

Cross Cutting Themes



🏠 Primary Care

What we said*

1
Healthy Ambitions highlighted the importance of strong primary care across all clinical pathway groups. Primary Care is the first port of call for the vast majority of service users in the region and accounts for over 90% of patient contacts with the NHS. The importance of primary care in the original Healthy Ambitions work led to the establishment of a 'primary care think-tank' with the same status as the eight clinical pathway groups. Our aim is to see universally high quality primary care that is flexible to respond to patients' needs, regardless of where, when or to whom they are delivered.

While there are numerous examples of good practice in primary care across the region, there is also evidence of unacceptable variations in quality, access and patient experience of services.

The 'primary care think-tank' put forward a range of proposals for improving quality and tackling variation in primary care across the region. These included:

- Strengthening commissioning of primary care to maximise the benefit from the levers to improve quality
- Supporting greater public and patient involvement in services and greater choice
- Improving the availability of information to allow comparison and benchmarking, to support more informed commissioning decisions, and to allow patients to make more informed choices.

*Full details can be found at:
www.healthyambitions.co.uk/resource_list.html

What we have done

2
Since publication of Healthy Ambitions we have:

- Delivered Phase 1 of the primary care dataset (Health Intelligence Practice Profiles). These profiles contain a range of practice level information on the practice demographics, quality and accessibility of services, and allow benchmarking of performance with similar practices. The profiles are already being used locally to inform discussions between PCTs, practice based commissioning consortia and general practices. Work has recently begun on Phase 2 of the work which will build in a range of new information, including prescribing data and commissioned activity.

David Wild – PEC Chair,
Calderdale PCT.

'The presentation used in these profiles really makes the data come alive, and we believe this information should be used to support all commissioning choices. We have arranged a series of local events to promote and explain the information.'

- Increased primary care capacity, access and quality through the Equitable Access in Primary Care Programme. The new GP practices will provide extended opening hours and the new health centres will be open 7 days a week from 8am until 8pm. The Health Centres will provide access to a GP for registered and non-registered patients who pre-book appointments as well as for patients who simply want to walk in and wait to be seen by a GP in some of the most deprived and under-doctored areas of Yorkshire and the Humber. By the end of 2009, fourteen new GP-led Health Centres and ten new GP practices will be open for business.

What we will do next

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There has been good progress in improving primary care locally. However we believe that there is a need for concerted effort to further build on the strengths and tackle variation in primary care, in particular:

- Driving world class commissioning for primary care locally, so that primary care services are commissioned with the same rigour and robustness as other services
- Applying the national primary and community care strategy to Y&H, and make best use of this to improve services locally
- Supporting practice based commissioning so that clinicians are able to drive improvements for their patients across the whole spectrum of care.

PCTs will be responsible for taking this agenda forward, and in doing so they will be supported by a region wide primary care delivery board. This will be chaired by Rob Webster, CE at NHS Calderdale, with clinical support. The aim of the board will be to gather and build on best practice locally and translate national policy into practical advice for PCTs, to oversee the development of PBC within the region, and to hold PCTs to account for delivering improvement in primary care. This board will be made up of PCT managers and clinicians, and report to Chief Executives.*

Who will ensure that this happens?

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Annette Laban, SHA Director of Performance and Delivery, will have responsibility for overall delivery of the primary care recommendations.

*For further details see chapter on governance

 Social Marketing

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Healthy Ambitions identified a number of areas where the potential existed for a social marketing approach to have an impact on the behaviours which have an influence on healthy lifestyles. A regional social marketing programme has been developed and agreed by commissioners that aims to deliver significant impact on those behaviours.

A regional marketing collaborative will initially have 3 key roles:

- To develop and deliver best practice through 7 strategic priority projects
- To support capability development throughout the region through focussed 'learning by doing' events
- To provide leadership on the insight agenda for the region.

The seven priority projects, identified by our clinicians in Healthy Ambitions are: Obesity, Mental Health, Stroke, End of Life, Primary Care Access, Education and Training and Marketing Services. Each project has been agreed by all PCTs and has a PCT Chief Executive 'sponsor' who sits on a marketing steering group.

The collaborative also has a duty to train NHS staff and share best practice. The first development event has already been planned and will be based on best practice created in Doncaster PCT in delivering improved Early Detection of Lung Cancer. The aim is for participants to replicate the process and to achieve a region-wide rollout.

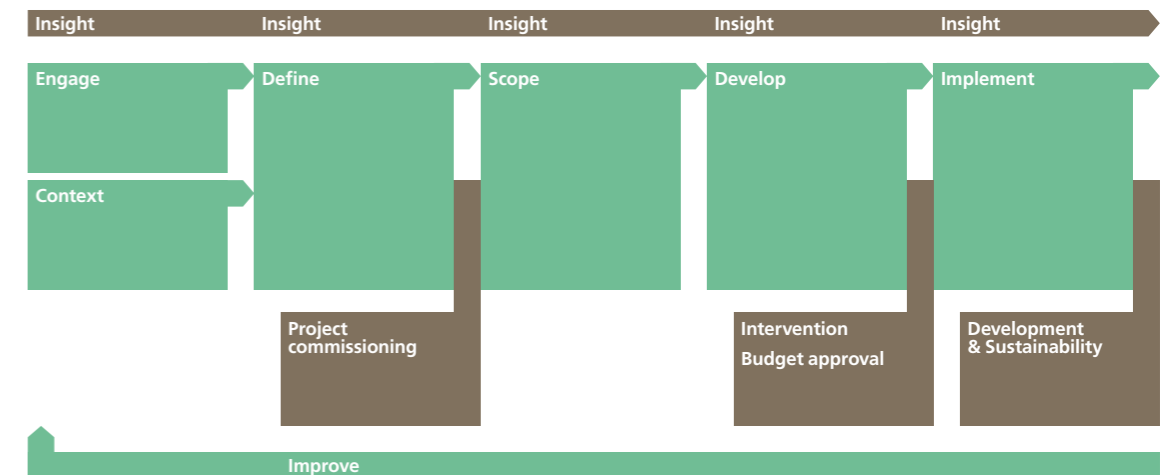
A small core expert team will support the running of the collaborative and its projects, as well as identifying how to place marketing and insight within the commissioning and provision of NHS services.

Adopting best-practice as the NHS marketing standard

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The following model has been agreed by the collaborative and will be adopted in line with best practice:

Fig.1 Social Marketing Model



Region-wide marketing collaborative priority projects

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Primary Care Access

[Sponsor Rob Webster](#)

[Chief Exec, NHS Calderdale](#)

There are two specific challenges to address:

- a Raising public awareness of the primary care options, whilst promoting a sense of responsibility to use services appropriately
- b Engaging the GP population in the changing needs and wants of patients, and encouraging them to develop their services accordingly.

This project will set out to determine how users and providers of primary care services currently behave and why. It will identify how we could influence a change in these behaviours.

Obesity

[Sponsor Simon Morrill](#)

[Chief Exec, NHS Bradford](#)

The requirement to offer vascular checks to all over 40 creates an opportunity to engage our communities in healthier lifestyles. Most PCTs will focus assessment and management on the 'High Risk' 20%; however, we must also deliver motivating and appropriate support for all if we are to ensure continuing improved health and high levels of recall attendance.

This project will identify motivations to change (learning from insights already gained in the Change 4 Life project and locally), developing a set of possible 'interventions and advice' that can be applied region-wide, but tailored for local service infrastructures.

Marketing Services

[Sponsor Karl Milner](#)

[\(SHA Director of Communications\)](#)

This project will identify a core 'roster' of proven expert partners in all marketing disciplines which will include national, regional and local providers. It will also identify common communication materials across the NHS, where a combined approach can yield greater cost effective impact.

End of Life

[Sponsor Alan Wittrick](#)

[Chief Exec, NHS Wakefield](#)

This project will establish a robust insight base and commission a research process, involving engagement with terminally ill patients and clinicians – leading to the delivery of a campaign.

Education & Training

[Sponsor Ailsa Claire](#)

[Chief Exec, NHS Barnsley](#)

This project will develop commissioning capacity in social marketing for local health communities.

Stroke

[Sponsor Jan Soberaj](#)

[Chief Exec NHS Sheffield](#)

The NHS (and the Stroke Association) is committed to promoting stroke as a medical emergency, both amongst the population at large and amongst clinicians. This project will examine the appetite of all stakeholders working within stroke services – from health improvement through to patient care and aftercare (including social services) – to adopt a customer view of the services they provide.

Mental Health

[Sponsor Ailsa Claire](#)

[Chief Exec, NHS Barnsley](#)

Recognised as a strategic region-wide priority, the likely area of focus will be around 'anti-stigma'. Contact is currently being made with the regions five key service providers in order to gain an understanding of the context for this project.

Information Management and Technology

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The SHA's National Programme for IT team, working in partnership with Local Health Communities (LHCs), has a key role in developing the information and IT infrastructure to underpin the models of care set out in Healthy Ambitions.

What is needed to support delivery of Healthy Ambitions?

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The SHA's NPfIT team aims to support delivery in the following ways:

- Delivering better, safer care: by ensuring that there is person-based information for clinical and care processes, which can be shared across organisational boundaries and available at the point of need, along with innovative technology to promote care closer to home
- Empowering staff to improve NHS performance: making information available to support research, planning and management, thereby improving the quality of care
- Empowering patients and the public: making information available about health, services, patients' own health and wellbeing and providing patients with secure access to their own electronic records thereby increasing their involvement in shaping the NHS and the choices available to them.

The longer term strategic aims of the NPfIT team, working in partnership with LHCs, are identified below and include those outlined in the 2009/10 Operating Framework.

- Electronic administrative systems (Advanced PAS)
- Electronic ordering and receipt of pathology and radiology tests (Order Communication)
- Electronic prescribing, dispensing and stock control linked to medical records (ePrescribing)
- Electronic production and transmission of clinical letters
- Systematic use of clinical codes in every NHS IM&T application
- Shared electronic patients records (the Detailed Care Records Service)
- Diagnostic images available electronically (PACS)
- Secure electronic communication between GPs and consultants
- Secure remote access to clinical systems.

All of the Clinical Pathway Groups identified that effective and integrated informatics and exploiting the use of technology was essential to the provision of high quality care for patients and the attached table indicates some of the current key developments and which pathways the SHA in partnership with local teams can currently, or potentially support.

The Clinical Pathway Groups which made particular recommendations requiring support from the NPfIT team are listed below:

End of Life CPG recommended that:

- High quality communication systems between services are required with the effective use of IM&T, to support seamless care.

Cross organizational care planning and communication processes across the health care system are already being developed and there is a clear recognition of the importance of effective communication between services for patients receiving end of life care. An event is planned in February 2009 looking at the benefits of an integrated system in palliative care services.

Maternity and Newborn CPG recommended that:

- The introduction of the maternity phase of Connecting for Health should be accelerated.

See section 11 in the attached table. Interim solutions are being developed where national solutions are not yet available. National contractual constraints often take priority over both the timing and priority of system release.

Long Term Conditions CPG recommended that:

- In order for our recommendations to become a reality, it is vital that support is given to providing the necessary joined up IT, information, premises and trained workforce.

The Yorkshire and Humber model for the future of Diabetes Care (see section 17 in attached table) paves the way for how technology can support integrated care planning to improve the care provided to people with Long Term Conditions.

Planned Care CPG recommended that:

- Clinical IT systems must be integrated, and fully utilised by clinicians. Integration of safe clinical services will not happen without robust IT systems.

A number of developments are underway which support this including work to ensure clinical requirements are captured by developing effective clinical engagement and understanding of IT systems. This ensures that systems are fit for purpose (see section 16 of attached table).

- Many people would like more care to be provided at home. In our focus group work, more care at home attracted the most support from a range of proposals. Technological developments in treatments and health monitoring means that the current range of home treatments should be expanded and be more widely available.

A number of projects are currently underway where technology is being used to support mobile working (section 9 of table), particularly for district nursing teams. Remote tele-consultation services are also available, for example in the prison service. Further opportunities for supporting patients in their own home are being explored currently.

- In addition to the ready availability of relevant clinical information for the treating clinician the CPG considered there should be a much more up-to-date IT use by patients. This includes:
 - Expanding patient booking of generalist care appointments on line
 - Patients seeing the test results on line
 - Patients tracking progress along their care pathway on line
 - Making Choose and Book two way, that is enabling specialist clinicians to send discharge information and book patient appointments on generalist clinics for stitch removal or other similar reasons
 - Supporting self-care.

A number of initiatives underway support IT use by patients. For example health space (section 12 in attached table) is available for patients who wish to have access to a web-based health organiser to support self care.

Acute CPG recommended that:

- The Y&H IT strategy should address the need for the rapid transfer of patient information in the urgent care setting. NPfIT solutions that allow the transfer of patient information (electronic record, electronic prescribing etc) should be accelerated such that it becomes the norm to share records across different parts of the NHS (with appropriate confidentiality safeguards).

Work around these requirements is underway for example in a number of A&E departments and Out of Hours services across the region the use of Systmone is supporting better consistency of care across routine primary and urgent care (see point 8 in attached table)

Mental Health CPG recommended that:

- Using choose and book methodologies (and IT) the gateway person could book a new referral into a slot in the diary of the therapist/ MH practitioner to allow rapid access with no queues.

Although Mental Health is not part of the Choose and Book targets it is possible for this recommendation to be achieved if IT systems currently used are Choose and Book compliant or replaced with Choose and Book compliant systems.

Who is taking this work forward?

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Locally, information management and technology plans are being developed which are aligned with the Healthy Ambitions pathway recommendations and with national and local NHS priorities. These plans will be underpinned by an assurance process run by the SHA to ensure that the appropriate infrastructure, including capacity and capability, exists locally.

To ensure NPfIT and wider technology development supports commissioning and contracting processes and into wider service development the SHA NPfIT team is working with LHCs to developing capacity and capability to deliver robust business change and ensure wise investment for the future. The SHA NPfIT team continues to support deployments of primary, secondary and community systems.

When is it happening?

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All the work mentioned above, and in the table at fig.1 below, has started. However different areas are at different stages in the process and the programme of work is also influenced by national developments; particularly in relation to contractual detail. The SHA assurance framework will be developed over the next few months and local IM&T Plans to be assessed against this.

Where is it happening already?

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Fig.1 demonstrates the more detailed work the SHA's NPfIT team has underway and the ways in which this supports the delivery of Healthy Ambitions recommendations.

Who will make sure that this work happens?

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Both the SHA assurance process and the local accountability structure for delivery of IM&T strategy will ensure that the platform for delivery is in place.

Fig.1

	1	2	3	4
Healthy Ambitions Enabling IM&T Developments	*Development of a PAS with integration with other systems and sophisticated reporting	*Order Communications & Diagnostics Reporting (including pathology/radiology tests ordered in primary care)	*Letters with coding (discharge summaries, clinic & A&E letters etc)	*Scheduling for beds, tests, theatres etc)
Staying Healthy	●	●	●	
Maternity & Newborn	●		●	●
Long Term Conditions	●	●	●	●
Children	●	●	●	●
Planned Care	●	●	●	●
Acute	●	●	●	●
Mental Health	●		●	●
End of Life	●	●	●	●
Comment	Better integration between providers of care & improved reporting to support service reform	Speed of results improved. Potential for more mobile diagnostics & electronic transfer of results	Ensures effective handover between services & continuity of care/staying healthy	More effective capacity planning/utilisation

	5	6	7	8	9
*ePrescribing (including TTO medicines)					
Roll out of choice agenda through Choose & Book					
Development of integrated records across health & social care					
Electronic patient record available at point of care (subject to appropriate information governance)					
Care closer to home including opportunity to access clinic systems in multiple physical locations (Mobile working)					
Staying Healthy	●				●
Maternity & Newborn	●	●		●	●
Long Term Conditions	●		●	●	●
Children	●			●	●
Planned Care	●			●	●
Acute	●			●	●
Mental Health	●	●	●	●	●
End of Life	●			●	●
Comment	Can reduce waits for prescriptions	C&B already available for planned care	Using SAP development to support this	Ensures consistency of care, reduces duplication of testing, & enables professionals not routinely involved in an individuals care to understand past medical history & consequently make more effective/appropriate clinical decisions. Supports choice	Most workstreams identified the need to look at new ways of working & to support care closer to home where possible. Examples include use of telemedicine, teleconsultation, telecare for LTC, older people & mobile working particularly for community nursing

NB green dots show where the development is critical to supporting the pathway, grey dots where there is an opportunity to explore how the development could support other pathway redesign.

*Part of 5 clinical aims in operating framework

Fig.1 Continued

	10	11	12	13	14	15	16	17
Healthy Ambitions Enabling IM&T Developments	Development of systems to support networking, discussion, sharing lessons etc – Espace	Development of Interim solutions where national solutions not yet available e.g. Evolution Maternity System, ORMIS theatres, PARIS, A&E etc	Health space development – web based personal health organiser to support self-care	Promotion of consistent IT systems – help to deliver consistent approach to recording and improved data quality	Learning Lessons Project to help try spread good practice	Development of Business Change methodologies for both IM&T enabled service improvement (Transformational Lifecycle) and optimisation of use of IT systems	Development of NPfIT User Groups to define information & data requirements & to be conduit to enhance NPfIT products	Diabetes LTC IT programme – transforming care planning & consequently the patient pathway using SysTmOne
Staying Healthy 	●	●	●	●	●	●	●	●
Maternity & Newborn 	●	●	●	●	●	●	●	●
Long Term Conditions 	●	●	●	●	●	●	●	●
Children 	●	●	●	●	●	●	●	●
Planned Care 	●	●	●	●	●	●	●	●
Acute 	●	●	●	●	●	●	●	●
Mental Health 	●	●	●	●	●	●	●	●
End of Life 	●	●	●	●	●	●	●	●
Comment	Each workstream identified a need to develop clinical networks to support delivery of HA. An espace site has been set up for each workstream but increased clinical engagement is required for this to work	Where NPfIT products are currently not available, interim solutions are being developed	All workstreams identified the need to develop support mechanisms to enable people to self care	All workstreams identified having access to information was key to improving service delivery	Pockets of small scale technological developments are developed locally (e.g. text message reminders/ results etc). The SHA is developing a framework to try promote & capture learning (both small and large scale)	These methodologies can be used by workstreams as a framework for service improvement	This will facilitate engagement & ownership as well as delivering products that are fit for purpose	Learning from this will support development of other LTCs. Also potential for using learning to support integrated pathway development across organisations in all workstreams

NB green dots show where the development is critical to supporting the pathway, grey dots where there is an opportunity to explore how the development could support other pathway redesign.

Workforce and Education

What is needed to support the delivery of Healthy Ambitions?

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A number of workforce and education themes run through all or many of the pathway recommendations:

- Increasing emphasis on prevention means more staff are needed in public health and in primary and community care with the skills to deliver the health inequalities and well being agenda – e.g. a widespread ability to undertake brief interventions
- Additional services provided in primary and community care (such as diagnostics, minor surgery, home births, emergency treatment and choosing to die at home) mean:
 - Making the best use of highly skilled staff – using GPs to see more complex cases and making better use of people such as community pharmacists
 - Developing new and extended roles for other staff, e.g. assistant practitioners in mental health and audiology, maternity support workers and staff who work across health and social care, and more specialist roles for nurses e.g. in diabetes and asthma care

- Better managed care means more dedicated staff to work as care coordinators/care navigators
- An increased focus on leadership for staff at all levels. This means we must develop capacity to systematically identify and develop talent, and in particular harness the existing potential of the clinical professions. Alongside local programmes, the SHA is taking steps to develop expertise in:
 - Defining leadership needs
 - Designing and delivering leadership interventions and/or commissioning leadership development which adds value.

Delivery of most workforce and education elements of pathways is dependent on:

- Increasing practice placement training capacity & supporting placement quality particularly in primary and community care settings
- Improving clinical skills facilities across the region – high quality simulated learning environments are increasingly vital to deliver fast responsive health services closer to the patient
- Much closer alignment of strategic workforce planning with service and financial planning. Commissioners and providers must work together with their HR staff at local level to understand the workforce and education implications of service changes for patient pathways.

Fig.1 Roles of different parts of the system in workforce development

	Key responsibilities	Example products
National	<ul style="list-style-type: none"> • Improvement against national priorities • Policy Development • Accountability to taxpayers • International benchmarking 	<ul style="list-style-type: none"> • High Quality Workforce strategy
SHA	<ul style="list-style-type: none"> • System leadership driving workforce and education improvement and alignment to service needs • Sound stewardship of MPET funds and investment in education and training • Set & performance manage clinical placement contracts with providers to ensure VFM, fitness for purpose and quality • Area wide talent management and leadership planning 	<ul style="list-style-type: none"> • Area wide 5 year workforce strategy and development plan • Learning and Development Agreements
Commissioner	<ul style="list-style-type: none"> • Publication of commissioning intentions drives local planning processes • Assessment of the quality, sustainability and deliverability of the summation of provider plans to identify key strategic of health and social care risks for the local economy (includes local labour market issues) • Development of shared improvement goals and the facilitation of cross boundary working 	<ul style="list-style-type: none"> • System wide 5 year workforce strategy and vision for the local health economy
Providers	<ul style="list-style-type: none"> • Workforce plan for own needs • Best employment practice • High quality clinical placements • Local employment and widening participation initiatives • Encourage research and innovation to inform practice • Investment in CPD and lifelong learning 	<ul style="list-style-type: none"> • Integrated 5 year business plans to identify future staff including numbers, skill mix and education training requirements

Sources of evidence: SHA assurance process, world class commissioning, staff survey, student feedback etc.

Who is taking this forward and where is it happening?

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- PCTs and providers are working with the SHA and Deanery to identify and address workforce risks and education needs requiring a system-wide approach
- New clinical placements have already been created in diverse settings such as GP practices, occupational health departments, BUPA and Corus. A project to create multidisciplinary advanced training practices in primary care has begun.
- The MPET review should facilitate creation of the training and education infrastructure in primary and community care by funding placement costs for staff other than doctors and dentists
- The SHA is investing substantially to ensure that up to date, high quality clinical skills facilities are accessible to all localities.
- All 10 universities in Y&H are mapping their healthcare provision against Healthy Ambitions pathways to be able to respond to the needs of health communities or individual organisations.
- Credit-based contracts for continuing professional development (CPD) with each university in Y&H are flexible enough to accommodate bespoke programmes for individual (or groups of) organisations. Educational content to meet Healthy Ambitions pathway recommendations can therefore be designed and delivered locally. Details of all education provision commissioned by the SHA are available in the Guide to Funding on the SHA website. http://www.yorksandhumber.nhs.uk/reports_and_publications/#F A CPD search engine to provide direct links to CPD courses supported by the SHA is being developed.

Risks and Issues

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Recruitment difficulties in particular staff groups may be a risk to delivering Healthy Ambitions, both now and in the longer term if not tackled. In many cases they are reinforced by the age profile of the current workforce.

Solutions are many and varied but include new and extended role development (e.g. midwifery support workers and family practitioners); increased education commissioning (e.g. radiographers); creation of new training posts for doctors; additional consultant appointments; improved preceptorship programmes for newly qualified nurses and midwives; return to practice programmes (e.g. for nurses and midwives), and in some cases international recruitment. Funded apprenticeships and basic level qualifications are available through the SHA/LSC partnership and the Support Staff Learning and Development Fund.

Many of the workforce and education implications are already being addressed through educational contracts. For example End of Life Care is included in all pre-registration curricula. CPD programmes have been commissioned that focus on communication skills training for palliative care and inter – professional advanced communication skills training is available for all sectors.

Some – such as supporting more widespread role development in the pharmacy workforce and understanding the workforce implications of the rainbow model for the staying healthy pathway – are still to do.

More detail is available in the SHA's publication 'Workforce Ambitions' which sets out what is happening, what is planned and what is still left to do.

Who will make sure that this work happens

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Tim Gilpin, Director of Workforce and Education and the workforce and education team will work with pathway delivery boards and task groups, health communities, clinical networks, PCTs and NHS Trusts, universities and a wide range of stakeholders to ensure that this work is taken forward.



Finance

Local Financial Context

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NHS Yorkshire and the Humber has successfully delivered its overall financial strategy since its inception in 2006. The financial strategy for 2009/10 and beyond is built on these firm foundations laid in the delivery of a planned surplus and the knowledge that no single PCT expects to overspend its budget. The financial strategy is to invest the current surplus of approximately 3% over the next 2 or 3 years leaving a reasonable level of contingency with which to manage any financial risk. The additional investment made through reducing the surplus, along with growth in annual funding, is expected to deliver significant health benefits for patients across the health economy.

Future Resource Implications

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The DH has given a commitment to the level of funding to be expected over the next 2 years. For NHS Y&H the average growth for the next two years is 5.7% and 5.6% respectively, ranging from a maximum 7.8% to a minimum 5.3% in 2009/10 and 6.9% to 5.2% in 2010/11. This equates to an increase in funds of £441m in 2009/10 and £459m in 2010/11. This represents a significant amount of new money that needs to be spent wisely in a planned way to maximise the benefits for patients.

We are not able to predict what will happen to the financial position of the NHS beyond 2010/11. The wider economic climate is likely to impact on the NHS as it will other public finances. With this in mind it is imperative that the funding available over the next 2 years is used to deliver our strategic priorities set out in this document and improve the health of our local populations.

PCT Financial Plans

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Every PCT has submitted a financial plan that aligned with its overall strategy at the end of October 2008. These medium term financial plans will be refreshed at the end of March 2009 in order to reflect the recently published financial allocations and Operating Framework.

It is expected that PCTs will have further developed their investment plans to ensure delivery of their local strategy, which will have been informed by Healthy Ambitions. The SHA will provide an overall analysis of these revised plans and demonstrate their alignment with Healthy Ambitions. It is expected this comparative analysis across each PCT will show how much funding is being invested across each Healthy Ambitions pathway. The methodology for this work is currently being explored with PCTs.

National Tariff

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2009/10 will see the introduction of a new national tariff (HRG V4) along with the introduction of a new suite of rules and levers to foster innovation and improvement. HRGv4 is a new currency designed so that pricing can support the delivery of services independent of their setting. Other developments include the unbundling of diagnostic imaging from the inpatient tariff, the provision of non mandatory tariffs for the acute phase of rehabilitation and the introduction of planned same day tariffs for day case patients to incentivise the shift of activity to less acute settings.

DH recognise the need for innovation and improvement. The PbR 2009/10 draft guidance states 'PbR is meant to be a tool not a strait-jacket. Having a national price for defined units of care is useful for both commissioners and providers'. 'However we recognise that a national pricing structure can never reflect the reality of the most innovative care occurring locally. Therefore, in line with the principle of subsidiarity, there needs to be the opportunity for local discretion, so that PbR is not seen as a barrier to providing the best care for patients. Within PbR, the application of such local discretion to national currencies and/or prices is referred to as flexibility'.

It is vital that these flexibilities are used to promote health improvement. The SHA currently provides PbR support to all Trusts and PCTs and this expertise can be called upon to work through when it would be appropriate to use these flexibilities to enhance patient care.

The tariff and quality

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We have developed the Quality Assurance and Improvement Scheme. The scheme covers the eight clinical pathways set out in Healthy Ambitions and covers the three quality domains of patient safety, effectiveness of care and patient experience.

The scheme is divided into two parts. The core (Part 1) scheme covers 24 quality indicators across acute, ambulance, mental health and community care services (CQUINS). PCTs also have flexibility to develop local schemes (Part 2) to support delivery of their key objectives set out in their strategic plan.

The scheme will begin in the financial year 2009-10, during which time additional indicators will be developed implementation in 2010-11.

The impact of this innovative approach will be monitored during the year to determine if these incentives achieve the objective of improving quality as defined by the measures themselves.

Within primary care, the national Quality and Outcomes Framework for GPs, rewards quality.

Personal health budgets

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The Long Term Conditions pathway recommended that we look at the scope to enable individual patients to have a personal health budget to put them more in control of their care. The Department of Health's [High Quality Care for All](#) gave a commitment that piloted schemes would be introduced and the legal framework amended to enable NHS resources to be given directly to patients to direct their own care. The Department of Health has invited PCTs to bid to pilot personal health budgets for three years starting in summer 2009. Areas suggested for piloting are: NHS continuing healthcare, mental health services, learning disability services, maternity services, end of life care and some long term conditions.

PCTs participating in the pilots would receive support for project costs but the budgets themselves would be funded from existing allocations. It will be important that the learning from the pilots is informed by, and in turn contributes to, work within local government to introduce personalised budgets for all clients of adult social services. A separate DCSF/DH pilot programme under the [Aiming High for Disabled Children Programme](#) invites local authorities and PCTs to pilot individual budgets for disabled children.

NHS Yorkshire and the Humber sees the opportunity to pilot personal health budgets as an important element of taking forward work to increase the quality of care through the involvement of people in managing their own care. Links will be made with long term conditions pathway delivery arrangements and with local government colleagues dealing with personalization developments to help share learning and best practice.



Performance & Outcome Metrics

Measuring our progress

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It is now crucial that we are able to measure and demonstrate our progress.

Whilst PCTs will be developing their own suite of indicators to assess progress against their local strategies, we also agreed to develop a set of regional indicators relating to the eight clinical pathways set out in Healthy Ambitions.

The indicators are based on routinely available data and we believe that together they can act as a starting point for understanding delivery of Healthy Ambitions. As new data becomes available (including those generated through the quality in contracts scheme) we will revisit the dataset and add additional indicators as appropriate.

We have developed a dashboard which presents the data to allow progress to be tracked over time and make comparisons across PCTs. This will be updated each month and published on the SHA website.

Progress against these indicators will be built into the PCT business cycle and in particular we would expect to see:

- Clear read across between improvements on these indicators and the goals set out in the PCTs' strategic plan and world class commissioning outcomes choices
- The approach to delivery against these trajectories will be set out in the PCTs annual operating plan.

2009-10 will run as a development year and PCTs will determine their trajectories against each indicator locally. Beyond this the indicators will be subsumed more formally into the normal performance management cycle between the Strategic Health Authority and PCTs. This will involve:

- Performance against the indicators will be discussed at the SHA Board
- Individual PCTs performance managed in the usual way through the six month and annual review process.

Fig.1 Dashboard of PCT Healthy Ambitions Indicators

Clinical Pathway	Indicators	Frequency
Staying Healthy	• Obesity prevalence amongst reception and year 6 children	Annual
	• The proportion of patients in a practice who have had their BMI recorded.	Quarterly
	• % Obesity (<16yrs). (This figure will only be used if the BMI recorded data quality threshold of 56% has been achieved).	Quarterly
Maternity and Newborn	• Percentage of mothers breastfeeding on discharge home	Quarterly
	• Percentage of mothers still breastfeeding at 6-8 weeks.	Quarterly
	• Staffing ratios: Midwives employed per 1000 births and levels of consultant cover	Monthly
Long Term Conditions	• Admissions and readmissions from a diabetes related episode	Monthly
	• Length of stay for diabetes – admissions and readmissions	Monthly
	• % of people with diabetes offered diabetic retinopathy screenings	Quarterly
	• Patients with diabetes in whom the last HbA1c is 7.5 or less	Annual
Children's	• Number of children admitted to hospital for asthmatic episodes (by 5 year age band under 20yrs)	Monthly
	• Re-admission rates for children with asthmatic episodes (within 3 months)	Monthly
	• Average length of stay for asthma	Monthly
Planned Care	• Number of outpatient appointments per spell of treatment (hip and knee)	Monthly
	• Admission and readmission rates (within 3 months) (hip and knee)	Monthly
	• Average length of stay (hip and knee)	Monthly
	• Day surgery rate	Monthly
Acute Episode	• Stroke mortality per 100,000	Annual
	• Stroke and TIA admissions and readmissions per 100,000 population	Annual
	• Stroke and TIA readmissions within 3 months	Monthly
	• % of patients receiving thrombolysis within 60 mins of ambulance call	Quarterly
Mental Health	• % of TIA with a higher risk of stroke who are treated within 24 hrs	Quarterly
	We are working to identify how we might develop metrics as follows:	All Quarterly
	• Acute Care Pathway: - Assessment within 4hrs for people entering the Urgent Care Pathway requirement urgent assessment of need for home treatment or in-patient care	
End of Life	• Non Urgent pathway - Baseline data will be collected on the number and percentage of service users of all ages referral to a non-urgent pathway who receive an assessment by a qualified practitioner within 14 days of referral (number of days to be decided)	
	• Percentage of patients who die at home	TBC
	• Percentage of wards on which patients are on The Liverpool care pathway (or equivalent).	

Quality & Innovation

Introduction

25

Healthy Ambitions sets out an ambitious programme for change in NHS Y&H. Successful implementation will depend on harnessing the creativity and energy of staff at every level in every NHS organisation across the region.

Key Strategic Aims

26

We will work with NHS organisations across Y&H to promote quality improvement and innovation in the following ways:

NHS Quality Foundation for Yorkshire and the Humber

27

In 2009, to meet our new statutory responsibility for promoting innovation, we will work with the NHS in Y&H and with other partners to co-create and establish an NHS Quality Foundation for Y&H. Building on the relationships, networks and partnerships already in place the NHS Quality Foundation will enable front-line leaders, teams and organisations to innovate and improve.

An emerging model for the NHS Quality Foundation (fig.1) is being developed through dialogue with senior executive and clinical leaders from both NHS and partner organisations across the region.

The NHS Quality Foundation will support the implementation of Healthy Ambitions in four ways:

- The provision of dynamic, responsive strategic intelligence to support delivery of high quality health and social care
- Support for innovation and improvement at every level in the NHS

- Support for developing business and systems excellence in organisations and health communities across the region. Ensuring service functions connect directly and effectively with mainstream business processes
- Ensuring the NHS in Yorkshire and the Humber is recognised nationally and internationally as a leading centre for quality improvement and innovation

The NHS Quality Foundation will adopt a broad interpretation of innovation from discovery to adoption and will promote and support innovations that seek to improve the safety and effectiveness of healthcare and the patient's experience. We will develop our approach to PROMS and PREMS and ensure that patients perceptions of outcomes and experience are a key feature of our approach. These will include innovation in care delivery, business processes, products and technology.

It is anticipated that the NHS Quality Foundation will facilitate events for leaders to meet together and explore key strategic issues. These might include, for example, the more complex challenges in implementing Healthy Ambitions. The output of these events will guide the NHS Quality Foundation in piloting innovative solutions to support the delivery of agreed priorities and system wide service challenges.

There are many partners with significant expertise within our region already actively engaged in innovation and improvement work. Amongst others, these partners include our local NHS organisations and clinical networks, Medipex – the regional NHS Innovation Hub; Higher Educational Institutions, Yorkshire Forward – the Regional Development Agency, local business, the NHS National Innovation Centre, the NHS Institute for Innovation and Improvement, the Institute for Healthcare Improvement and the Jönköping County Council in Sweden.

A Chief Executive will be recruited in early 2009 to lead the development of the Quality Foundation with a formal launch planned for October 2009.

This programme of support will be taken forward in 2009 as part of work to support the development of PCTs as World Class Commissioners.

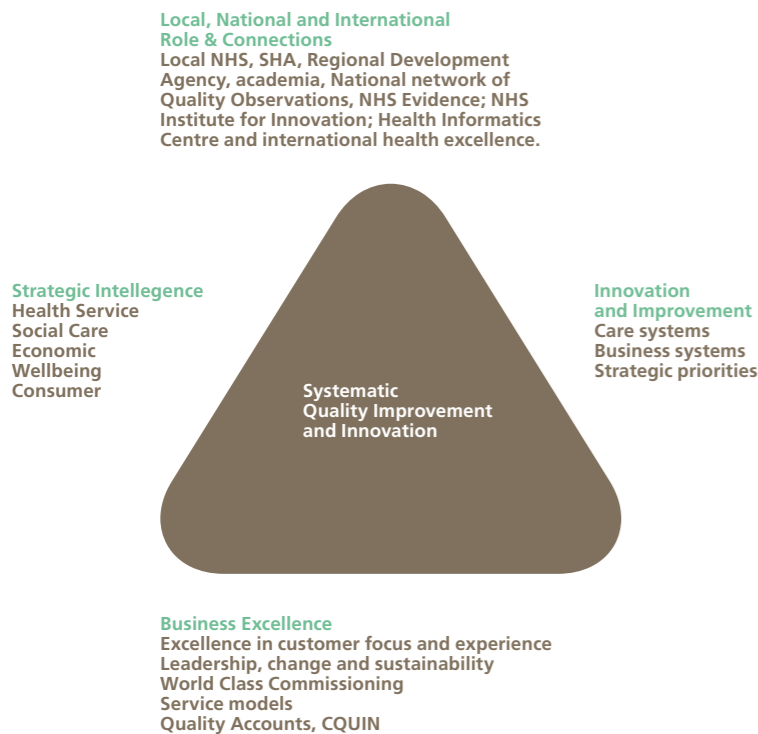
Supporting PCTs in local implementation

28 We will work with PCTs as leaders of the local NHS, in supporting the local delivery of Healthy Ambitions. Our impact will be in supporting PCTs to develop capacity and capability within health communities for leading large scale change. We will applying effective innovation and improvement methodologies and align pilot opportunities to support delivery. We will industrialise the spread of innovations and promote recognition and reward for the delivery of quality improvements and innovations.

Who will make sure that this work happens

29 The strategic aims set out in this chapter reflect significant cross directorate working on quality improvement and innovation. Rosamond Roughton, NHS Y&H Director of Strategy and System Reform will oversee the delivery of the strategic aims working in partnership with the SHA senior management team, the local NHS and other partner agencies.

Fig.1 Quality Foundation for Yorkshire and Humber – An Emerging Model



Health Intelligence

30 Driving improvements in quality relies on high quality, timely data. Y&H Public Health Observatory (YHPHO) is an NHS organisation providing high-quality health intelligence to improve planning and decision-making in the NHS, local and regional government sectors.

Health Intelligence Yorkshire and the Humber – 'HIYAH'

31 The fourteen PCTs in the region have agreed to support a step change in the capacity of the health intelligence function at regional and local level. YHPHO is co-ordinating this work on their behalf. A HIYAH Commissioning Board and a PCT Health Intelligence Leads Group have been established to oversee this work. An initial set of project briefs have been agreed including the development of a regional training programme for health intelligence analysts.

A number of YHPHO and HIYAH workstreams have been developed to support the recommendations made in Healthy Ambitions. Examples of the support the PHO plan to offer for the delivery of each clinical pathway include:



Staying Healthy

- Gathering of cost-effectiveness evidence relating to healthy weight, alcohol and smoking cessation as part of the development of the National Public Health Library
- Analysing the National Child Measurement Programme data, providing data on the weight and measurement of children in Reception (4-5 years) and Year 6 (aged 10-11 years) to assess overweight and obesity levels
- Populating the key indicators within the alcohol performance tracking process led by NHS Yorkshire and Humber/Regional Public Health Group, Government Office
- Developing the use of geo-demographic data to support social marketing
- Providing a learning network for practitioners working to support their local population to improve their mental health, be more physically active and to eat more healthily.



Maternity and Newborn

- Ongoing analysis of progress against the national infant mortality targets, with supporting briefing material where appropriate
- Establishing ChiMat to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health. A regional programme will be developed to support the Healthy Ambitions workstream.



Long Term Conditions

- Developing prevalence modelling tools such as the PBS Diabetes Prevalence model
- Developing diabetes community health profiles, providing downloadable PDFs with a summary of diabetes related data for all PCTs in England to allow appropriate benchmarking
- Undertaking analysis of ketoacidosis admissions in collaboration with the University College London
- Working with national partners to develop the National Diabetes Information Service (NDIS) to improve access to high quality diabetes data and information
- Developing LTC indicators within the practice level profiles already available in order to identify potential variances in approach to care and management. Particular reference will be made to prescribing and outcome measures within primary care
- Supporting the development of tools and guidance through the Association of PHOs with regard to Joint Strategic Needs Assessment (JSNA).



Children's Services

- Active involvement in the work currently being led by the National Clinical Director for Diabetes together with the Royal College of Paediatrics to assess the number of children with diabetes in England
- Continuing to establish a national theme based observatory CHiMat to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health. A regional programme will be developed to support Healthy Ambitions
- Developing a health needs assessment template for children with diabetes through ChiMat for use by commissioners.



Planned Care

- Providing access to high-level HES analysis support to underpin service review planning and reconfiguration planning
- Continuing to act as a source of regional expertise on primary care profiling in relation to quality and access to primary care services.



Acute Care

- Leading on the development of a cardiac/stroke commissioning e-Toolkit to support the work of the three cardiac/stroke networks in the region.



Mental Health

- Providing access to the data from the Mental Health Minimum Dataset in order to support joint mental health needs assessment across the region.



End of Life Care Pathway Group

- Exploring the practical use of existing indicators of end of life care including analyses on place of death data and deaths in hospital within 72 hrs of admission in people known to have a terminal illness.



Primary Care

- The health intelligence practice profiles provide practice level information on a range of quality and access measures. PCTs will consider how this information can be made accessible to their populations to help support choice of general practice.

YHPHO will continue to work closely with the SHA and PCTs (through HIYAH) to identify opportunities where high-quality health intelligence can help develop services in line with Healthy Ambitions recommendations and regional priorities.