	How – key SHA, commissioner and provider actions	Lead
Improve patient experience in acute trusts, as measured by the in-patient survey – organisations to improve on previous year's performance in line with their agreed vital signs trajectories	Key target in national acute trust patient experience performance framework and new patient experience outcomes framework (currently under consultation – consultation to close 11.10.10)	<ul style="list-style-type: none"> <li>• SHA to work through commissioners to performance manage and support trusts in line with regional framework (based on national performance management framework)</li> <li>• Action plans developed by commissioners to address any issues identified within provider organisations</li> </ul>	Angela Hamilton, Associate Director, Patient Experience and Engagement

<p>Provision of same sex accommodation regionally – 100% compliance with DH definitions; any breaches reported as per protocol</p>	<p>National and regional priority.</p>	<ul style="list-style-type: none"> <li>• Quarterly reporting and monitoring of performance</li> <li>• Significant financial consequences for breaches</li> </ul>	<p>Angela Hamilton, Associate Director, Patient and Public Engagement</p>
<p>Ensure regional engagement and promotion of the carer agenda – co-ordinate NHS input to the Regional Strategy for Carers</p> <p>Ensure all PCT's have up to date carers strategies that reflect the national and regional strategy</p>	<p>Regional priority</p>	<ul style="list-style-type: none"> <li>• SHA contribution to Regional Strategic Partnership for Carers</li> <li>• Firm up on delivery to systems to support carers</li> <li>• Support the development of links between NHS and Local Authority/Social Care carers leads</li> <li>• Monitor updating/currency of Carers Strategies annually</li> </ul>	<p>Angela Hamilton, Associate Director, Patient and Public Engagement</p>
<p>New system for complaints</p>	<p>National priority</p>	<ul style="list-style-type: none"> <li>• All trusts to comply with new complaints system</li> <li>• Support system to understand and utilise new complaints system effectively</li> <li>• Support system to learn from complaints</li> <li>• Support national development of complaints data collection – SHA is a member of the National Project Board</li> </ul>	<p>Angela Hamilton, Associate Director, Patient and Public Engagement</p>

Support creative models of engagement and measuring experience that promote quality and reflect diversity	Regional priority	<ul style="list-style-type: none"> <li>• Support the development of Healthwatch</li> <li>• Support to LINKs, GP Consortia and PCT's during transition</li> <li>• Work with Quality Observatory regarding patient experience intelligence gathering mechanisms e.g. National Patient Surveys, SUIs, PALS, Patient Opinion etc. to ensure alignment and to be able to triangulate information</li> <li>• Ensure Equality and Diversity (and SHA Equality Scheme principles) are reflected in the Quality Strategy</li> </ul>	Angela Hamilton, Associate Director, Patient and Public Engagement
Patient involvement in regulation in medical training	Regional priority	<ul style="list-style-type: none"> <li>• Regional lay members involvement</li> <li>• Higher education institutions PPI network promoting and involving service users, carers and families in health, nursing and social care training</li> <li>• Patient, service user and carer involvement embedded in educational commissioning contracts</li> </ul>	
<p><b>SUPPORTING/ENABLING WORK</b></p> <ul style="list-style-type: none"> <li>• Developing and supporting commissioners (PCT/PBC)</li> <li>• Build capacity and capability via the Patient Engagement Leads Network</li> <li>• Improve the range and use of patient experience metrics – specifically complaints, PALS, PROMS and PREMS in line with the national development of a range of surveys and measures that give emphasis not just to acute care, but the full range of services</li> <li>• Incentivising improvement through regional and local CQUINs</li> </ul>			

## 6 CLINICAL EFFECTIVENESS

### Our aim

- Excellent care for all - up to date and evidence-based
- The right care for the right patient at the right time

Regional goal and measure (by end of March 2012)	Rationale for inclusion	How – key SHA, commissioner and provider actions	Lead
<p>Compliance with applicable NICE guidance –</p> <ul style="list-style-type: none"> <li>• Compliant with all NICE technology appraisals within 6 months of issue, unless otherwise stated by NICE</li> <li>• Compliant with all NICE guidelines within 3 years of issue</li> </ul>	<p>As per White Paper – Equity &amp; Excellence: Liberating the NHS</p>	<p>SHA</p> <ul style="list-style-type: none"> <li>• Provide advice and support to trusts on managing NICE guidance</li> <li>• Set up system to receive assurance from commissioners on providers' compliance</li> <li>• Provide guidance on how KPIs for compliance with NICE guidance could be included in all contracts</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Write requirement for compliance into contracts</li> <li>• Robustly monitor compliance with NICE guidance by providers</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• To implement relevant NICE guidance and report to the lead commissioner accordingly</li> <li>• To measure compliance and report to the lead commissioner accordingly</li> </ul>	<p>Martin Ferris, Head of Clinical Audit &amp; Effectiveness</p>

<p>All providers to be compliant with NICE quality standards –</p> <ul style="list-style-type: none"> <li>• Dashboard for standards to be populated within six months of issue</li> <li>• Compliant with standards within two years of issue</li> </ul>		<p>SHA</p> <ul style="list-style-type: none"> <li>• Provide advice and support to trusts on managing NICE standards</li> <li>• Set up system to receive assurance from commissioners on providers' compliance</li> <li>• Provide guidance on how compliance could be included in all contracts</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Write requirement for compliance into contracts</li> <li>• Robustly monitor compliance by providers</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• To implement relevant standards and report to the lead commissioner accordingly</li> <li>• To measure compliance with standards and report to the lead commissioner accordingly</li> </ul>	<p>Martin Ferris, Head of Clinical Audit &amp; Effectiveness</p>
<p>All commissioners and providers comply with Healthcare Quality Improvement Partnership (HQIP) criteria for clinical audit (2009)</p>	<p>Nationally recognised standard</p> <p>Compliance will also achieve NHS Litigation Authority standard</p>	<p>SHA</p> <ul style="list-style-type: none"> <li>• Ensure that all PCTs and Trusts are aware of the criteria and provide advice and support in implementation</li> </ul> <p>Commissioners</p> <ul style="list-style-type: none"> <li>• Include compliance as a KPI within provider contracts</li> <li>• Monitor performance of providers</li> </ul> <p>Providers</p> <ul style="list-style-type: none"> <li>• Develop processes which meet the criteria and report to commissioner</li> </ul>	<p>Martin Ferris, Head of Clinical Audit &amp; Effectiveness</p>

## **7 KEY REGIONAL ENABLERS FOR QUALITY IMPROVEMENT**

### **LEADERSHIP**

#### **a) Leading by example and leading the region to focus on quality**

In our leadership role, we will seek to ensure and to demonstrate that quality is the 'organising principle' in all that we do and that we engage clinicians, patients and the public in our pursuit of quality improvement.

- We will ensure that quality features as the first item of core business on all our Board agendas and that we actively engage with clinicians (eg through the Senior Clinical Leaders and the Clinical Leaders Network) and with patients, service users and carers. We will involve patient representatives at a strategic level. We will hold the Boards of PCTs and non-FT providers to account about how they do this, eg through Board to Board meetings.
- The SHA leads numerous networks which are an important mechanism for the diffusion and adoption of best practice across the region. These include Chairs, Chief Executives, Medical Directors, Directors of Nursing, Chief Pharmacists, Allied Health Professionals, Patient Experience and Engagement Leads, Supervisors of Midwives and the Yorkshire Effectiveness and Audit Regional Network.
- Through the Specialised Commissioning Group, directly and through other mechanisms, the SHA influences the work on quality of the region's clinical networks, for example the cancer networks.

#### **b) The Quality Observatory**

The Quality Observatory will support the SHA, PCTs, provider organisations and others in the measurement and analysis of quality indicators and in the production and promotion of resources to put Yorkshire and the Humber at the forefront of quality improvement. The Observatory will draw on the resources of NHS Evidence, the Information Centre and others, utilise local sources of intelligence eg that from Deanery visits to provider organisations and make links with other Quality Observatories across the country.

#### **c) Innovation**

As an SHA we have a duty to support innovation. It is through creativity linked to the management of large scale change that we shall both spread innovation and be successful at improving quality and cutting cost.

In light of the current economic climate it is now more important than ever to embed innovation in everything we do to deliver services in a better and more efficient way. Innovation will help us to address the big challenges set out in Healthy Ambitions and to creatively and effectively address issues such as an ageing population, chronic disease and health inequalities, as well as delivering the QIPP (Quality, Innovation, Productivity and

Prevention) agenda, which focuses on delivering the best patient care in the most efficient way.

We will focus our innovation resources and large scale change effort on supporting the delivery of Healthy Ambitions and on achieving quality and cost improvements. To support this work we are participating in a national campaign led by the NHS Institute on behalf of the NHS Management Board and the National Leadership Council, in partnership with Harvard University, to support over 1,000 leaders in our region in leading quality and cost improvements by March 2011. This work is embedded in our regional QIPP strategy and details of the work can be found at [http://www.yorksandhumber.nhs.uk/what\\_we\\_do/improving\\_patient\\_care\\_and\\_service\\_quality/innovation\\_and\\_improvement/](http://www.yorksandhumber.nhs.uk/what_we_do/improving_patient_care_and_service_quality/innovation_and_improvement/)

The Regional Innovation Fund (RIF) has been a useful catalyst in generating and sharing innovative ideas for improving health and healthcare within the region. We funded 15 projects in 2009/10. We will support the successful development of the projects in 2010/11 and prepare for their wider adoption and spread across the region. Details of the projects can be found in our 2009/10 Annual Innovation Report available at [http://www.yorksandhumber.nhs.uk/what\\_we\\_do/improving\\_patient\\_care\\_and\\_service\\_quality/innovation\\_and\\_improvement/](http://www.yorksandhumber.nhs.uk/what_we_do/improving_patient_care_and_service_quality/innovation_and_improvement/)

We plan to invest £1 million RIF funding in 2010/11 to support the Health Innovation and Education Cluster for Y&H (HIEC) in their mission to turn best practice into common practice across the region. We will do this by commissioning the HIEC to promote the adoption and spread of high impact innovations in patient safety, long term conditions and maternal and infant health across Y&H. We also plan to invest £1 million in supporting the development of the regional Tele-health programme. For more information about the HIEC contact Dr Dawn Lawson, Managing Director of the HIEC at [dawn.lawson@bradfordhospitals.nhs.uk](mailto:dawn.lawson@bradfordhospitals.nhs.uk)

The SHA has a service level agreement with the NHS Institute to support the NHS in Y&H in delivering innovations and improvements to meet the commitments set out in Healthy Ambitions, our regional QIPP plans and wider corporate strategy. The Institute provides a number of additional programmes of support outside of the regional contract, for example to the national QIPP Safe Care programme.

Key priorities in our 2010/11 agreement include the adoption and spread of the Productive Series across a range of service settings including community services, maternity services and operating theatres, transforming dementia and stroke pathways. For more information on the services available to support your work please contact the NHS Institute's regional lead, [beverley.leckenby@institute.nhs.uk](mailto:beverley.leckenby@institute.nhs.uk) .

Over the next 18 months the SHA will pro-actively highlight the innovative work of the NHS in Yorkshire and Humber in the local, national and specialist media. A Communications Co-ordinator for Innovation and Improvement at the SHA is now in place to do this.

One of the main communications objectives for the Innovation and Improvement Programme is to raise the profile of evidence-based good practice innovation across Yorkshire & Humber and beyond. This will be done through regional and national awards, attending the Healthcare Innovation Expo in March 2011, the SHA's regional Annual Innovation Report 2010/11 and through the development of regional and national partnerships to promote innovation and encourage the diffusion and adoption of innovation across the region.

## **ACCOUNTABILITY AND ASSURANCE**

### **a) SAAP – Single Accountability and Assurance Process**

Under the new SAAP, the SHA will review key quality indicators alongside other indicators of organisational health such as leadership, finance and workforce on a monthly basis, examining inter-dependencies and taking action as appropriate. Through this process, our understanding of quality will be improved as we review organisational performance in the round. We will hold PCTs to account for delivery against their quality ambitions as articulated in their strategic and operational plans. We will also ensure that safety and other aspects of quality remain central across care pathways, geographical and professional boundaries and that the region, as a whole, delivers the 'Vital Signs' targets and contracted quality requirements.

## **SYSTEM REGULATION**

### **a) Assurance of safety**

The SHA will develop its existing systems for the assurance of safety across the region - notably in relation to HCAI, incidents, safety alerts, independent investigations and its statutory Local Supervising Authority (supervision of midwives) function. An important priority is to formally report to the SHA Board the impact of action taken in Yorkshire and the Humber in response to the Francis Report. This is scheduled for November 2010.

### **b) Partnership working with regulatory bodies**

- We will continue to develop our partnership with the Care Quality Commission (CQC) and work with PCTs and trusts to ensure that they understand and meet registration requirements and respond appropriately to any regulatory action. We will actively participate in performance reviews and risk summits with CQC and other regulators, notably the HSE.
- We will support organisations in the FT pipeline, liaising with Monitor and using the Monitor quality governance framework for assessment purposes.
- We will continue to liaise with professional regulatory bodies eg the GMC and NMC, recognising their role in setting professional standards and the regulation of these. NHS Y&H has been at the forefront of the proposals to reform medical regulation – including piloting of the GMC Affiliates role and the new models of revalidation of doctors. We will therefore continue to support actively all Trusts (including FTs) and

PCTs to prepare for the implementation of medical revalidation and the establishment of Responsible Officers. We will also continue to provide a practical test bed for the regional affiliate role for the GMC. We will use the lessons learnt from this work to influence thinking on regulatory reforms in other clinical disciplines. We will promote a system of openness and accountability in regulation of healthcare professionals with patients and carers being active partners in this process.

**c) Use of commissioning levers**

- We will be actively involved in the Quality Forum chaired by the Chief Executive of NHS Doncaster. This Forum is responsible for the development of regional CQUINS.
- We will work with commissioners to introduce contractual incentives and penalties for service quality improvements and breaches respectively.
- We will support PCTs in the robust monitoring of quality in providers, including evaluation of the action taken in response to SUIs.

**CAPACITY BUILDING**

**a) Education, training and research and development**

- In support of our leadership function, a key priority will be to design and deliver Board development resources, in particular to strengthen the role of Non-Executive Directors to lead the quality agenda. This will support promotion of a culture across the region in which quality truly is the 'organising principle' in all that we do.
- Other key programmes of development include the Clinical Leaders Network and the TAPS (Training for Action in Patient Safety) programme for multi-disciplinary teams including junior doctors.
- We will continue to support local initiatives, for example the Sheffield Quality Improvement Academy.
- We will continue to work in partnership with universities and colleges to develop quality within pre and post registration curricula, including standardisation to address key issues such as prescribing and discharge practice and supporting development of simulation training to underpin safer clinical practice. The Deanery is continuing to develop a number of leadership posts to support junior doctors in training. The Deanery is also working with the three Medical Schools and Trusts to develop and improve standardised delivery of undergraduate and postgraduate safety education to doctors in training across Yorkshire and the Humber.
- We will continue to stage learning and sharing events to embed learning and necessary practice development changes in relation to good practice and in response to major inquiries
- We will continue to work with the research community to maximise the impact of relevant research on clinical services. Specifically, we will use the output of the two regional CLARCHs to inform commissioning and service delivery. An important example of research activity in relation to quality is the Bradford Institute for Health study into involvement and empowerment of patients in patient safety, which our regional patient safety champions are contributing to.

## **b) Use of information management and technology (IM & T)**

- Through the Y & H Programme for IT, we will maximise the use of IM & T to achieve improve service quality, for example telehealth.

## **ADVOCACY AND INTERPRETATION**

We will work with partner organisations such as the Overview and Scrutiny Commission Network, Yorkshire Regional Forum, and LINKs to develop strong links and best practice in involvement and engagement between our PCTs and their local community partners in order to respond to patient needs and drive up quality.

We will continue to influence DH policy in relation to quality matters and regulators' quality standards. For example, the SHA has had significant involvement of the national direction for Patient Experience outcomes and measures via the National PPE Leads Network.

## **7 RISKS TO DELIVERY**

Key potential risks are outlined as follows:

- a) Suitable indicators/measures are not readily available for all goals, presenting challenges for the assessment of progress. This issue is recognised and we are working with the Quality Observatory and others to improve data and analysis of quality.
- b) The proposed radical changes to the system may introduce additional risks as key functions are transferred or discontinued and new roles and responsibilities are determined. The new system will need to be carefully designed and managed to avoid gaps or duplication and efforts are needed now to preserve the 'corporate memory' at all levels.
- c) Capacity for delivery – there is clearly potential for reduced staffing in future to impact negatively on service quality, a risk which needs to be mitigated by integrated workforce and service planning.
- d) Education and training must be fit for purpose to deliver the skills and competencies required by clinicians and other staff to offer the highest possible quality of service.
- e) For some of the goals in this plan, investment is required for future benefits to be realised, which is clearly a risk in the current financial climate. On-going assessment of priorities and rigorous control of expenditure will be required.

## **8 IMPLEMENTATION AND MONITORING OF THIS PLAN**

In the context of a rapidly changing environment, this plan will be formally reviewed on a quarterly basis and revised as appropriate by the NHS Y & H Quality Improvement Team (terms of reference including membership shown at Appendix A). New priorities may well emerge from analysis of Quality Accounts. Progress will be reported to the SHA Board and to the Chief Executives Forum on a six monthly basis.

### **NHS Yorkshire & the Humber Quality Improvement Team**

#### **Membership**

##### **SHA**

Sarah Harkness, Chair: Non Executive Director  
Prof Chris Welsh, Director of Care, Quality and Productivity (link to Healthy Ambitions Pathway Leadership Boards, clinical networks and SHA SMT and Board)  
Rachel Gregson, Associate Director, Integrated Governance  
Angela Hamilton, Associate Director, Patient & Public Involvement (link to patient networks)  
David Thompson, Associate Director, Clinical Engagement (Chief Nurse, link to clinical networks)  
Laura Hibbs, Associate Director, Innovation  
Sue Hillyard, Associate Director, Performance (link to Quality Forum which is responsible for the development of regional CQUINs)  
Karen Warner, Patient Safety Manager (link to Patient Safety Champions)  
Martin Ferris, Clinical Audit and Effectiveness Co-ordinator  
Prof Sarah Thomas, Postgraduate Dean  
Prof Brian Ferguson, Director, Quality Observatory  
Jo Franklin, Associate Director, QIPP  
Dr Andrew Clark, Deputy Regional Director of Public Health  
Dr Colin Pollock, Deputy Regional Director of Public Health  
Helen Smith, Associate Director of Workforce Strategy  
Tim Lowe, Associate Director of Finance  
Rose Hand, Assistant Chief Information Officer, Yorkshire and Humber Programme for IT  
Natalie Norman, Business Support Manager

##### **NHS in Y & H**

Sue Smith, Associate Director of Integrated Governance & Safety, NHS Kirklees – PCT representative  
Mark Emerton, Consultant Orthopaedic Surgeon, Leeds Teaching Hospitals NHS Trust - Acute sector representative  
Nicola Lees, Director of Nursing, Bradford District Care Trust – Mental Health and Learning Disabilities sector representative  
Steve Page, Director of Standards and Compliance, Yorkshire Ambulance Service GP consortia representative  
Director of Adult Social Services representative

##### **HIEC**

Dr John Wright/Dr Rebecca Lawton, Co-Directors, HIEC Patient Safety Theme  
Dr Dawn Lawson, Managing Director, HIEC

##### **CQC**

Adam Brown, Area Manager, Care Quality Commission

**Others (including policy leads and patient representatives) to be co-opted as agenda dictates**

## **Terms of reference**

1. To work collaboratively to develop and deliver the Quality Improvement Plan, within the context of the SHA's wider QIPP Programme.
2. To work with stakeholders within the SHA, across the health community and others to achieve the specific goals within the Plan.
3. To identify and where necessary secure the necessary resources for delivery (financial, people, other).
4. To engage key partner organisations to support delivery (notably the Institute for Innovation and Improvement and the National Patient Safety Agency).
5. To draw on the best practice available nationally and internationally in delivery of our goals.
6. To promote Yorkshire and the Humber as a centre of excellence.
7. To monitor the progress of work on a quarterly basis, agree activity in order to deliver the specific goals within the Plan and to revise the Plan as necessary in the light of changing circumstances.
8. To approve progress reports to the SHA Board and Chief Executives Forum on a six monthly basis.
9. To take an overview of the system, to promote the safe and effective handover of functions for safety and quality assurance and improvement to GP consortia and other new organisations

## **Organisation**

Meetings will be held quarterly meetings serviced by the Integrated Governance Business Manager, with agendas and papers circulated the week before the meeting and an action log following the meeting circulated within the following week.

USEFUL WEBLINKS

[www.yhpho.org.uk](http://www.yhpho.org.uk)

[www.healthyambitions.co.uk](http://www.healthyambitions.co.uk)

[www.institute.nhs.uk](http://www.institute.nhs.uk)

[www.nmc-uk.org](http://www.nmc-uk.org)

[www.npsa.nhs.uk](http://www.npsa.nhs.uk)

[www.cqc.org.uk](http://www.cqc.org.uk)

[www.gmc-uk.org](http://www.gmc-uk.org)

[www.hse.gov.uk](http://www.hse.gov.uk)

[www.nice.org.uk](http://www.nice.org.uk)

[www.hpc-uk.org](http://www.hpc-uk.org)

[www.hcsu.org.uk](http://www.hcsu.org.uk)

[www.hqip.org.uk](http://www.hqip.org.uk)

[www.nhsla.com](http://www.nhsla.com)

[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

[www.midwife.org.uk](http://www.midwife.org.uk)

[www.nmc-uk.org.uk](http://www.nmc-uk.org.uk)

