Date of Meeting: 17 May 2016					1. **Paper No: 4**	
Title of Paper: Care, Quality and Safety requirements for service redesign and service change						
Is this paper for	**Discussion**		**Decision**	**X**	**Information**	
Purpose of Paper: This paper is to inform the Transition Board on the work to date by the Care, Quality & Safety work stream. The focus of any service redesign is to improve care, quality and safety. Over time it is anticipated that quality will be central to this process rather than as currently, a supporting work stream.						
Action Required: The Transformation Board is requested to: • Agree the purpose of the Care, Quality and Safety group is to both deliver quality assurance and quality improvement. • The areas for service assurance and improvement						
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Care and Quality Transformation Board

1. Background

This paper is to inform the Transition Board on the work to date of the care and quality work stream. The focus of any redesign is to improve quality and over time it is anticipated that quality will be central to this process rather than as a supporting work stream.

Overall the health services in Oxfordshire deliver good quality care but there are some aspects of care that need attention. At this point in time there is no health organisation registered with the CQC in Oxfordshire in special measures. CQC are currently inspecting primary medical services in Oxfordshire.

Quality in healthcare is defined as patient experience, patient safety and clinical effectiveness.

2. **Patient experience**:

There are common themes of patients being dissatisfied with access to care, lack of clarity about their care, lack of involvement in care planning, inadequate information, multiple visits when one might do/hand-offs, not being involved in their care inadequate explanation, discharge processes causing issues, waiting times, booking and appointment issues. This is both by provider processes and how pathways are commissioned.

Overall Friends and Family test are positive but the percentages responding are often small.

3. Patient safety gaps;

Primarily these are avoidable mortality and morbidity, surgical incidents, transfer between services, handover between shifts/care givers, recognition and management of the deteriorating patient, clinical risk assessment, prescribing mistakes, diagnostic errors and delays, HCAIs, VTE, UTIs, falls, pressure ulcers.

4. **Clinical effectiveness gaps**:

Primarily these are clinical variation in practice within services in primary and secondary care.
Achieving best practice around patient concordance/engagement/activation/self management support
Effective monitoring of NICE compliance and implementation of clinical best practice across all pathways

5. Overview of Quality

Health related quality of life and the proportion of people with long term conditions:

- Fewer people living with recorded hypertension, smoking, obesity, CHD, diabetes, COPD, asthma, CKD, and osteoarthritis compared to CfV comparator CCGs.
- Fewer alcohol related and self-harm admissions.
- Similar rates for cancer, depression, psychosis.
- Higher rates of injuries due to falls and community based pressure ulcers.
- Major causes of year lost due to disability e.g. back pain (GBD) have no local data.
- Room for improvement among all of these, but it will be stretching from good to best in most areas

We perform above national average for all public health indicators related to health spend and quality of life for people with long term conditions. But we aren't improving in every area. Better life expectancy at birth for men (1.4 years) and women (0.9 years) overall and for most

causes amenable to healthcare. However, a life expectancy gap (most to least deprived quintile) is 6.3 years for men, and 2.5 years for women. Improvements are still possible across the board. For some specific sub-areas we are behind or in line with the national average, notably:

- Road injuries
- Winter deaths
- Suicide

6. Urgent Care

OCCG with providers are seeking an urgent care system that enables more care closer to home, reduces costs, is safe and highly responsive.
NHS constitution standards on Red 1 ambulance response times and ED 4 hour waits are not currently met, and are a priority for the system.
The implementation of the Integrated Urgent Care Commissioning Standards https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf is central to improving the quality of urgent care

This includes:

- Pathway based clinical governance
- The development of a live, up to date local directory of services, including social care, mental health and third-sector services.
- Continuous audit and improvement
- Development of new roles within the workforce

Compliance with NICE guidance and Safer, Faster, Better: good practice in delivering urgent and emergency care. A guide for local health and social care communities.
http://www.nhs.uk/NHSEngland/keogh-review/Documents/safer-faster-better-v28.pdf
The increased focus on ambulatory management and care closer to home introduces clinical and operational risks requiring close monitoring.
The current urgent care system is complex. This is an opportunity to simplify and refine the urgent care system.

7. Integrated care for the frail older population

The challenges include:

- DTOC continues to be a key focus for the 5YFV
- Ensuring that care closer to home is safe through effective governance, training and clinical risk management
- Effective diabetes services that improve outcomes and cost e.g. 8 processes of care, early diabetic education
- A rationalised and cost effective stroke pathway that enables clinicians to better serve patients
- Preventing falls with injury and pressure ulcers in the community and care settings
- Ensure end of life choice is given, and we improve the proportion of people able to die outside of a hospital setting
- Effective rehabilitation and discharge across bed based care.

8. Planned care and diagnostics

- Over the next few years, co-produce a process to analyse of quality based on outcomes data and processes to support evidence based pathways and practice
- Develop the clinical governance systems of new hub/ point of care model
- Continual improvement around cancer targets and RTT
- Ensure urgent care services don't disrupt planned care service quality
- Develop an interoperable patient record across the system
- Missed opportunities to communicate between primary and secondary/community care
- Deliver care on a biopsychosocial model instead of a purely medical model to support patient activation and self-management

9. **Maternity**:
    - Electronic patient record (not blue notes)
    - A re-procurement / re-evaluation of GP risk assessments for expectant mothers
    - Ensuring midwives have access to GP notes
    - Work to improve the consistency of the advice from health visitors and midwives
    - Work to continuously improve the whole perinatal mental health system
    - Improve choice for women, especially in relation to their chosen place of birth
    - Compliance with NICE (cg192), National Maternity Review, RCOG and RCM guidelines https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

10. **Children:**
    - Primary care skills and capacity issue
    - Tackling child mental health through CAMHS access issues and transformation work, as well as a review of support for parents to manage their children's mental health
    - Tackling childhood obesity and preventable long term conditions such as athsma (public health)
    - Integrated care for children that are highly dependent on health and social care services
    - More local care for children with planned care needs, as the adult population
    - Health and social care joint working to promote health and psychosocial resilience of children
    - Improving waits, travel and other key aspects of experience
    - Supporting better health seeking behaviours from families to help manage demand
    - Admissions and mortality for Asthma in those under 18, admissions from upper respiratory tract infections in those under 1, admissions from unintentional and deliberate harm in under 5s

11. **Mental health and learning disability**

    - Improve mortality rates
    - Improve general health
    - Increase the use of personal health budgets
    - Transformation of services from inpatient to community and routine healthcare settings
    - Improve the quality and coverage of health checks
    - Develop a forensic pathway for people with LD
    - Work to monitor and ensure that healthcare access and patient outcomes are equitable across LD, autism, dementia and normal IQ patients
    - Patients need meaningful choice and control over care
    - Improve the transition from child to adult services (applies generally to CAMHS)
    - Effective crisis management

12. Mental health:

- Improve mortality and physical health
- CAMHS access times
- Risk around perinatal and urgent care pathways
- Access to tier 3 and 4 psychology
- Supporting carers
- Lack of integrated patient records

13. Progress to date

A cross organisational group has been established and has responsibility for taking the care and quality work forward. The group will review the work undertaken to take and the individual identified as the lead will offer a perspective on the quality of service to the work stream lead. Integrating the quality lead with the work stream is a more productive approach to service redesign. The transformation board need to inform the care and quality group if it sees their role as one of quality assurance or one of quality improvement. As stated at the outset of this paper improving quality should be at the heart of all service redesign.