NHS
Surrey Downs
Clinical Commissioning Group

Governing Body

Friday, 27th May 2016

Quality Strategy 2016 – 2018

Agenda item 15 Paper 9	
Author:	Eileen Clark, Chief Nurse and Head of Quality
Executive Lead:	Steve Hams, Interim Director of Clinical Performance and Delivery
Relevant Committees or forums that have already reviewed this paper:	Quality Committee Seminar Clinical Cabinet Executive Management Team
Action required:	TO AGREE
Attached:	Draft Quality Strategy [v0.5] 2016 - 2018
CCG Strategic objectives relevant to this paper:	Strategy implementation Quality and Performance
Risk	None
Compliance observations:	**Finance:** Successful delivery of the Quality Strategy will ensure the CCG is able to secure its Quality Premium and will be able to commission effective and efficient services from providers.
	Engagement: The Draft Quality Strategy has been shared with members of the Quality Committee, Heads of Service, Executive Management team and key NHS providers.
	Quality impact: Delivering the Quality Strategy clearly articulates our quality goals and aspirations for the next two years.
	Equality impact: The Quality Strategy adheres to principles of equality and diversity.
	Privacy impact: N/A
	Legal: The NHS Constitution gives patients" the right to expect NHS bodies to monitor, and make efforts to improve continuously, the

	quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.”

EXECUTIVE SUMMARY

Following a number of reviews by the Quality Committee it was agreed that a refreshed Quality Strategy would be developed.

The Quality Strategy reflects our commitment to the commissioning of high quality care for now and for future generations, it provides both national and local context which has helped shape our delivery plan for the next two years.

Earlier version of the Quality Strategy has been discussed through seminar and a formal meeting of the Quality Committee, the Clinical Cabinet and the Executive Management Team. The Quality Strategy seeks to strike a balance between how the CCG will be held to account by NHS England for delivering quality through commissioning and how the CCG will hold its providers to account for delivering quality services.

The CCG Improvement and Assessment Framework for 2016/17 provides much of the drive and assessment of CCG performance in relation to quality, over the coming months we will develop further insight and analysis on quality, linked to our delivery plan for 2016/17.

The Governing Body is invited to discuss and approve the Quality Strategy and receive a further update in six months.

Date of paper	17th May 2016
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Quality Strategy 2016 - 2018

Improving care together
across Surrey Downs

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1. Introduction

High quality care is effective, safe and ensures a positive patient experience. Following his review in 2008[1], Lord Darzi defined quality as:

“Care which is "clinically effective, personal and safe"

This definition of quality is now enshrined in legislation through the Health and Social Care Act, 2012 and is the basis upon which, this Quality Strategy is developed.

Ultimate responsibility for safeguarding the quality of care provided to patients rests with each provider organisation and their respective Boards. However, Clinical Commissioning Groups (CCGs), as statutory organisations are required to commission the best possible services to and outcomes for patients within financial allocations. Therefore, NHS Surrey Downs CCG (SDCCG) has a statutory duty to secure continuous improvements in the care that we commission and to seek assurance around the quality and safety of those services using a range of information which includes both hard data and softer intelligence.

The vision of NHS Surrey Downs CCG is that:

“Focused clinical leadership and patient engagement will revolutionise the delivery of local healthcare through our three geographical localities, whilst remaining within cost-constraints of NHS Funding, improving quality of care and health outcomes for patients. Services will be local, affordable, responsive and measurable for our population we serve”

This vision is underpinned by a set of values and standards with the principle aim of narrowing health inequalities, enhancing quality and safety, involving patients in everything that we do and working within the resources that are available to us.

The aim of this Quality Strategy is to provide a continuous focus on improving the quality and safety of services that we commission over the next 2 years. In addition, it will identify and monitor key areas of Service Redesign in order to give assurance that key benefits are realised for patients through a Quality Framework and associated delivery plan.

Delivery of this strategy is co-dependant on bringing together other strategies and plans, most notably our organisational development strategy which focuses on developing a workforce with capacity and capability and our primary care strategy which seeks to strengthen primary care.

[1] Darzi A (2008) *High Quality Care for All: NHS Next Stage Review (Final Report)*

2. National Context

The NHS Outcomes Framework[2] identified the need to move away from simply measuring outputs in the form of activity, to measuring the outcomes and effectiveness of interventions for patients. The five domains of the NHS Outcomes Framework are covered by three dimensions against which the quality and safety of services should be measured; they are **Effectiveness, Patient Experience and Safety.**

The Francis Report[3] of the inquiry into the systemic failings at the Mid Staffordshire NHS Foundation Trust and *Transforming Care: A National Response to Winterbourne View Hospital*[4] identified that quality is as much about the behaviours and attitudes to patients as it is about the transactional aspects of service delivery.

In addition to this, Professor, Sir Bruce Keogh led a review, in 2013 into the care and quality of treatment provided at a number of acute hospitals that had been identified as outliers on mortality indicators. This and criticisms about the involvement of the Care Quality Commission (CQC) in a number of high profile cases led to a wholesale review of its operations and following this, the expectation from the government that the CQC would, through a new inspection regime, make the definitive judgements on the quality within providers.

The NHS Constitution[5] first published in March 2012 and updated in 2013, set out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this constitution in their decisions and actions.

The *Five Year Forward View*[6] and the Sustainability and Transformation Plans (STPs) that are being developed across agreed areas are all being driven by the "triple aim" of (1) improving the health and wellbeing of the whole population; (2) better quality for all patients, through care and redesign; and (3) better value for taxpayers in a financially sustainable system. In response to this, NHS England is introducing a new Improvement and Assessment Framework for CCGs (CCG IAF) which will align in one place, NHS Constitution and other core performance and financial indicators, outcome goals and transformational challenges and will enable there to be oversight and additional insight into performance and quality.

The General Practice Forward View[7] sets out an ambitious five year programme of reform and transformation within general practice. It recognises the important contribution primary care has in securing high quality care, it equally recognises that practical steps need to be taken to improve investment, workforce, workload and care redesign.

[2] http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf
[3] http://www.midstaffspublicinquiry.com
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
[5] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[6] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv_web.pdf
[7] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

An important component of ensuring that CCGs deliver value for their local population is a better understanding of where there is opportunity to improve health outcomes for better value. NHS England have launched the Right Care programme[8], the genesis of which lies in the original Quality, Improvement, Prevention and Productivity (QIPP) programme initiated by the Department of Health in 2009

The primary objective for Right Care is to maximise value:

- the value that the patient derives from their own care and treatment
- the value the whole population derives from the investment in their healthcare

To build on the success and value of the Right Care programme, NHS England and Public Health England are taking forward the Right Care approach through new programmes to ensure that it becomes embedded in the new commissioning and public health agendas for the NHS.

As one of the first wave of CCGs to use Right care, we will be focusing on three priority areas, namely respiratory, musculo skeletal and patients with complex needs.

Our Quality Strategy reflects our commitment to the commissioning of high quality care for now and for future generations.

3. Local Context

There are key challenges that have been identified as issues by SDCCG within our Commissioning Plans. These include:

- Financial deficit with an agreed Financial Recovery Plan performance against which is being closely monitored by NHS England
- The CCG is currently under "NHS England Directions" and as a result has restrictions on some activities and plans
- A large QIPP delivery plan which includes the development of a range of new services and clinical pathways
- The emerging Strategic and Transformation Plan and the potential impact on existing commissioning arrangements
- A desire to integrate local services between health, social care and partners
- Workforce – demographics and skills required

An additional challenge is the complex provider landscape within which NHS Surrey Downs CCG operates and this is further complicated by the different arrangements that we and neighbouring commissioning organisations have with Commissioning Support Units (CSUs). This complexity, and the current hosting arrangements that the six Surrey CCGs have organised as a collaborative, which means that the CCG needs to gather data and intelligence from a large number of different sources, often making it more difficult to get a clear assurance from providers about the quality and safety of the services that they provide.

[8] http://www.rightcare.nhs.uk/

We are responsible for commissioning a wide range of health services for the population of Surrey Downs, these services include acute (hospitals), community (community hospitals and community nursing), mental health services and ambulance services, we also support NHS England who are responsible for commissioning primary care services.

We are the lead commissioner for Central Surrey Health who provides adult and children's community services; we are an associate commissioner for some 20 different NHS providers, making for a complex and dynamic commissioning and provider landscape.

As well as commissioning services from a range of NHS providers, we work in partnership with a range of organisations such as Surrey County Council through the Better Care Fund to commission a wide range or voluntary and private sector providers of services for example, smoking cessation services, meals on wheels and access to psychological therapies.

As part of the Surrey Collaborative (a collaborative of six CCGS in Surrey) we host the Continuing Health Care Team, the Medicines Management team and the Individual Funding Requests Team.

4. Commissioning intentions

Each year CCGs are required to articulate a key set of commissioning priorities, these priorities will be focused on ensuring that the residents of Surrey Downs continue to have access to essential health services, we also take the opportunity to review areas where we feel additional impetus is required in order to be able to address areas of health concern, for example cancer or heart disease.

During the past 12 months we have been working hard to secure improvements in a variety of areas where we know that greater health gain can be achieved for local residents within the allocation of funding we receive from NHS England. We have used the analysis from the Right Care programme to further understand where there are opportunities to imporve outcomes for patients and deliver better value for money.

Our commissioning priorities are called 'commissioning intentions', we have published our commissioning intentions for 2016/17 and they focus on seven priority areas:

- Planned care
- Cancer
- Urgent care and integration
- Children's and young people's services
- Mental health services
- Medicines optimisation
- Continuing healthcare

5. Current measures and general assurance

As described previously, quality is systemic, relying upon many different individuals, commission. Information about these services needs to be drawn from a wide variety of sources to ensure that the most relevant and up to date information is used.
The vision in the future is for all NHS Staff to measure what they do as a basis for improving quality. The CCG currently draws upon the following sources of data to support assurance around the quality of commissioned care:

- Performance data for the Operating Framework priorities that are relevant to quality (i.e. infection rates, waiting times)
- Summary Hospital Mortality Data (SHIMI)
- Safety Thermometer
- Never Events and Serious Incident/Incident reporting including the actions taken by providers to prevent the reoccurrence of similar incidents
- Relevant Public Health data such as Immunisation and vaccination data
- CQC inspections – registration details, warning notices and related CQC notifications
- Serious Case Reviews (SCRs) and Safeguarding Adult Reviews (SARs)
- Central Alert System (CAS), closure rates and outstanding issues
- Adherence to safer staffing guidance and how this information is communicated to patients and the public
- Compliance with mandatory training
- Insight and feedback from our local population about local services
- Friends and Family Test (FFT) and other patient experience data
- Staff surveys
- Complaints management, themes and trends
- Patient Advice and Liaison Service (PALs) data
- Maternity services, Local Midwifery Authority reports and audits
- Feedback from GPs and other healthcare professionals about patient experience and any clinical concerns raised
- Quality Impact Assessment of CCG service redesign and improvement plans
- Quality impact assessment of provider cost improvement programmes (CIPs)
- Peer reviews, recommendations and action plans
- Clinical audit/confidential enquiries.
- Local Quality Surveillance Groups
- Media – both traditional and social media
- Patient websites such as Patient Opinion, NHS Choices, NHS Connect and local user groups
- Surrey Healthwatch
- Professional regulators
- Care Quality Commission – soft intelligence
- Information from NHS Improvement
- Whistleblowing and similar reports from staff and the public

In addition, there are a number of other methodologies that support the measurement and analysis of quality which the CCG uses to support the performance management and monitoring of contracts. These include:

- Quality Schedules in contracts
- Nationally agreed quality metrics such as CQUINs
- CCG Outcome Indicators
- NHS Constitution metrics
- Quality Accounts

The Quality Team also undertake observational “Walk Rounds” of commissioned services, often in response to concerns, which gives an opportunity to talk to patients to understand their experience of care and staff to hear directly from them any concerns that they might have.

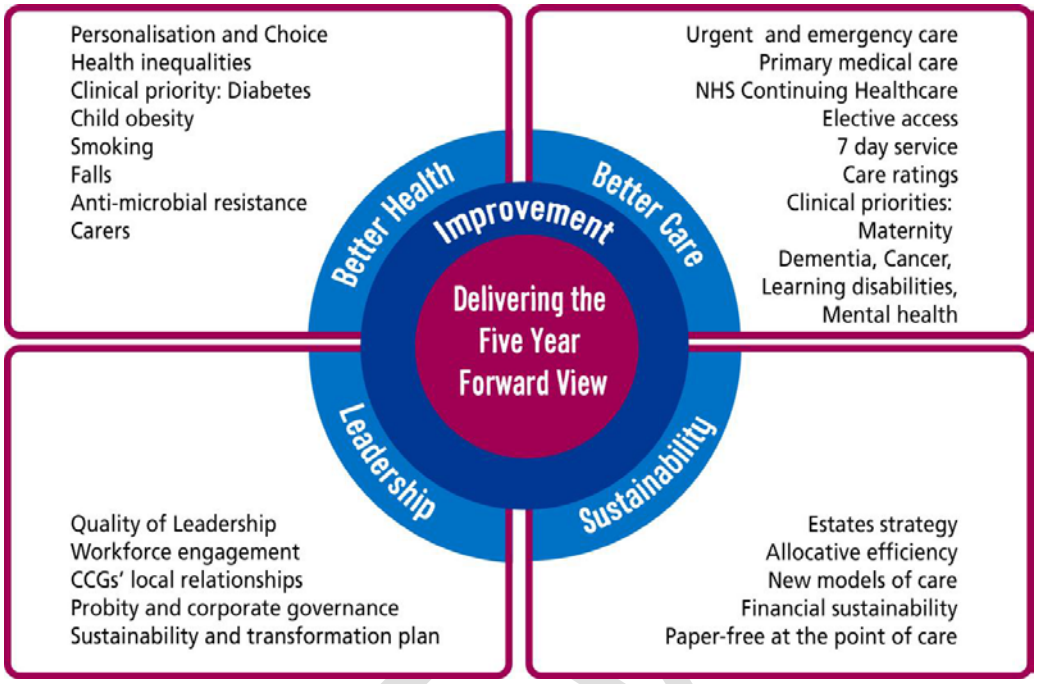
6. Quality Framework for 2016/17

The CCG Improvement and Assessment Framework for 2016/17 has been developed with four domains and will focus on six clinical priorities – **Mental health, dementia, Learning disabilities, Cancer, Diabetes and maternity**. It has been designed as a dynamic tool to enable CCGs to focus on the emerging opportunities facing the NHS in future years such patient safety and patient and public engagement.

The four domains are:

- **Better Health:** how well the CCG is contributing towards improving the health and wellbeing of its population and how it is affecting the demand curve from our population
- **Better Care:** focussing on care redesign, performance of constitutional standards and a range of outcomes
- **Sustainability:** Financial balance and securing good value for patients and the public from our commissioning activity
- **Leadership:** The quality of leadership, the quality of our plans, how it works with partners and governance arrangements in place to ensure probity.

This framework is summarised in the diagram below:



The CCG will use this framework to focus on its areas of delivery during 2016/17; this strategy specifically focusses on the 'Better health' and 'Better care' aspects of delivery and commissioning, however we recognise that quality requires 'leadership' and 'sustainability' and these two aspects are 'enablers' for delivery.

7. What we will focus on during 2016/17

As a commissioning organisation we will focus on delivering the following:

- The CCG Improvement and Assessment Framework 2016/17
- Meeting the standards as outlined in the CCG Quality Premiums
- Delivering the NHS Constitution Standards
- Monitoring and improving the CCG Outcome Indicators
- Ensuring service redesign programmes and QIPP programmes have robust Quality Impact Assessments (assurance)

We will hold our providers to account by:

- Securing contractual improvements by seeking assurance through Standard NHS Contract Quality Schedules
- Developing, monitoring and supporting providers to obtain CQUINS outcomes
- Ensuring commissioned providers deliver against the NHS Constitution Standards
- Quality and Outcomes Framework (primary care)
- Ensuring providers undertake Quality Impact Assessment of QIPP (assurance)

- Ensuring commissioned services welcome assessments by the CQC and where improvements are required monitor and support action plans
- Review provider Annual Quality Accounts to ensure providers are accountable to patients they serve

We will work with lead commissioning organisations and actively participate in the commissioning assurance process for providers in the following ways:

- Leading and/or attending monthly provider Clinical Quality Review Group meetings using 'Key Lines of Enquiry' and triangulation of data and information as our assurance methodology
- Effectively managing providers contracts and using contract levers where standards are not being met
- Work with other CCGs as part of the Surrey wide commissioning collaborative
- Work with other public sector organisations such as Surrey County Council to safeguard services within care homes
- Undertake a series of risk based visits to providers where we require additional assurance of service quality
- Undertake thematic reviews to provide additional assurance
- Share information and intelligence as part of the system wide Quality Surveillance Group (QSG)
- Work collaboratively with Healthwatch Surrey and system regulators such as the CQC, NHS Improvement and NHS England to ensure timely identification and escalation of provider concerns
- Where appropriate act as a system leader to support improvement in the commissioning and/or delivery of services

8. Delivery plan 2016/17

Our delivery plan for 2016/17 and key measures is detailed below:

<u>Cancers diagnosed at early stage</u>

- Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year.

Or

- Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year.

<u>Increase in the proportion of GP referrals made by e-referrals</u>

- Meet a level of 80% by March 2017 (March 2017 performance only) and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100% e-referrals),

Or

- March 2017 performance to exceed March 2016 performance by 20 percentage points.

Overall experience of making a GP appointment

- Achieve a level of 85% of respondents who said they had a good experience of making an appointment,

Or

- A 3 percentage point increase from July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment

Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care

- Part a) reduction in the number of antibiotics prescribed in primary care

- Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care

Right care (local priorities)

- % of people aged 18 and over with a long-term condition who report using their written care plan to manage their day to day health.

- Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population

- Delayed transfers of care from hospital per 100,000 population aged 18+

NHS Constitution Gateway (quality premiums)

- Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral.

- Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department.

- Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.

- Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes.

For our NHS providers

NHS staff health and well-being (for all providers)

- Introduction of health and wellbeing initiatives
- Healthy food for NHS staff, visitors and patients
- Improving the uptake of flu vaccinations for front line staff within Providers

Timely identification and treatment of sepsis (for acute providers)

- Timely identification and treatment for sepsis in emergency departments
- Timely identification and treatment for sepsis in acute inpatient settings

Antimicrobial Resistance and Antimicrobial Stewardship (for acute providers)

- Reduction in antibiotic consumption per 1,000 admissions
- Empiric review of antibiotic prescriptions

Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) (for mental health providers)

- Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses
- Communication with General Practitioners

For our care homes

Timely identification and treatment of sepsis

- Identification and treatment of urinary tract infections

Pressure ulcers

- Timely risk assessment and intervention, with co-ordinated training for staff

Dementia care planning

- Development of an individualised care plan which is agreed with the resident and their carers/family as appropriate ensuring their regular review

9. Implementation, monitoring and reporting of the Quality Strategy and Framework

A delivery plan is enclosed in appendix 1 and will be monitored through the Quality Committee on a four monthly cycle and to the Governing Body bi-annually.

10. Responsibilities

The Executive Sponsor of this strategy is the Director of Clinical Performance and Delivery in collaboration with the Chief Nurse/Head of Quality.

Oversight and assurance for delivering the programme of activity will be reviewed by the Quality Committee on behalf of the Governing Body.

NHS Surrey Downs Clinical Commissioning Group
Quality Strategy 2016 – 2018
Delivery Plan

	Owner	Baseline	Actions	Update
<u>Cancers diagnosed at early stage</u> • Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year. Or • Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year.	Interim Director of Clinical Performance and Delivery Clinical Director for Planned Care	43%	• Work with Surrey Public Health to ensure consistent public messaging about the signs and symptoms of cancer • Ensure robust public health services are available for the Surrey Downs population i.e. smoking cessation and weight management • Improve awareness of cancer within general practice led by our clinical lead for cancer • Ensure easy access to diagnostic services • Ensure providers deliver timely access as outlined in the cancer standards of the NHS Constitution	
<u>Increase in the proportion of GP referrals made by e-referrals</u> • Meet a level of 80% by March 2017 (March 2017 performance only) and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100% e-referrals), Or • March 2017 performance to exceed March 2016 performance by 20 percentage points.	Director of Strategy and Commissioning Head of Primary care	30%	• Develop practice based performance improvement measures and socialise via locality Chairs/meetings • Identify technology gaps which inhibit use of electronic referrals • Identify training needs to support the use of technology	

	Owner	Baseline	Actions	Update
<u>Overall experience of making a GP appointment</u> • Achieve a level of 85% of respondents who said they had a good experience of making an appointment, Or • A 3 percentage point increase from July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment	Director of Strategy and Commissioning Head of Primary care	69%	• Review practice plans for patient engagement • Identify variation within practices and work with NHS England to develop improvement plans • Support practices in developing robust complaints service • Support practices to access technology enablers which reduce non attendance • Scope a patient experience improvement programme for practice based non clinical staff	
<u>Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care</u> • Part a) reduction in the number of antibiotics prescribed in primary care • Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care	Head of Medicines Management Clinical Director for Prescribing	1.030 (ITEMS/STAR-PU) - 11.3 (ITEMS/ITEMS) %	• Appointment of a Clinical Director for Prescribing • Revise the Surrey Downs Medicines Optimisation Committee • Link improvements to the level 1 and 2 prescribing scheme • Link improvements to the Primary Care Standards • Develop a business case for an antimicrobial prescribing pharmacist to lead policy and improvement • Through locality teams develop opportunities for GPs to work across the secondary care interface with consultants • Nominated GP to support the Clostridium Difficile root cause analysis assurance process	

	Owner	Baseline	Actions	Update
<u>Right care (local priorities)</u> • % of people aged 18 and over with a long-term condition who report using their written care plan to manage their day to day health. • Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population • Delayed transfers of care from hospital per 100,000 population aged 18+	Head of Urgent Care and Integration Clinical Director for Urgent Care and Integration	4.3% - 473.10 per 100,000 - 9 per 100,000	• Progress with integration plans and optimise the three locality teams (community hubs) focusing on people aged over 65 with multiple health conditions • Ensure System Resilience Group are sighted and have plans to reduce delayed transfers of care, working with partners to deliver improvements	

	Owner	Baseline	Actions	Update
<u>NHS Constitution Gateway (quality premiums)</u> • Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral. • Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department. • Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer. • Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes.	Interim Director of Clinical Performance and Delivery Director of Commissioning and Strategy	94.7% - 93.7% - 82% - 72.6%	• Improvement plans and outcomes measured monthly via the provider Contract Review Group meetings • Update to be provided following Q1 performance review • Support the lead SECAmb Surrey commissioner in bringing about improvements in the 999 service • Use contractual leavers should there be a continued deterioration in performance against key standards	
<u>NHS staff health and well-being (for all providers)</u> • Introduction of health and wellbeing initiatives • Healthy food for NHS staff, visitors and patients • Improving the uptake of flu vaccinations for front line staff within Providers	Interim Director of Clinical Performance and Delivery	To be confirmed by June 2016 (Provider CQUINS)	• Improvement plans and outcomes measured quarterly via the provider Clinical Quality Review Group meetings • Update to be provided following Q1 performance review	

	Owner	Baseline	Actions	Update
<u>Timely identification and treatment of sepsis (for acute providers)</u> • Timely identification and treatment for sepsis in emergency departments • Timely identification and treatment for sepsis in acute inpatient settings	Interim Director of Clinical Performance and Delivery	To be confirmed by June 2016 (Provider CQUINS)	• Improvement plans and outcomes measured quarterly via the provider Clinical Quality Review Group meetings • Update to be provided following Q1 performance review	
<u>Antimicrobial Resistance and Antimicrobial Stewardship (for acute providers)</u> • Reduction in antibiotic consumption per 1,000 admissions • Empiric review of antibiotic prescriptions	Interim Director of Clinical Performance and Delivery	To be confirmed by June 2016 (Provider CQUINS)	• Improvement plans and outcomes measured quarterly via the provider Clinical Quality Review Group meetings • Update to be provided following Q1 performance review	
<u>Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) (for mental health providers)</u> • Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses • Communication with General Practitioners	Interim Director of Clinical Performance and Delivery	To be confirmed by June 2016 (Provider CQUINS)	• Improvement plans and outcomes measured quarterly via the provider Clinical Quality Review Group meetings • Update to be provided following Q1 performance review	

	Owner	Baseline	Actions	Update
<u>Timely identification and treatment of sepsis</u> • Identification and treatment of urinary tract infections <u>Pressure ulcers</u> • Timely risk assessment and intervention, with co-ordinated training for staff <u>Dementia care planning</u> • Development of an individualised care plan which is agreed with the resident and their carers/family as appropriate ensuring their regular review	Head of Continuing Health Care	To be confirmed by June 2016 (Provider CQUINS)	• Improvement plans and outcomes measured quarterly via the provider Clinical Quality Review Group meetings • Update to be provided following Q1 performance review • Link improvements to the Primary Care Standards for nursing homes	