Improving quality through systems
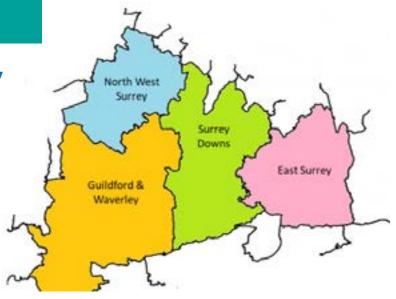
Case studies

Case study 1: Surrey Heartlands ICS

Overview
- **Population:** circa 1.1 million.
- Quality lies at the heart of Surrey Heartland's vision. The ICS has a commitment to delivering high-quality care and outcomes for its population by focusing on quality improvement, workforce development, and multi-professional leadership.

Key principles to Surrey Heartlands' approach to quality improvement
Surrey Heartland's approach to delivering quality is founded on the following key shifts:

Barriers	Opportunities
Differing views on quality	Shared definition of quality, based on what matters to people using services
Gaps in information sharing	Single version of the "truth" through aligned reporting, consistent quality metrics based on outcomes, agreed definitions and clear communication
Duplication in reporting	Aligned, streamlined governance processes for providers and commissioners, to reduce the bureaucratic burden
Performance focus on metrics that are not based on outcomes	Shared ambitions for shared outcomes and reduced variation in quality of care across the system
Focus on finance not quality	Recognition that high-quality care costs less
Commissioner and regulator's requirements	System requirements, including collective management and ownership of quality challenges, removing hierarchy and increasing collaboration between providers and commissioners for whole system improvement

The approach to quality management is built around continuous quality improvement and the recognition that routine quality oversight is most effectively done at place level. Co-design and co-production with people using services and staff is also central to the approach.

Quality Assurance
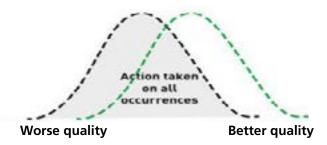

Quality Improvement

Quality oversight in Surrey Heartlands

Robust quality oversight arrangements have been put in place to manage risks and drive continuous improvement:

- **An executive lead for quality**, the Director of Multi-professional Leadership - who has responsibility for overseeing quality improvement, planning, and assurance functions across the ICS. The executive quality lead sits on the Senior Executive Leadership Team, and the regional NHSEI quality oversight group.
- **A Joint Intelligence Group (a revised Quality Surveillance Group)** - bringing together partners from across the system to share intelligence and information on quality issues, identify quality improvement priorities, and identify joint action needed to resolve issues (including escalation). The group meets monthly and includes representatives from the ICS, Regional NHSEI team, providers, local authority, regulators, primary care, maternity, public health, plus people with lived experience.

- **Use of triangulated data for quality assurance** – drawing on soft intelligence, hard data (e.g. audit reports, complaints, serious incidents), and information from horizon scanning (e.g. national guidance, regulator ratings, benchmarking, best practice), to monitor quality performance, identify learning and inform whole system quality improvement.
- **An improvement-focused approach to provider assurance** - structured around key questions such as: Do you know where unwarranted variation in quality of care exists? Do you know where you stand relative to the best? Do you know your rate of improvement? Do you know how good you are?
- **Good working relationships with Regional NHSEI teams and regulators** - including clear processes for sharing learning, requesting support, and escalating issues, as well as an effective two-way flow of information.
- **Mechanisms to enable coproduction** – such as workshops including system partners, NHSEI, and other regulators.

Key achievements

Although temporarily stood down due to a required focus on the COVID-19 pandemic response, some aspirations of the Joint Intelligence Group have been expedited, including:

- Rather than continuing to hold separate commissioner contractual Clinical Quality Review Group Meetings for each provider, through building trusted relationships with providers, **ICS quality leads now attend provider meetings** to observe and seek assurance directly.
- **Increased collaborative working**, and commitment across system partners' quality leads, to reducing barriers to joint working and removing notions of hierarchy.
- Working towards a **single version of outcome-based system metrics** to reduce unwarranted variation in quality of care across the ICS. These will be integrated into the system oversight framework.

Key lessons

- Surrey Heartlands are exploring the use of **technology to support quality oversight in real time**, with a focus on ongoing assurance, targeting follow up conversations where the data indicates that there may be an issue requiring further exploration.

- It is important to ensure that **lessons learned are widely shared and implemented across the whole system**, and Surrey Heartlands are looking at developing effective ways to do this as an ICS – for example, by introducing a Patient Safety Specialist Network Forum, looking at ways to share learning from serious incidents via a shared system newsletter, and adding to or adjusting system metrics to support improvement.
- Navigating inconsistently used terminology and language has been challenging, therefore Surrey Heartlands is considering **developing and agreeing system-wide definitions**, for terms such as 'system', 'place', and 'provider collaborative'.
- Another **key challenge has been managing risks across the system**, requiring the development of key relationships to improve collaboration with all ICS partners.
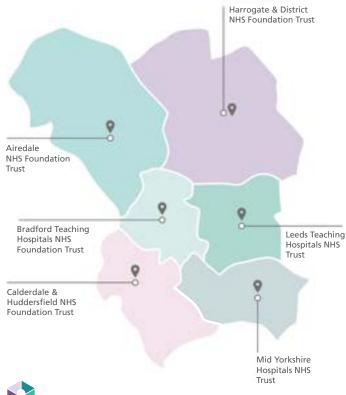- Challenges of developing the ICS alongside **managing the resultant organisational change**.

For more details about Surrey Heartlands, go to www.surreyheartlands.uk/our-priorities

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Case study 2:
West Yorkshire Association of Acute Trusts (WYAAT)

Overview

- **ICS:** West Yorkshire and Harrogate (WY&H) Health and Care Partnership (HCP)
- **Population:** 2.6 million
- **Overview:** WYAAT is a Provider Collaborative comprised of the six acute trusts in West Yorkshire & Harrogate. The collaborative delivers a portfolio of transformation programmes and provides a single acute voice into the ICS. WYAAT, and associated acute trusts, are a core part of the WY&H HCP and have played a significant role in its development as a partnership and an ICS.
- **Established:** December 2016
- **Reason for establishment:** Recognition by the trusts that many of the challenges they faced could not be resolved individually by trusts and that they needed to work collaboratively to improve care for the people of West Yorkshire and Harrogate
- **Purpose:** "On behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the West Yorkshire Association of Acute Trusts (WYAAT) service area"
- **Key programmes:** portfolio of 11 programmes covering clinical services, corporate and clinical support. These have had a tangible impact on the quality of care and outcomes delivered across the system.
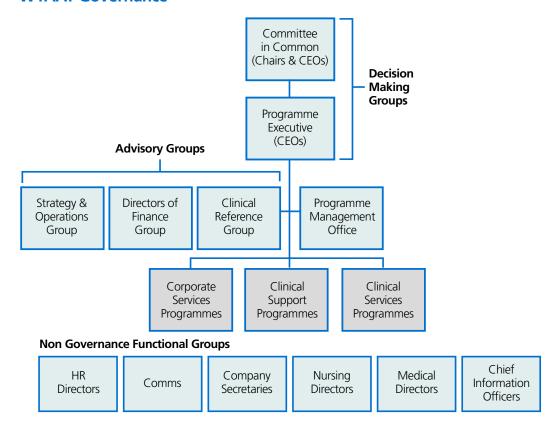

Harrogate & District NHS Foundation Trust

Airedale NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

Leeds Teaching Hospitals NHS Trust

Calderdale & Huddersfield NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

The West Yorkshire Association of Acute Trusts is made up of six trusts working closely together to plan health and care services across the area.

Operating model

- **Committee in Common** (Trust Chairs and CEOs) established through MOU between the member trusts.
- **Dedicated PMO with 20 staff**, which supports the trusts to collaborate. A Clinical Reference Group, Strategy and Operations Group and Directors of Finance group provides assurance that programmes are clinically, financially and operationally sound.
- **WYAAT governance structure sits parallel to the WY&H HCP** with direct input into System Leadership Executive, System Oversight and Assurance Group and the WY&H Partnership Board. Furthermore, WYAAT PMO colleagues and programmes are embedded into the various partnership programmes and alliances e.g. Planned Care and Cancer Alliances.
- WYAAT trusts provide a c.£2m budget and also access NHSEI transformation funding via the ICS.
- **Programmes are clinically led, collaboratively developed and support workforce development**, sustainability and wellbeing, as well as ensuring improvements in the sustainability and quality of care.

WYAAT Governance

Decision Making Groups

- Committee in Common (Chairs & CEOs)
- Programme Executive (CEOs)

Advisory Groups

- Strategy & Operations Group
- Directors of Finance Group
- Clinical Reference Group
- Programme Management Office

- Corporate Services Programmes
- Clinical Support Programmes
- Clinical Services Programmes

Non Governance Functional Groups

- HR Directors
- Comms
- Company Secretaries
- Nursing Directors
- Medical Directors
- Chief Information Officers

A focus on driving improvements in the quality of care and outcomes

WYAAT is committed to enabling continuous improvement in quality, patient safety and experience. WYAAT's vision is to 'deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients'.

Quality is assured and delivered through:

- **WYAAT Programme Executive** (Chief Executives) with executive groups including WYAAT Clinical Reference Group (Medical Directors and Directors of Nursing), with Programme Director Matt Graham, Medical Lead Dr Sal Uka and a dedicated PMO of Programme Managers, Quality Improvement experts and Clinical leads.
- **A WY&H Clinical Strategy for acute services** informing the HCP's capital and estates strategy, financial strategy etc. This strategy continues to evolve considering the impacts of the COVID-19 pandemic and legislative changes to ICSs.

The premise of the strategy (to fulfil the vision) is to bring clinical and operational colleagues from within WYAAT and the wider partnership into collaborative forums to agree and deliver specific workstreams for improvement.

- At place level, the Clinical Strategy aims to ensure **coherence between WY&H and place plans**. WYAAT members are also members of their place partnerships and provider collaboratives.

Key achievements

- **West Yorkshire Vascular Service:** vision is a single, shared regional service across five acute trust providers. Through collaborative working, the service has embedded regional clinical pathways and a virtual ward to ensure equality of care and access for patients across the region, improve patient experience in delivering facets of their case closer to home, and ultimately improve patient outcomes across the region. The service reacted as one to a critical COVID related staffing issue and is creating regional development pathways to improve the recruitment and retention of staff.

- **Yorkshire Imaging Collaborative (YIC):** a combined technology and business transformation project aimed at unifying radiology imaging and report sharing between acute trusts across Yorkshire. The Xero Exchange Network enables clinicians to see radiology images taken at any site and at any time, reducing the time for clinical opinions, transfers and need for duplicate scans. The YIC has supported the development of Specialty Interest Groups embodying the approach of clinical and operational engagement to agree optimal ways of working. These groups will also be key to the next phase of image exchange providing a platform for reporting across Yorkshire.
- **WYAAT Learning from Incidents:** commissioned by Medical Directors in 2019, brings clinical and corporate quality & safety leads together in a regular bi-monthly forum. Over time, this group has created the culture and environment for open and transparent sharing of learning from serious incidents and never events as a collaborative approach to patient safety. The group, now aligned to the WY&H LMS, are developing a shared approach to SI training and investigations with the key focus of shared learning and QI. The group has also discussed specific issues related to the reporting and investigation process regarding hospital-onset COVID-19 and deaths related to hospital-onset COVID-19. A process was agreed that is lean and proportionate, identifying rapid learning points to assist clinical teams in practice, to be applied consistently across WYAAT.
- **WY&H Ophthalmology:** exemplifies the role of WYAAT within the WY&H partnership in developing regional pathways for cataract surgery, age-related macular degeneration (AMD) and glaucoma. Pathways have gained commissioner approval and have been supported by the development of shared decision-making tools, regional referral forms, standard clinical thresholds and improved patient information.

Key lessons
- Organisations must come together around a **shared purpose** to improve care for the local population.
- **Robust governance, active participation and transparent decision-making** are key to system assurance and collaboration. However, this must resonate with colleagues at all levels and not just those in executive roles.
- True collaboration matures over time and is best achieved through **joint clinical and operational engagement** ideally supported by a PMO.
- **Programmes should complement organisational strategies and be integral to place and system-based ambitions.** The purpose and impact of each programme must be clear, must link back to the overall strategy and be tracked against performance. Logic models are developed in WYAAT for this purpose.
- Partnership working must include early and **meaningful co-design** (not just engagement) with patients and the public, recognising the increasing value of the voluntary care sector organisations.

For more details about WYAAT, go to
wyaat.wyhpartnership.co.uk

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Case study 3: Our Dorset

Overview

- **ICS:** Our Dorset
- **Population:** 800,000.
- Our Dorset ICS covers the whole county, from the rural west (including Dorchester) to the more urban east (including Poole, Bournemouth and Christchurch). Our Dorset is comprised of one CCG, three acute foundation trusts, one county-wide community and mental health trust, an ambulance trust and two local authorities.
- Quality is a core theme in the system's Long-Term Plan for health and wellbeing, Our Dorset – Looking Forward, which emphasises that everyone, including staff, has the right to feel valued, safe and confident in the quality and equity of health and care services provided.
- **The system has a Quality Framework** for 2020-22 to enable and support system working for quality. The framework builds on the NQB Shared Commitment and focuses on four key enablers: 1) leadership, 2) quality improvement, 3) assurance and 4) intervention when standards and not being met. www.dorsetccg.nhs.uk/wp-content/uploads/2020/11/Quality-Framework-2020-2022.

Quality oversight in Our Dorset

Our Dorset has established the following quality oversight arrangements to ensure effective management of quality risks across the system and continuous quality improvement:

- **An executive lead for quality** – the Director of Nursing and Quality – who sits on the System Leadership Team (SLT) and reports to the Governing Body. The executive lead is responsible for overseeing quality improvement, planning and assurance across the system.
- Defined governance and escalation processes for quality oversight.
- **A system-level Quality Surveillance Group**, which brings together system partners (commissioners, local authorities, primary care, acute trusts, ambulance trust, lay members, CQC, HEE) to:
  - Provide assurance and improvement for quality
  - Create a culture of support, collective leadership, mutual holding to account and challenge;
  - Systematically bring together the different parts of the system to share intelligence.
- **Board level accountability for quality** – a system quality report is presented at Governing Body, SLT and Finance Committee meetings, summarising quality performance and identifying matters where system intervention to improve or escalate is merited.

- **Clear processes to escalate quality concerns to regional teams and regulators** – the executive lead for quality sits on the regional quality oversight group.
- A review is being undertaken to further strengthen quality governance and reporting. For example, it is expected that the Infection Prevention and Control (IPC) network will report into the QSG going forward.
- **A Clinical Reference Group**, comprised of Directors of Nursing, Medical Directors and Allied Health Professional leads, to support planning and decision-making across the system.
- **A quality dashboard**, which summarises performance against agreed measures for patient safety, patient experience, clinical effectiveness, as well as CQC ratings. See https://www.dorsetccg.nhs.uk/wp-content/uploads/2021/03/09.1-Quality-report-170321.pdf

Key achievements
- **Enhanced Health in Care Homes** - the system's quality team have offered significant support to care homes throughout the pandemic. This has included:
- Roll out of the **RESTORE2™** deterioration tool to all care homes in Dorset. Care homes have been provided with resources, training and equipment in order to use RESTORE2™. This has been a system approach with support from both local authorities, community nursing teams and primary care
- Delivery of **online IPC training to care homes**, supported living and domiciliary care providers. This has been delivered collaboratively with local authority quality teams

- Verification of **Live Extinct (VOLE) training**.
- Clear quality oversight arrangements have been in place to support this work.
- **Learning Disabilities Mortality Review (LeDeR) programme** - the Dorset LeDeR programme has undergone a review in the past 12 months. The team has been restructured, a system steering group has been developed and quality assurance processes have been refreshed. This has enabled the back log of reviews to be cleared and for the team to successfully meet the required performance measures for allocation and completion.

Key lessons
- The need to have **quality oversight discussions in the right amount of detail** – enough detail to understand the issues and gain assurance, whilst at the same time recognising the diversity of system membership and the need to keep system partners engged in an area of discussion that may not be directly related to their role.
- The importance of building a **culture and leadership for quality**, in particular building a shared understanding of quality, psychological safety, clinical curiosity and a culture of constructive challenge.
- The purpose and role of quality oversight groups must be agreed by all system partners and regularly reviewed to ensure they are fit for purpose.

For more details about Our Dorset, go to www.ourdorset.nhs.uk/

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