Quality Handover
SHIP PCT Cluster
2012/13
Today’s presentation

- Background to Quality Handover Document
- Principles for quality handover
- Recipients of quality information
- Governance arrangements
- Phasing of work programme
- Risks and opportunities
- Issues which have emerged to date
- Quality profiles
- Examples of local work to improve quality
- Communications plan
- How can we work together?
Background to Quality Handover Document

History of failures during previous reorganisations in health and social care, incl. Mid Staffs

Need to draw on learning captured in publications:

- Review of Early Warning Systems 2010
- Maintaining and improving quality during transition 2011
- National Quality Board – How to Guide Maintaining Quality during the Transition – Preparing for Handover 2012
Principles for quality handover

- Clear framework providing national consistency
- Balance of formally documenting information with face-to-face handover
- Responsibilities for both senders and receivers
- Need for triangulation of information incl. patient experience
- Quality handover needs to include all commissioned services
- Board assurance for sign off of Quality Handover required for sending and receiving organisations
Recipients of quality information

- CCGs
- NHS Commissioning Board incl. Specialised Commissioning and Primary Care Commissioning
- Public Health
- Commissioning Support South
- CQC
- Local Authorities
- LINks
- Health Overview and Scrutiny Committees
- Providers
### Phasing of work programme

- Project team set up
- Transition and Legacy Clinical Quality Work Stream Group set up
- Leads identified
- Plan submitted to SHA in June

|----------------|---------------|-----------------|
| -Gather hard and soft intelligence  
-Regularly discuss emerging issues  
-Clinical Governance Committee  
-Board of Clinical Commissioners  
-SHIP Cluster Board  
-Quality Handover V1  
-Wider engagement and triangulation  
-Discussion with providers | -Maintain live document, mainstreaming alongside wider monitoring processes  
-Initial round of face-to-face meetings with receiving organisations  
-Continued review of emerging issues and problem solving  
-V2 of Quality Handover to SHA  
-National Quality Board Assurance process within the 4 regions | -Maintain live document  
-Round 2 of face-to-face meetings  
-Continued review of emerging issues and problem solving  
-Quality Handover document taken to public Board meetings of sending and receiving organisations |
## Risk and opportunities

<table>
<thead>
<tr>
<th>Risks (actions defined in register)</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process could get in the way of addressing real issues</td>
<td>• Analysis of trends and triangulating information may identify previously hidden quality issues</td>
</tr>
<tr>
<td>• Very high volume of data leading to loss of focus</td>
<td>• Future proofing reporting based on Quality Handover format</td>
</tr>
<tr>
<td>• Capacity/potential loss of key staff</td>
<td>• Accelerating organisational development in CCGs</td>
</tr>
<tr>
<td>• Lack of engagement of receiving organisations</td>
<td>• Long lead time to handover enables receivers to build knowledge over time</td>
</tr>
</tbody>
</table>
Issues which have emerged to date

- Accountabilities between CCG and CSS
- Lack of national guidance re lead commissioning arrangements
- Risks associated with newly commissioned services – NHS 111, Home Oxygen
- Specialist Commissioning including gaining assurance on London contracts and clarifying risks associated with new ‘Minimum Take’ Handover across a care pathway with multiple commissioners, i.e. children’s services
- Live reviews, i.e. vascular, diabetes
Quality profiles

**Profile contents:**
*Quality Dashboards:*
- Key Quality Indicators
- Infection Control
- Serious Incidents Requiring Investigation

**Quality Profile by Domains of Care**
*(as per 2012/13 NHS Outcomes Framework):*
1. Preventing people from dying prematurely (Effectiveness of Care)
2. Enhancing quality of life for people with long term conditions (Effectiveness of Care)
3. Helping people to recover from episodes of ill-health or following injury (Effectiveness of Care)
4. Ensuring that people have a positive experience of care (Patient Experience)
5. Treating and Caring for people in a safe environment and protecting them from avoidable harm (Patient Safety)
### 1.1 HOSPITAL MORTALITY:

<table>
<thead>
<tr>
<th>Year:</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11:</td>
<td>SHMI 119 now 112</td>
<td>IoW SHMI &amp; HMSR results for 10/11 were the subject of a contract query</td>
</tr>
<tr>
<td></td>
<td>HSMR 124 now 107</td>
<td>in January 2012 - The Trust continues to address mortality through</td>
</tr>
<tr>
<td></td>
<td></td>
<td>detailed actions plans at directorate level which focus on clinical care and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>coding/record keeping. Plans are being monitored through acute SLA,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CQRM and CCG Performance Board. CQC also required the Trust to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>undertake additional audit activity and as a result are satisfied that the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trust is taking all necessary measures.</td>
</tr>
</tbody>
</table>

### 1.2 CLINICAL AUDIT:

<table>
<thead>
<tr>
<th>Year:</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12:</td>
<td>39 national clinical audits and 1 national confidential enquiry</td>
<td>The reports of 7 national clinical audits were reviewed by the provider in</td>
</tr>
<tr>
<td></td>
<td>covered NHS services that NHS Isle of Wight provides. During that period NHS Isle of Wight</td>
<td>2011/12 and the Isle of Wight NHS Trust intends to take the following</td>
</tr>
<tr>
<td></td>
<td>participated in 77% national</td>
<td>actions, amongst others, to improve the quality of healthcare provided:</td>
</tr>
<tr>
<td></td>
<td>clinical audits and 100% national confidential enquiries of the</td>
<td>· Implement a Policy for ‘Safe Provision of Paediatric Surgery and</td>
</tr>
<tr>
<td></td>
<td>national clinical audits and national confidential enquiries which it</td>
<td>Anaesthesia’ in line with NCEPOD recommendations.</td>
</tr>
<tr>
<td></td>
<td>was eligible to participate in.</td>
<td>· Hand held records have been implemented for patients which ensure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>that they have had the correct blood monitoring before lithium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>prescriptions are re-issued.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>· Work is ongoing to support the prescribing of antipsychotic drugs in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>children with ADHD by paediatricians; work is currently ongoing on a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>shared care protocol with GPs.</td>
</tr>
</tbody>
</table>
Examples of local work to improve quality
Isle of Wight NHS Trust

### 2.1 DEMENTIA CARE:

<table>
<thead>
<tr>
<th>Year: 2012/13</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National dementia CQUIN</td>
<td>The Trust has invested time and additional resource to achieve this CQUIN to ensure maximum outcome for patients. The Trust is well placed, as an integrated Trust with Mental Health services, to ensure that patients identified at risk of dementia are referred and screened quickly by the specialist memory service. The Trust is currently achieving over the 90% target set. It has also been successful in securing additional funding to redesign ward environments for dementia patients.</td>
</tr>
</tbody>
</table>

### 3.3 A&E DATA:

<table>
<thead>
<tr>
<th>Year: April – date 2012</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Trust has consistently failed the accident and emergency waiting times national standard (of at least 95% of patients spend 4 hours or less in A&amp;E) since April 2012.</td>
<td>Higher levels of activity at the front door, capacity issues and patient flow preventing admission of patients onto wards. • Unscheduled Care Group set up jointly with commissioners. • Winter action plan in place. • Daily review of performance in place. • National review on patient flow through hospital undertaken – awaiting report of findings</td>
</tr>
</tbody>
</table>
Examples of local work to improve quality
Isle of Wight NHS Trust

### 4.7 PEAT

<table>
<thead>
<tr>
<th>Year</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
</table>
| 2011 | Environment = Excellent  
Food = Excellent  
Privacy and Dignity = Excellent | Excellent rates achieved. |
| 2012 | Environment = Excellent  
Food = Good  
Privacy and Dignity = Excellent | It has not been possible to determine why the rating for food has decreased from excellent to good at this time. |

### 5.20 CARE QUALITY COMMISSION COMPLIANCE ISSUES RAISED

<table>
<thead>
<tr>
<th>Year</th>
<th>Summary</th>
<th>Main risks, mitigating action being taken, and whether resolved:</th>
</tr>
</thead>
</table>
| 09/2011 | The CQC found the Trust to be non-compliant with Outcome 4: Care and Welfare of People who use services, in respect to nursing documentation on MAAU.  
Compliant. | In response action was taken to improve documentation in MAAU to maintain compliance (and the wider organisation) through the review and the implementation of revised Nursing documentation.  
This has been identified as a priority in the Trust’s Quality Account for 2012 and has been reviewed on a monthly basis by CQRM and quarterly as a CQUIN in the Trust’s 2012/13 contract. The trust is now deemed to be compliant by CQC |
Communications plan

- Face-to-face meetings with receiving organisations
- Governance meetings: relevant Boards and committees
- Update LINKs/HealthWatch
- Internal communications: newsletter, intranet
- External communications: CCG stakeholder newsletters, websites
- Public Board meetings
How can we work together?