Quality counts

Our Quality Strategy 2014 - 2019
our commitment to patient safety, participation and quality of care
Reference

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- Members
- CCG staff
- Patient Reference Groups/ People’s Council
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- Nursing Strategy 2014-19
- Primary Care Strategy
Superseded documents
- Quality Framework 2012, Quality Strategy Version 1
Sponsoring Director | Dr Cheryl Crocker

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1. Introduction
Commissioning is a tool for ensuring high quality, cost effective care which relies on adequate and meaningful data. Quality underpins the work undertaken by commissioning groups.

The Nottinghamshire Clinical Commissioning Groups are working in partnership to improve health and change lives. The mission is to improve the health and wellbeing of people in Nottinghamshire with a specific aim to improve quality by delivering improved safety, effectiveness of services and improved patient experience. The three quality domains are:

- Patient safety (the safety of treatment and care provided to patients)
- Patient experience (the experience patients have of the treatment and the care they receive)
- Clinical effectiveness (measured by both clinical outcomes and patient-related outcomes)

Quality is only achieved when all three domains are met, delivering on one or two is not enough. To achieve a good quality service the values and behaviours of those working in the NHS need to remain focussed on patients first. An organisation that is truly putting patients first will be one that embraces and nurtures a culture of open and honest cooperation.

To achieve this:

- Staff need to feel able to raise concerns about the quality of care at an early stage
- Clinical teams need to understand the quality of service they are providing to patients through a system of measurement and benchmarking
- Commissioners support providers to deliver high quality care
- Healthcare systems need to work collectively to work in partnership in order to monitor, share intelligence and to support improvement where potential or actual failures in the quality of care being provided to patients are identified
- Patients are actively listened to and proactively engaging with patients and the public to understand concerns

2 Patient safety
The last decade has seen a number of key publications that have informed and shaped the patient safety agenda. These include the recent Francis Report: The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013), www.midstaffspublicinquiry.com/report

This report builds on the Independent Inquiry, published in 2010 following the failings in Mid Staffordshire NHS Foundation Trust between 2005 and 2009. Patients were failed first and foremost by the Mid Staffordshire hospital but also at a national level by the regulatory and supervisory system which should have secured the quality and safety of patient care.

The second inquiry was commissioned to help understand how these failings were allowed to happen by the wider system. The final report makes 290 recommendations designed to change culture and make sure patients always come first. There are 5 themes outlined in the report:

1. Clearly understood fundamental standards and measures of compliance
2. Openness, transparency and candour throughout the system to be enforced
3. Improved support for compassionate caring and committed nursing
4. Strong and patient centred healthcare leadership.
5. Accurate, useful and relevant information


The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end. In response a number of patient safety collaboratives have been set up to improve safety.


As a response to the Francis Report a paper: How to ensure the right people, with the right skills, are in the right place at the right time : A guide to nursing, midwifery and core staffing capacity and capability was published in November 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf) This outlines the role of commissioners in relation to staffing to:

‘Actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract’. Commissioners must assure themselves that safe staffing is in place, monitor quality outcomes where staff capacity and capability pose a threat and use appropriate contractual levers to bring about improvements. The Nursing Strategy actively seeks to ensure system wide development of workforce.’
These landmark reports set out a commitment to improve the quality of services/care for patients through a number of mechanisms including actions for providers, commissioners and regulators. It provided learning for the system as a whole and has culminated in the recognition of the need for cultural change in the NHS.

Previous landmark publications, whilst having their place, failed to achieve long term change: ‘An Organisation with a Memory’ (2000), ‘Seven Steps to Patient Safety’ (2004), ‘Safety First’ (2006) and ‘High Quality Care for All’ (2008) and the House of Commons Health Committee: Patient Safety (2008/9). This latter important publication challenged health care organisations to commit to patient safety in a way not seen before in the health service before the Francis Inquiry.


The CCGs have undertaken a gap analysis against the 290 recommendations and as a result an action plan is in place to ensure we are fully compliant as commissioning organisations.

Patient safety includes:

2b Safeguarding children and vulnerable adults
“The role of NHS Commissioners” DoH 2013 outlines commissioners role in preventing and responding to neglect, harm and abuse to children and adults in the most vulnerable situations, including the commissioning of services for women and children who experience violence or abuse. Clinical Commissioning groups will prioritise the safety and welfare of children and vulnerable adults across all commissioned and contracted services.

The Children Act’s 1989 & 2004 outline statutory roles and responsibilities and duties relating to safeguarding and promoting the welfare of children for NHS organisations and partner agencies. These duties are summarised in ‘Working Together to Safeguard Children’ Department of Health (DH) 2013.

CCGs will:
• Take into account the views of children, young people and carers to influence the commissioning of services
• Comply with statutory requirements and national and local quality standards set by the Care Quality Commission and NHS Midlands and East
• Provide leadership for safeguarding across NHS and partner organisations
• Have sound monitoring and accountability arrangements for safeguarding across the organisation

Transforming Care: A national response to Winterbourne View Hospital (Dec 2012)

The Winterbourne Review sets out specific actions for the care of patients with learning disabilities and provides a salutary reminder of the failings in care for this group of vulnerable people. A county wide multi agency project group is leading this work to ensure that those patients identified as being ready to move from hospital accommodation are supported to do so.
Transforming care
Winterbourne View: Transforming care one year on, DoH (December 2013)

CCGs are:
• Reviewing placements and supporting everyone who is inappropriately in hospital to move to community based support. Locally agreed plans to ensure quality care and support services based on the model of good care.
• Working with local authorities have joint strategic plans to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.
• Maintaining registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care – held within specialist commissioning.
• Involved with on-going development of pooled budgets between health and social care

2c Care Homes
Nationally and locally, the quality of care delivered to residents has a high profile, with the financial viability of some organisations playing a significant role in poor care delivery.

This report pulls together the findings of more than 35,000 CQC inspections of the quality of health and social care services carried out in 2012/13.

Key findings
• Overall in 90 per cent of cases, people were treated with dignity and respect and were receiving care, treatment and support that met their needs and were safe. However in 10% of cases people received poor quality care. There has been no overall improvement in the NHS around treating people with dignity and respect.
• 1 in 5 inspections of nursing homes revealed safety concerns, including failure to give out medicines safely or not carrying out risk assessments when starting to care for someone, plus ongoing staffing pressures.
• There is a link between high staff turnover in residential homes and numbers of death notifications, which may suggest that increased turnover of staff results in gaps in care.
• More than 10 per cent of inspections of residential homes uncovered problems with either safeguarding and safety of residents, staffing issues, or issues with the care and support received by residents (e.g. people not being helped to eat and drink enough).
• More than 10 per cent of home care agencies did not meet CQC standards in staffing or monitoring quality.
• Over 9 per cent of people aged 75 years or older experienced at least one emergency admission to hospital for a potentially avoidable condition. In half of these cases there were failures which were found to have a major or moderate impact on people.
• Those patients with dementia have poorer outcomes in hospital compared with those without dementia.
• 1 in 10 inspections of NHS community healthcare services identified safety and staffing as an issue.
• 1 in 8 inspections of Mental health, learning disability and substance misuse services identified issues with staffing.

As a result commissioners, CQC and Local Authority have set up a Strategic Review of the Care Home Sector in Nottinghamshire. The aims of this group were to:
• To review the measures that are currently in place to identify and monitor risks to service users arising from poor quality provision
• To note the strengths of existing arrangements and identify any gaps with a view to making recommendations on how these measures can be improved
• To establish the details on current care home provision across Nottinghamshire County and Nottingham City, including identifying gaps in provision
• To identify the range and nature of support available to care homes by different agencies and the extent to which these are accessed by specific care homes
• To identify what, if any, additional measures commissioners and providers could consider taking to develop quality across the care home sector
• To consider emerging government and Care Quality Commission initiatives and make recommendations to enable early implementation

In addition CCGS will:
• Work closely with other agencies and stakeholders to improve the quality of care for older people.
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- Work proactively to prevent deterioration in quality
- Take an active part in shaping the future market in order to provide consistent high quality care homes for our citizens.

2d Infection Prevention and Control (IPC)
All healthcare organisations are expected to minimise the risk of healthcare acquired infection to patients by complying with the ‘Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance’. The code provides the core essential elements that a healthcare organisation must meet in order to be registered with the Care Quality Commission.

NHS England has set out a ‘zero tolerance’ approach which is explicitly targeting zero cases of MRSA blood stream infections. Everyone Counts: Planning for Patients 2013/14 endorses this. IPC is a crucial component of safe systems providing health and social care. Its importance is underlined within the Annual Report of the Chief medical officer (Davies 2013) and the UK five year Anti-microbial Resistance Strategy (2013).

Achievement of ongoing improvements in reducing health care associated infection requires provider and commissioner commitment. Since the abolition of Primary Care Trusts the expertise resource has been dispersed among a number of NHS Commissioning organisations and Local Authorities. This poses challenges and opportunities including; communication across organisations, retention of specialist resources, ability to react and cross organisational boundaries, potential lack of clarity around accountability and responsibility when dealing with incidents/performance.

This has been recognised in a recent publication from the IPS and RCN (2013): Infection prevention and control within health and social care: commissioning, performance and management and regulation arrangements (England). The CCGs will:
- Ensure we have a robust whole health economy IPC agenda in order to drive HCAI numbers down.
- Commissioners and providers will work together to share learning and ensure we have robust and effective communication between organisations.
- We will commission appropriate high quality services that are compliant with all guidelines and standards.

3 Patient experience
Patient Experience allows any organisation to understand what it does well and what it can do to improve. Triangulation of data from complaints, compliments, stories and patient satisfaction surveys help organisations understand how they can improve the services they deliver.


This report builds on the Francis Inquiry and reflects the key messages from Robert Francis QC ‘A health service that does not listen to complaints is unlikely to reflect its patients’ needs. One that does is more likely to detect the warning signs that something requires correction, to address such issues and to protect others from harmful treatment’.

The Patient Association is a charity established following the first Francis Inquiry in 2010. The association has been instrumental in driving forward change such as the Care Campaign. This joint campaign by Nursing Standard and the Patients Association aims to tackle poor care and the causes of poor care. The Health Foundation Speaking Up project was established in 2012 to pilot a new methodology for managing complaints.

NICE have published guidance Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (2012) resulting in 14 quality statements. These statements are used to assess the quality of all out patient experience stories.
4. Compassion in Practice

Nursing, Midwifery and care staff our vision and strategy (2012) and developed the 6 Cs: care, compassion, competence, communication, courage and commitment. [www.england.nhs.uk/nursingvision](http://www.england.nhs.uk/nursingvision) action area two of the nursing and midwifery vision sets out the ambition for improving patient experience

Both documents emphasise the importance of:
- Involving patients in shared decision-making about their treatment and care
- Empowering patients to be active participants and partners in their own care, enabling self-care
- Welcoming the involvement of family and demonstrating awareness and accommodation of their needs as care-givers
- Respecting patient centred values, preferences and expressed needs
- Coordinating care across the health and social care system
- Information, communication and education on clinical status, progress, prognosis and processes of care in order to facilitate autonomy, self-care and health promotion
- Delivery of essential care with compassion (recognizing the need for nutrition, hydration, physical comfort, including pain management, comfortable surroundings and help with activities of daily living)
- Managing expectations and providing emotional support and alleviation of fear and anxiety
- Ensuring continuity as regards information, especially over transition, to help patients care for themselves away from a clinical setting and coordination, planning and support to ease transitions
- Enabling access to care with attention, for example, to time spent waiting for admission and placement in a room in an inpatient setting or for discharge


5. Clinical Effectiveness

Clinical effectiveness is about delivering the best possible care for patients through timely and appropriate treatments but also ensuring the right outcome for patients – “right person, right place, right time”. Clinical effectiveness is made up of a range of quality improvement activities and initiatives including: evidence, guidelines and standards to identify and implement best practice, quality improvement tools, (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatments and services based on:
- the views of patients, service users and staff
- evidence from incidents, near-misses, clinical risks and risk analysis
- outcomes from treatments or services
- measurement of performance to assess whether the team/department/organisation is achieving the desired goals
- identifying areas of care that need further research
- information systems to assess current practice and provide evidence of improvement
- assessment of evidence as to whether services/treatments are cost effective
- development and use of systems and structures that promote learning and learning across the organisation

6. Governance for Quality

Although individuals and clinical teams are at the frontline and responsible for delivering quality care, it is the responsibility of the Governing Body (the board) to create a culture within the organisation that enables clinicians to work at their best, and to have in place arrangements for measuring and monitoring quality and for escalating issues. Clinical commissioning boards’ learn from mistakes and promote an environment where staff and patients are encouraged to identify areas for improvement.

We have developed our capability to proactively scan provider quality data and have redeployed staff to bring added rigour to this process. We combine business intelligence, survey results, patient feedback, complaints, incidents and PALS contacts to give us an overall picture of provider hotspots.

Key areas where quality is already driving commissioning include:
- Quality standards are built into service specifications and contract quality schedules
- Quality is an integral aspect of the current review of clinical referral thresholds for secondary care
- Commissioning for Quality and Innovation (CQUIN) scheme and contract quality schedules.
- These are closely aligned with our strategic initiatives and include innovate schemes to improve the safety and experience of patients
- We hold providers to account for quality through regular quality scrutiny panels.
- In line with NHS England Framework of Excellence in Clinical Commissioning for CCGs (draft Nov 13) we will strive for excellence by:
  - Ensuring we can demonstrate that CCGs learn from patients’ experience and complaints and act upon them.
  - We will assure that our provider organisations have effective systems for identifying and minimising risk to clinical quality, handling safety incidents and managing concerns over
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- professional performance.
- Every one in the CCG will understand their safeguarding responsibilities.

Assuring and Escalating Quality Issues
The Governing Body’s Assurance Framework provides a single process for managing local priorities, standards and Integrated Governance arrangements. Quality is scrutinised at a number of levels from Governing Body down to provider scrutiny panels. We actively encourage patient and lay people to take part in our quality reviews and quality visit programmes.

We seek multiple levels of assurance about our commissioned services. We have early warning systems/dashboards in place for our commissioned services and undertake a comprehensive programme of quality visits. We take patient stories and complaints to our Governing Bodies.

We work closely with our local partners such as the CQC, Local Authority and Healthwatch to share intelligence. We are active members of the NHS England Area Team Quality Surveillance Group where we share quality information.

7. Our Ambition
Our ambition is to commission excellent, safe and cost effective healthcare for Nottinghamshire. “Equity and excellence: Liberating the NHS” (DoH, 2010) sets out a vision for the NHS focused on improving quality and achieving world-class healthcare outcomes by ensuring that care providers:

- are genuinely centred on patients and carers ‘No decision about me without me’
- achieve quality outcomes that are among the best in the world
- refuse to tolerate unsafe and substandard care
- reduce mortality and morbidity

This strategy sets out how we will ensure quality is at the heart of commissioning.

What this means for Patients
- Patients will receive the right treatment, in the right place, at the right time
- Patients will be
- kept safe from avoidable harm
- treated as an individual (their needs and concerns addressed)
- treated with respect and dignity
- treated/cared for in a safe environment free from infection

What this means for Staff
Our Organisational Development Strategies sets how we will develop our staff.
- Staff will recognise their contribution to our quality and its improvement
- Staff will be supported to focus on the quality of the services we commission
- Staff will have the necessary training and development to improve, monitor and scrutinise quality
- When things have not gone well, we will focus on learning lessons and improving quality
- When things go well, information and learning will be shared so others can learn.
8. Quality Priorities

Patient safety aim: we will commission safe services for our local community. Patient safety will be our highest priority.

Patient experience aim: we will commission patient-centred services that meet expectations.

Clinical effectiveness aim: we will commission safe, effective and evidence-based care that delivers the best health outcomes across a range of conditions as set out in NHS Outcomes Framework and NICE Quality Standards.

Aligned to our commissioning intentions and values our priorities for 2014-2019 are:
1. Reduction of avoidable pressure ulcers
2. Reduction of falls and harm from falls
3. Improvement in patient experience and complaints management
4. Reduction of health care acquired infections (HCAI)
5. Safeguarding vulnerable adults and children
6. Improve quality of care home services
   In addition focussed quality initiatives will be driven through Commissioning for Quality and Innovation (CQUIN):
   7. Reduction in harm through CQUIN development
      • Transfers of care
      • Falls
      • Medicines Management
      • Emergency Surgery
      • Sepsis
      • The deteriorating patient
      • Theatre safety culture (reduction of never events)
      • Reduction of pressure ulcers
      • Harm associated with in dwelling urinary catheters

We are developing five year CQUINs across all provider organisations and agencies which allows for longer term investment and collaborative working. The aim is to develop simple CQUIN that then build year-on-year. The result of agencies and organisations working together is that we see a bigger improvement than we would when working in silos.

This strategy will build on the work to date in order to develop key objectives from the system level aims that will improve quality. A Quality improvement Plan will be developed. We have developed three system level aims based on the three domains of quality:

Primary Care Quality
The Quality Strategy will complement the Primary Care Strategy. The Area Team has responsibility for Primary Care and quality monitoring. Key areas of work identified are:
* Falls
* Pressure Ulcers
* CQC compliance
* HCAI reduction
## Implementation Framework

If we are to realise our ambition to commission excellent, safe and cost effective healthcare for Nottinghamshire the CCG needs to create an infrastructure to support this. We have identified 4 key areas:

- Leadership
- Measurement for Improvement
- Culture for quality improvement
- Capacity and capability (OD plan)

### Aim

**To provide an infrastructure to support the commissioning of excellent, safe and cost effective healthcare for Nottinghamshire.**

### Driver

**Leadership**

**Measurement for improvement**

**Culture**

**Capacity and capability**

### Actions

**Governing Body development**

- Quality reports are developed, received and scrutinised by the Governing Bodies and sub committees.
- Quality metrics developed which support our strategy.
- Quality and Safeguarding Forum has been set up to share learning from incidents, complaints, safeguarding and this learning is disseminated across the organisations.

**Development of quality metrics and regular reporting.**

- GB members understand their duties and use data intelligently.

**MaPSaF cultural survey undertaken with Governing Bodies**

- Development of a primary care strategy.

- Risk management systems have been supported by an organisational risk management framework, a programme of proactive risk assessments and the compilation of an organisation-wide risk register. The Governing Bodies have received development sessions to assist them to develop the Board Assurance Framework.

- The LISQ programme supports staff to understand why reporting is necessary. As such staff are encouraged to report incidents not just internally but to the National Reporting and Learning System (NRLS).

**LISQ programme and 2 accelerated learning events commissioned and delivered from the NHS Institute for Innovation and Improvement (ongoing development with NHS IQ).**

- Organisational Development plan developed.

- The quality team has been reviewed and a number of additional posts have been approved and recruited to in order to support the quality strategy.
Leadership
The importance of quality improvement for our strategic and day-to-day objectives has to be communicated to all our staff, who must be successfully engaged. The Governing Body will oversee implementation of the Quality Strategy, promote an improvement culture, support effective local leadership, and ensure an appropriate infrastructure.

Our clinical leaders will need to develop and implement a plan which is both challenging and realistic, and which recognises and articulates that improving quality is a mechanism for improving safety and patient experience.

Providing inspirational leadership is essential for the development of a mature safety culture. Our leaders will be developed to engage meaningfully with our member practices and our providers in order to promote quality.

Measurement for Improvement
‘High Quality Care for All’ envisaged that healthcare organisations would develop systems to define and measure quality, and deliver it in all their services, at all levels. We will continue to develop innovative and established process and outcome measures for use and reporting quality at the Governing Body.

Culture
Assessing the organisation’s baseline safety survey is essential to identify gaps and develop an action plan to improve. A mature safety culture will promote reporting and learning. The Manchester Framework (MaPSaF) was used to identify the maturity of our safety culture. This is depicted below:

Levels of maturity with respect to a safety culture
Manchester Patient Safety Framework (MaPSaF)
National Primary Care R&D Centre
University of Manchester
www.npsa.nhs.uk

Each CCG undertook a table top exercise to review the culture from the perspective of the Governing Body. The individual results were discussed and collated. These can be seen below.

Nottingham North and East CCG

<table>
<thead>
<tr>
<th>Dimension of patient safety culture</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall commitment to quality</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority given to patient safety</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceptions of the causes of patient safety incidents and their identification</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigating patient safety incidents</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational learning following a patient safety incident</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about safety issues</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel management and safety issues</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff education and training about patient safety issues</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team working around safety issues</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Where we are now?
What the surveys demonstrated was patient safety has a fairly high priority and there are numerous systems (including those integrating the patient perspective) in place to protect it. However, these systems are not widely disseminated to staff or reviewed. They also tend to lack the flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Safety is regarded as an issue for some staff, but not all.

Where we want to be:
Patient safety is integral to the work of the organisation and its staff and is embedded in all activities. Responsibility for safety is seen as being part of everyone’s role and this is reflected in individuals’ contracts. Staff are constantly assessing risks and looking for potential improvements. Patient safety is a high profile issue throughout all levels of the practice, and is a top agenda item at meetings. Patient involvement in, and review of, patient safety issues is well-established.

Capacity and capability
Staff and leaders need to understand their role in promoting quality. Education and training is key to support the development of staff and is reflected in the Organisational Development plan.

Staff engagement
In addition to the key areas outlined above it is essential that staff are fully engaged. Therefore an engagement plan will be developed to ensure successful implementation of the quality strategy.

10. Performance Management of the Quality Strategy
The Governing Body will use the extant committee infrastructure to provide assurance that this Quality Strategy is being implemented and monitored. An annual report will be presented to the Governing Body.

Performance Management of the Quality Strategy
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Appendix 1

Healthcare Associated Infection Prevention & Control (HCAI)

Strategic Aim: no avoidable HCAI

Strategic intent:

- **Professional leadership** will be evident and aims for no avoidable HCAIs
- The **culture** of organisations will enable professionals to identify poor practice which contributes to the risks of HCAI acquisition and takes appropriate action to avoid them
- The **capacity and capability** of professional workforce will enable the aim of no avoidable HCAI to be met
- HCAI rates will be monitored for improvement

### Aim: no avoidable HCAI

#### Measuring for improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI Data Capture System (DCS)</td>
<td>Review mandatory surveillance data MRSAb, C.difficile, MSSAb, E-Coli bacteraemia</td>
<td>CCG Quality team</td>
<td>Monthly</td>
</tr>
<tr>
<td>Care home dashboard</td>
<td>Development of care homes’ dashboard with IPC contribution</td>
<td>CCG Quality team IPC team</td>
<td></td>
</tr>
<tr>
<td>Quality visits/ audit</td>
<td>Strengthen IPC element of the quality visit agenda. Monitoring of standards driving improvements</td>
<td>Provider organisations CCG Quality team IPC team Area Team</td>
<td></td>
</tr>
<tr>
<td>Quality schedules and contracts</td>
<td>Contracts, service specifications and quality schedules include relevant HCAI elements and support the aim of achieving no avoidable HCAIs.</td>
<td>CCG Quality and Contract Monitoring team</td>
<td></td>
</tr>
<tr>
<td>Safety Thermometer</td>
<td>Monitor reporting to 100% submission of safety thermometer data. Review the HCAI related elements of Safety Thermometer data</td>
<td>Provider organisations CCG Quality team</td>
<td></td>
</tr>
</tbody>
</table>

### Capacity and capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and education</td>
<td>Staff have access to and closely adhere to up to date evidence based policies, procedures and guidance</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence that a reduction in capacity may affects the organisation’s ability to meet the aim of no avoidable HCAI will be reported and actioned</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>Patient, relative and carer experiences will be captured to include environmental conditions, including bidness and cleanliness, hand hygiene and the availability of required equipment and resources</td>
<td>Provider organisations CCG quality team</td>
<td></td>
</tr>
<tr>
<td>Root cause analysis / post infection review</td>
<td>Investigations of HCAI related serious incidents will demonstrate a culture of no blame, learning and appropriate action for the organisations involved</td>
<td>Provider organisations CCG Quality team</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2

#### Safeguarding Children and Vulnerable Adults

**Strategic Aim:** Promote best practice to safeguard children and vulnerable adults across all areas of service provision and to comply with LSCB and LSAB procedures

**Strategic Intent:**
- Safeguarding arrangements and serious incidents will be monitored for improvement
- Professional Leadership will be evident which demonstrates clear lines of accountability around safeguarding from “Board to Floor”
- The Culture of organisations will enable professionals to recognise and respond to safeguarding concerns learn lessons from local and national serious incident reviews.
- The Capacity and Capability of professional workforce will enable safeguarding skills and competencies to be developed and maintained.

#### Aim: Safeguard children and vulnerable adults measuring for improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSCB S11 audit and NSAB self-assessment tools</td>
<td>Completion of NSCB &amp; NSAB self-assessment tools Annual review of compliance against standards</td>
<td>Provider organisations CCG quality team</td>
<td>Annually with review of outstanding issues as required.</td>
</tr>
<tr>
<td>CQC Safeguarding and Children in Care Inspection Framework</td>
<td>Contribute to CQC safeguarding review and implement any recommended actions.</td>
<td>Provider Organisations CCG Quality team</td>
<td>Unannounced inspection</td>
</tr>
<tr>
<td>Serious Incident reporting</td>
<td>Serious incident reporting for any incidents of failure to comply with NSCB, NSAB or internal safeguarding policies and procedures</td>
<td>Provider organisations Care homes</td>
<td></td>
</tr>
<tr>
<td>Quality schedules and contracts</td>
<td>Contracts and quality schedules will identify minimum organisational policy requirements: • Safeguarding Policy compliant with LSCB and LSAB procedures • Dealing with allegations against staff • Whistleblowing Policy</td>
<td>CCG quality and contract monitoring team</td>
<td></td>
</tr>
<tr>
<td>Monitoring quality of safeguarding responses</td>
<td>The organisation will monitor the quality of safeguarding referrals made by staff and use information to inform organisational development.</td>
<td>Provider organisations Care homes</td>
<td></td>
</tr>
</tbody>
</table>
### Capacity and capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and education</td>
<td>Staff induction programme includes reference to roles and responsibilities and relevant policies and procedures relating to safeguarding children and vulnerable adults.</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff will have undertaken training and development at a level appropriate to their role in compliance with intercollegiate guidance to ensure they are competent to recognise and respond to safeguarding concerns.</td>
<td>Provider Organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relevant staff will receive additional training in relation to: -</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mental Capacity Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PREVENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• MAPPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff supervision</td>
<td>Staff will receive regular protected supervision which facilitates reflective learning and professional development in relation to safeguarding.</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence of reduction in capacity which affects ability to respond to required standards will be addressed and reported as appropriate.</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Specialist advice</td>
<td>Safeguarding lead professionals will be identified who have additional training and competencies in safeguarding children and vulnerable adults, who are able to provide specialist advice on request to staff.</td>
<td>Provider organisations CCGs quality teams</td>
<td></td>
</tr>
</tbody>
</table>

### Culture

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient experience</td>
<td>The views and experiences of children and vulnerable adults will be captured and used to inform and develop service provision and quality of care.</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Culture of learning and improvement</td>
<td>The organisation will promote a culture where staff are able to report concerns. Incidents will be reported and investigated demonstrating a culture of no blame, learning and appropriate action for the organisation.</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Root cause analysis/ serious incident review</td>
<td>The organisation will co-operate with LSCB and LSAB serious case review and child death review processes, and when requested produce individual organisational management reviews and associated action plans. The organisation will co-operate with local Strategic Safety Partnerships and on request undertake individual management reviews in response to a domestic homicide review.</td>
<td>Provider organisations Care homes</td>
<td></td>
</tr>
<tr>
<td>Think family</td>
<td>The organisation will demonstrate a ‘think family’ approach to service provision, encouraging integration of adult and children’s services where appropriate to provide early support and intervention for vulnerable families.</td>
<td>Provider organisations</td>
<td></td>
</tr>
</tbody>
</table>

### Leadership

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<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional leadership</td>
<td>Key Leaders identified with responsibility for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Safeguarding children</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Safeguarding adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dealing with allegations against staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PREVENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• MAPPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based care</td>
<td>Current evidence base for recognising and responding to safeguarding children and vulnerable adults will be incorporated into care protocols and policies</td>
<td>Provider organisations</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Care homes

Strategic aim: To ensure high quality of care delivery in care homes

Strategic intent:
• Care Homes will be monitored for improvement
• Professional Leadership will be evident which supports improvement and promotes partnership working.
• The Culture of organisations will enable professionals to identify poor quality care and take appropriate action to quality monitor services.
• The Capacity and Capability of professional workforce will enable the aim of ensuring quality of care delivery in care homes.

### Aim: to ensure quality of care delivery in care homes

<table>
<thead>
<tr>
<th>Measuring for improvement</th>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality audit</td>
<td>Participation in joint annual audit program with local authority</td>
<td>CCG quality team in partnership with Local Authority</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality monitoring in reaction to safeguarding and reported quality concerns</td>
<td>CCG quality team</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of a suite of tools to review quality on a variety of levels including adapted ‘15 steps’ and ‘Indicators of Concern’</td>
<td>CCG quality team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care homes dashboard</td>
<td>Development of Care Homes dashboard</td>
<td>CCG quality team</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submission of data for Care Homes dashboard</td>
<td>Care homes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of care homes database</td>
<td>CCG quality team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHC Quality schedule and contract</td>
<td>Care home quality schedule and monitoring processes will be agreed and implemented across the County</td>
<td>GEM CCG quality team</td>
<td></td>
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</tr>
</tbody>
</table>

### Capacity and capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability</td>
<td>Staff have evidence based policies and guidance to adhere to</td>
<td>Care homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care Homes demonstrate that they have a registered manager and suitable management structures in place to support good care delivery</td>
<td>Care home providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contracts, service specifications and quality schedules include relevant HCAI elements and support the aim of achieving no avoidable HCAIs</td>
<td>CCG quality and contract Monitoring team</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence of reduction in capacity which affects ability to meet aim will be addressed</td>
<td>Care homes</td>
<td></td>
</tr>
</tbody>
</table>

### Culture

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>The lived experience of residents within care homes will be captured as part of the audit process</td>
<td>CCG Quality team in partnership with LA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care Homes demonstrate that they have a registered manager and suitable management structures in place to support good care delivery</td>
<td>Care home providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contracts, service specifications and quality schedules include relevant HCAI elements and support the aim of achieving no avoidable HCAIs</td>
<td>CCG Quality and Contract Monitoring team</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence of reduction in capacity which affects ability to meet aim will be addressed</td>
<td>Care homes</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Patient Experience

Strategic Aim: We will commission patient centred services that meet patient expectations.

Strategic Intent:
- Patient Experience will be monitored to aid service improvement
- Professional Leadership will be evident, which aims for Patient Experience to be incorporated into all new service pathways and re-design
- By engagement with all stakeholders, the Culture of Patient Experience will be embedded into all aspects of CCG business.
- The Capacity and Capability of the workforce will enable patients to become active partners in all areas of their NHS care

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information gathering</td>
<td>Participation in joint annual audit program with local authority</td>
<td>Patient Experience Team &amp; CCG Engagement Leads</td>
<td>Annual</td>
</tr>
<tr>
<td>Membership</td>
<td>CCG membership database to be improved to ensure most effective engagement is achieved.</td>
<td>Patient Experience Team &amp; CCG Engagement Leads</td>
<td></td>
</tr>
<tr>
<td>Reporting</td>
<td>Service Improvement log to be implemented to monitor lessons learnt from Patient Experience to assure outcomes are actioned.</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
<tr>
<td>Publicaiton and communication</td>
<td>Publish openly and transparently complaints data, via the website and Governing Bodies, etc.</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
</tbody>
</table>
### Capacity and capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity</td>
<td>Build, maintain and sustain relationships with the 3 South Nottinghamshire CCGs</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All staff will be aware that they have a duty to seek patient experience, improve where appropriate and record the outcome.</td>
<td>All South Nottinghamshire CCG staff</td>
<td></td>
</tr>
<tr>
<td>Capability</td>
<td>Educate workforce to recruit to the membership database to ensure the widest possible capture of the</td>
<td>All workforce</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any evidence of reduction in capacity which affects ability to meet patient expectations will be addressed</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
</tbody>
</table>

### Culture

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Effective engagement to support and involve GP practices in the capture of patient experience.</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
<tr>
<td>Learning from patient experience</td>
<td>Utilisation of intelligence from Patient Experience contacts and the membership database to be drawn upon when reviewing pathways and service re-design.</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Publication of lessons learnt to promote an open and transparent culture.</td>
<td>Quality and Patient Safety Team</td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td>Website re-design to build the patient experience profile and embed patient experience in everything the CCGs do</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
</tbody>
</table>

### Leadership

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional leadership</td>
<td>Key Leaders to be identified with responsibility for ensuring Patient Experience initiatives are embedded.</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
</tbody>
</table>

### Appendix 5

#### Falls

**Strategic Aim:** we will reduce the number of falls and harm from falls across our community.

**Strategic Intent:**
- Falls will be monitored and lessons learned shared to aid service improvement
- Professional Leadership will be evident, which aims for the prevention and management of falls
- By engagement with all stakeholders, a Culture of no avoidable harm will be embedded into all aspects of CCG business.
- The Capacity and Capability of the workforce will enable falls to be reduced

**Aim: No avoidable falls with harm**

#### Measuring for improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety thermometer</td>
<td>100% submission of safety thermometer data</td>
<td>Provider organisations, CCG Quality team</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Review of safety thermometer data</td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td>Care homes dashboard</td>
<td>Development of Care Homes dashboard which monitors falls with harm</td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submission of data for Care Homes dashboard</td>
<td>Care Homes</td>
<td></td>
</tr>
<tr>
<td>Provider dashboards</td>
<td>Monitoring of provider dashboard</td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td>Serious incident reporting</td>
<td>Serious incident reporting for falls with harm</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Quality schedules and contracts</td>
<td>Contracts and quality schedules will identify aim of no avoidable falls with harm</td>
<td>CCG Quality and Contract Monitoring Team</td>
<td></td>
</tr>
</tbody>
</table>

#### Capacity and capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training and education</td>
<td>Staff have evidence based policies and procedures to adhere to</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff will have undertaken training and development to ensure they are competent to deliver the aim</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence of reduction in capacity which affects ability to meet our aim will be addressed</td>
<td>Patient Experience Team</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6

Pressure Ulcers

Strategic Aim: No Avoidable Pressure Ulcers

Strategic Intent:
- Pressure Ulceration will be monitored for improvement
- Professional Leadership will be evident which aims for no avoidable pressure ulcers
- The Culture of organisations will enable professionals to identify causes of avoidable pressure ulcers and take appropriate action to avoid them
- The Capacity and Capability of professional workforce will enable the aim of no avoidable pressure ulcers to be met

<table>
<thead>
<tr>
<th>Aim: No avoidable falls with harm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measuring for improvement</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety thermometer</td>
<td>100% submission of safety thermometer data</td>
<td>Provider organisations, CCG Quality team</td>
<td>Annual</td>
</tr>
<tr>
<td>Review of safety thermometer data</td>
<td></td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td>Care homes dashboard</td>
<td>Development of Care Homes dashboard which monitors falls with harm</td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td>Submission of data for Care Homes dashboard</td>
<td></td>
<td>Care Homes</td>
<td></td>
</tr>
<tr>
<td>Provider dashboards</td>
<td>Monitoring of provider dashboard</td>
<td>CCG Quality team</td>
<td></td>
</tr>
<tr>
<td>Serious incident reporting</td>
<td>Serious incident reporting for falls with harm</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td>Quality schedules and contracts</td>
<td>Contracts and quality schedules will identify aim of no avoidable falls with harm</td>
<td>CCG Quality and Contract Monitoring Team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Leadership</td>
<td>Key Leaders identified with responsibility for reducing avoidable falls with harm</td>
<td>Provider organisations, including Care Homes</td>
<td></td>
</tr>
<tr>
<td>Strategic Leadership of falls agenda established in Nottinghamshire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based Care</td>
<td>Current evidence base for avoiding falls with harm will be implemented into care protocols and policies</td>
<td>Provider organisations, including Care Homes</td>
<td></td>
</tr>
</tbody>
</table>
**Capacity and capability**

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
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</thead>
<tbody>
<tr>
<td>Training and education</td>
<td>Staff have evidence based policies and guidance to adhere to</td>
<td>Provider organisations</td>
<td>Annual</td>
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<tr>
<td></td>
<td>Staff will have undertaken training and development to ensure they are</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>competent to deliver aim of no avoidable pressure ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Any evidence of reduction in capacity which affects ability to meet</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>aim of no avoidable pressure ulcers will be addressed</td>
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**Culture**

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<tr>
<th>Area</th>
<th>Action</th>
<th>By whom</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>Root Cause Analysis</td>
<td>Analysis for Serious Incidents of pressure damage will demonstrate a</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>culture of no blame, learning and appropriate action for the organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Strategic aims and actions required to achieve no avoidable pressure</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ulcers to be shared and embedded in organisations and professionals</td>
<td>including Care Homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategic aims of no avoidable pressure ulcers to be shared with</td>
<td>Provider organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patients and carers</td>
<td>including Care Homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategic aims of no avoidable pressure ulcers to be shared with</td>
<td>CCG Quality team</td>
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<td></td>
<td>external agencies and primary care</td>
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</tbody>
</table>

**Appendix 7**

**Strategic Commissioning**

**Specific Implications for Health and Social Care Sectors 14/15**

The following sections describe CCG outline commissioning intentions for different sectors of the health economy.

**3.1 Acute Hospital Services**

**3.1.3 Reduce Unnecessary Referrals**

For both planned and unplanned pathways of care, we will improve access to ambulatory care, advice and guidance and consultant triage to ensure that only patients who need secondary care intervention will receive it. Primary and community clinicians will continue to monitor referrals to secondary care and take steps to reduce them where clinically appropriate. It is anticipated that this will reduce the level of investment growth in the acute sector in comparison to previous years.

**3.1.4 Improved Discharge Planning and Communication**

CCGs will seek to improve the quality, content and timeliness of discharge and clinical letters, specifically Accident & Emergency discharge communication and co-ordination with Out of Hours (OOH) services. It is our intention to work towards the patients spell Healthcare Resource Group being included on the discharge/clinical letter.

**3.1.5 Commissioning For Outcomes**

As outlined in the commissioning principles outlined above, we will focus contracting on commissioning improved outcomes for frail older people patients.

**3.1.6 Reduced Hospital Stays**

CCGs will continue to develop services in conjunction with Local Authorities that reduce delayed discharges and which actively promote early discharge through community based rehabilitation. The length of stay for people admitted to hospital for medical treatment but who also have mental illness or learning difficulties will be brought in line with other people admitted for medical conditions. In order to support these schemes, we will continue to explore opportunities to reduce readmissions and to split/unbundle national tariffs.

**3.1.7 Financial Viability through Change**

As the Health Community works to reduce the overall size of the acute hospital sector, we will continue to maintain the financial viability of the local acute trusts by jointly developing and agreeing sustainable strategic models of service. This will include:

- Sensitively and intelligently supporting large scale and nationally prescribed strategic pathway initiatives in services such as stroke, pathology, vascular and major trauma.
- QIPP plans that as best as possible align the delivery of QIPP and the Trusts Cost Improvement Programme (CIP).
- Supporting non-recurrent funding proposals required to pump prime delivery of the agreed QIPP/CIP programme
3.2 Community Services

3.2.3 Improving data, information and outcome measures
CCGs will work with community service providers to develop appropriate performance metrics and outcome measures to ensure the effort in community services to deliver QIPP gains can be identified and incentivised.

3.2.4 Reducing Avoidable Hospital Admissions
There will be growth in community services to enable them to play a vital role in reducing secondary care utilization, in particular avoidable admissions into hospital. Services will be redesigned and new services developed alongside a review of funding flows to ensure appropriate investment. Access issues will be reviewed in order to ensure the most appropriate flexible service response is available including rapid response times and extended or out of hours service availability.

3.2.5 Developing new community service models
CCGs will work with community providers to explore different ways of working with a QIPP focus supporting early identification and intervention. In particular CCGs want to develop and embed the use of predictive modelling and assistive technology into services for older people and people with long-term conditions. CCGs will also improve access to and capacity of services for people at the end of their lives.

3.2.6 It will be a priority to improve access and co-ordination of services, in particular reducing fragmentation and duplication in service delivery for both adults and children with complex needs. Personal health budgets will be introduced to support individual tailored service responses for adults or children with complex and continuing care needs. CCGs will look to split/unbundle national tariffs to develop community based rehabilitation across the spectrum of Long-term and musculoskeletal conditions.

3.2.7 Joint Commissioning
It will also be important during 2014/15 to continue to ensure that services do not become fragmented as a result of the move of commissioning responsibility to either the Local Authority or NHS England. Therefore whilst needing to develop a better interface between different community providers, including social care, we will also do the same across commissioners to maximise joint commissioning opportunities, reduce fragmentation and improve quality and efficiency across specific pathways.

3.3 Mental Health Services

3.3.3 Dementia
Commissioners will continue to work with providers to support the early diagnosis of dementia, enabling primary and secondary health and care services to anticipate needs, and for people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

3.3.4 High quality service provision in Secondary Care
Reviewing community based services to ensure they adhere to local and national guidelines. Optimising service delivery in primary care and intervening early to manage and reduce the requirement for in-patient admissions.

3.3.5 Delayed Transfers of Care (DTOC)
Focus on reducing DTOC by working with our providers and partners across the Health and Social Care system to facilitate safe discharge from hospital. Leading to a reduction in unnecessary lengths of stay and improving patient outcomes.

3.3.6 Out of Area Treatments
Following on from previous year’s progress commissioners will continue to target a reduction in the number of patients sent out of area for specialist individual placements; by working closely with Health and Social Care colleagues to develop local facilities and services to enable step down and by ensuring the pathway into specialist placements is tightly managed.

3.3.7 Inpatient Rehabilitation
The recommendations from the Mental Health Utilisation Review will be implemented helping to redesign the local pathway and enabling timely discharge from hospital and a focus on recovery.

3.3.8 Learning Disabilities, Secondary Care
Following the interim Department of Health report which was a consequence of the investigation into Winterbourne View, during 2014/15 we will continue to review the Learning Disability Assessment and Treatment Units and Community Assessment and Treatment Teams and independent sector providers of individual placements. Our review will consider increasing assessment and treatment in the community and avoiding hospital provision.

3.3.9 Physical Health
In-line with the Mental Health Strategy (2011) we will continue to work with providers to implement processes that improve the physical health of patients accessing mental health services.

3.3.10 Primary Care psychological Therapies
Any Qualified Provider for Primary Care Psychological Therapies was implemented during 2012 and during the 2013/14 the AQP will be re-opened to any other providers. The introduction of new providers into the market will be managed to ensure specified outcomes are achieved. Work will be undertaken with primary care colleagues to promote patient choice within this service to ensure users are given the opportunity to select a provider that best suits their individual needs.

3.4 Ambulance Services

3.4.3 Response Times
We will continue to monitor and improve response times to requests for ambulance services, working with the local Ambulance Trust to improve services and to reduce the number of avoidable or inappropriate urgent requests from members of the public and local clinicians.

Supporting Care in a Community Setting
We will continue to work with service providers to develop patient pathways and procedures that avoid preventable journeys to hospital. This will include better integration with community based services, strengthening input into health community change programmes (such as the frail elderly programme) and a focus on improved end of life management.
Appendix 8

Quality team Structure

- Director of Nursing and Quality
  - Assistant Director of Nursing and Quality
    - Head of Quality and Patient Safety
      - Patient Experience Manager
      - Quality Assurance Officer
      - Adult Safeguarding Lead and Quality Monitoring Officer
      - Patient Experience Officer
      - Admin
      - Quality Monitoring Facilitator
Need information and advice?

The Patient Advice and Liaison Service (PALS) provides information and advice on local NHS services for patients, their families and carers.

Call: 0800 028 3693
email: pals.south@nottinghamnortheastccg.nhs.uk

Jargon buster

Clinical Commissioning Groups (CCGs): responsible for buying healthcare services for patients in a specific location. There are seven CCGs covering Nottinghamshire. This quality strategy covers the intentions of the South CCGs - Rushcliffe, Nottingham West and Nottingham North and East.

NICE: the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Care Quality Commission (CQC): the CQC check whether hospitals, care homes, GPs, dentists and other healthcare services are meeting national standards. They do this by carrying out inspections, publishing their findings and helping services improve.


Mid Staffordshire NHS Foundation Trust Public Inquiry Report: published the findings of the inquiry into Mid Staffordshire Foundation Trust after their poor standards of care had been exposed.

For more information about the strategies
www.nottinghamnortheastccg.nhs.uk/information-centre
www.nottinghamwestccg.nhs.uk
http://www.rushcliffeccg.nhs.uk/about-us-business-policies

Contact the South CCGs’ quality team on: 0115 883 1838 email: info@nottinghamnortheastccg.nhs.uk

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